

HB1546



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB1546

Introduced 1/31/2023, by Rep. Dan Ugaste

SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

Amends the Workers' Compensation Act. Provides that the Illinois Workers' Compensation Commission, upon consultation with the Workers' Compensation Medical Fee Advisory Board, shall adopt an evidence-based drug formulary. Requires prescriptions in workers' compensation cases to be limited to the drugs on the formulary. Effective immediately.

LRB103 05095 SPS 50109 b

A BILL FOR

1 AN ACT concerning employment.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Workers' Compensation Act is amended by
5 changing Section 8.2 as follows:

6 (820 ILCS 305/8.2)

7 Sec. 8.2. Fee schedule.

8 (a) Except as provided for in subsection (c), for
9 procedures, treatments, or services covered under this Act and
10 rendered or to be rendered on and after February 1, 2006, the
11 maximum allowable payment shall be 90% of the 80th percentile
12 of charges and fees as determined by the Commission utilizing
13 information provided by employers' and insurers' national
14 databases, with a minimum of 12,000,000 Illinois line item
15 charges and fees comprised of health care provider and
16 hospital charges and fees as of August 1, 2004 but not earlier
17 than August 1, 2002. These charges and fees are provider
18 billed amounts and shall not include discounted charges. The
19 80th percentile is the point on an ordered data set from low to
20 high such that 80% of the cases are below or equal to that
21 point and at most 20% are above or equal to that point. The
22 Commission shall adjust these historical charges and fees as
23 of August 1, 2004 by the Consumer Price Index-U for the period

1 August 1, 2004 through September 30, 2005. The Commission
2 shall establish fee schedules for procedures, treatments, or
3 services for hospital inpatient, hospital outpatient,
4 emergency room and trauma, ambulatory surgical treatment
5 centers, and professional services. These charges and fees
6 shall be designated by geozip or any smaller geographic unit.
7 The data shall in no way identify or tend to identify any
8 patient, employer, or health care provider. As used in this
9 Section, "geozip" means a three-digit zip code based on data
10 similarities, geographical similarities, and frequencies. A
11 geozip does not cross state boundaries. As used in this
12 Section, "three-digit zip code" means a geographic area in
13 which all zip codes have the same first 3 digits. If a geozip
14 does not have the necessary number of charges and fees to
15 calculate a valid percentile for a specific procedure,
16 treatment, or service, the Commission may combine data from
17 the geozip with up to 4 other geozips that are demographically
18 and economically similar and exhibit similarities in data and
19 frequencies until the Commission reaches 9 charges or fees for
20 that specific procedure, treatment, or service. In cases where
21 the compiled data contains less than 9 charges or fees for a
22 procedure, treatment, or service, reimbursement shall occur at
23 76% of charges and fees as determined by the Commission in a
24 manner consistent with the provisions of this paragraph.
25 Providers of out-of-state procedures, treatments, services,
26 products, or supplies shall be reimbursed at the lesser of

1 that state's fee schedule amount or the fee schedule amount
2 for the region in which the employee resides. If no fee
3 schedule exists in that state, the provider shall be
4 reimbursed at the lesser of the actual charge or the fee
5 schedule amount for the region in which the employee resides.
6 Not later than September 30 in 2006 and each year thereafter,
7 the Commission shall automatically increase or decrease the
8 maximum allowable payment for a procedure, treatment, or
9 service established and in effect on January 1 of that year by
10 the percentage change in the Consumer Price Index-U for the 12
11 month period ending August 31 of that year. The increase or
12 decrease shall become effective on January 1 of the following
13 year. As used in this Section, "Consumer Price Index-U" means
14 the index published by the Bureau of Labor Statistics of the
15 U.S. Department of Labor, that measures the average change in
16 prices of all goods and services purchased by all urban
17 consumers, U.S. city average, all items, 1982-84=100.

18 (a-1) Notwithstanding the provisions of subsection (a) and
19 unless otherwise indicated, the following provisions shall
20 apply to the medical fee schedule starting on September 1,
21 2011:

22 (1) The Commission shall establish and maintain fee
23 schedules for procedures, treatments, products, services,
24 or supplies for hospital inpatient, hospital outpatient,
25 emergency room, ambulatory surgical treatment centers,
26 accredited ambulatory surgical treatment facilities,

1 prescriptions filled and dispensed outside of a licensed
2 pharmacy, dental services, and professional services. This
3 fee schedule shall be based on the fee schedule amounts
4 already established by the Commission pursuant to
5 subsection (a) of this Section. However, starting on
6 January 1, 2012, these fee schedule amounts shall be
7 grouped into geographic regions in the following manner:

8 (A) Four regions for non-hospital fee schedule
9 amounts shall be utilized:

10 (i) Cook County;

11 (ii) DuPage, Kane, Lake, and Will Counties;

12 (iii) Bond, Calhoun, Clinton, Jersey,
13 Macoupin, Madison, Monroe, Montgomery, Randolph,
14 St. Clair, and Washington Counties; and

15 (iv) All other counties of the State.

16 (B) Fourteen regions for hospital fee schedule
17 amounts shall be utilized:

18 (i) Cook, DuPage, Will, Kane, McHenry, DeKalb,
19 Kendall, and Grundy Counties;

20 (ii) Kankakee County;

21 (iii) Madison, St. Clair, Macoupin, Clinton,
22 Monroe, Jersey, Bond, and Calhoun Counties;

23 (iv) Winnebago and Boone Counties;

24 (v) Peoria, Tazewell, Woodford, Marshall, and
25 Stark Counties;

26 (vi) Champaign, Piatt, and Ford Counties;

- 1 (vii) Rock Island, Henry, and Mercer Counties;
2 (viii) Sangamon and Menard Counties;
3 (ix) McLean County;
4 (x) Lake County;
5 (xi) Macon County;
6 (xii) Vermilion County;
7 (xiii) Alexander County; and
8 (xiv) All other counties of the State.

9 (2) If a geozip, as defined in subsection (a) of this
10 Section, overlaps into one or more of the regions set
11 forth in this Section, then the Commission shall average
12 or repeat the charges and fees in a geozip in order to
13 designate charges and fees for each region.

14 (3) In cases where the compiled data contains less
15 than 9 charges or fees for a procedure, treatment,
16 product, supply, or service or where the fee schedule
17 amount cannot be determined by the non-discounted charge
18 data, non-Medicare relative values and conversion factors
19 derived from established fee schedule amounts, coding
20 crosswalks, or other data as determined by the Commission,
21 reimbursement shall occur at 76% of charges and fees until
22 September 1, 2011 and 53.2% of charges and fees thereafter
23 as determined by the Commission in a manner consistent
24 with the provisions of this paragraph.

25 (4) To establish additional fee schedule amounts, the
26 Commission shall utilize provider non-discounted charge

1 data, non-Medicare relative values and conversion factors
2 derived from established fee schedule amounts, and coding
3 crosswalks. The Commission may establish additional fee
4 schedule amounts based on either the charge or cost of the
5 procedure, treatment, product, supply, or service.

6 (5) Implants shall be reimbursed at 25% above the net
7 manufacturer's invoice price less rebates, plus actual
8 reasonable and customary shipping charges whether or not
9 the implant charge is submitted by a provider in
10 conjunction with a bill for all other services associated
11 with the implant, submitted by a provider on a separate
12 claim form, submitted by a distributor, or submitted by
13 the manufacturer of the implant. "Implants" include the
14 following codes or any substantially similar updated code
15 as determined by the Commission: 0274
16 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens
17 implant); 0278 (implants); 0540 and 0545 (ambulance); 0624
18 (investigational devices); and 0636 (drugs requiring
19 detailed coding). Non-implantable devices or supplies
20 within these codes shall be reimbursed at 65% of actual
21 charge, which is the provider's normal rates under its
22 standard chargemaster. A standard chargemaster is the
23 provider's list of charges for procedures, treatments,
24 products, supplies, or services used to bill payers in a
25 consistent manner.

26 (6) The Commission shall automatically update all

1 codes and associated rules with the version of the codes
2 and rules valid on January 1 of that year.

3 (a-2) For procedures, treatments, services, or supplies
4 covered under this Act and rendered or to be rendered on or
5 after September 1, 2011, the maximum allowable payment shall
6 be 70% of the fee schedule amounts, which shall be adjusted
7 yearly by the Consumer Price Index-U, as described in
8 subsection (a) of this Section.

9 (a-3) Prescriptions filled and dispensed outside of a
10 licensed pharmacy shall be subject to a fee schedule that
11 shall not exceed the Average Wholesale Price (AWP) plus a
12 dispensing fee of \$4.18. AWP or its equivalent as registered
13 by the National Drug Code shall be set forth for that drug on
14 that date as published in Medi-Span ~~Medispan~~.

15 (a-4) By September 1, 2023, the Commission, in
16 consultation with the Workers' Compensation Medical Fee
17 Advisory Board, shall adopt by rule an evidence-based drug
18 formulary and any rules necessary for its administration.
19 Prescriptions prescribed for workers' compensation cases shall
20 be limited to the prescription drugs and doses on the closed
21 formulary.

22 A request for a prescription that is not on the closed
23 formulary shall be reviewed under Section 8.7.

24 (b) Notwithstanding the provisions of subsection (a), if
25 the Commission finds that there is a significant limitation on
26 access to quality health care in either a specific field of

1 health care services or a specific geographic limitation on
2 access to health care, it may change the Consumer Price
3 Index-U increase or decrease for that specific field or
4 specific geographic limitation on access to health care to
5 address that limitation.

6 (c) The Commission shall establish by rule a process to
7 review those medical cases or outliers that involve
8 extra-ordinary treatment to determine whether to make an
9 additional adjustment to the maximum payment within a fee
10 schedule for a procedure, treatment, or service.

11 (d) When a patient notifies a provider that the treatment,
12 procedure, or service being sought is for a work-related
13 illness or injury and furnishes the provider the name and
14 address of the responsible employer, the provider shall bill
15 the employer or its designee directly. The employer or its
16 designee shall make payment for treatment in accordance with
17 the provisions of this Section directly to the provider,
18 except that, if a provider has designated a third-party
19 billing entity to bill on its behalf, payment shall be made
20 directly to the billing entity. Providers shall submit bills
21 and records in accordance with the provisions of this Section.

22 (1) All payments to providers for treatment provided
23 pursuant to this Act shall be made within 30 days of
24 receipt of the bills as long as the bill contains
25 substantially all the required data elements necessary to
26 adjudicate the bill.

1 (2) If the bill does not contain substantially all the
2 required data elements necessary to adjudicate the bill,
3 or the claim is denied for any other reason, in whole or in
4 part, the employer or insurer shall provide written
5 notification to the provider in the form of an explanation
6 of benefits explaining the basis for the denial and
7 describing any additional necessary data elements within
8 30 days of receipt of the bill. The Commission, with
9 assistance from the Medical Fee Advisory Board, shall
10 adopt rules detailing the requirements for the explanation
11 of benefits required under this subsection.

12 (3) In the case (i) of nonpayment to a provider within
13 30 days of receipt of the bill which contained
14 substantially all of the required data elements necessary
15 to adjudicate the bill, (ii) of nonpayment to a provider
16 of a portion of such a bill, or (iii) where the provider
17 has not been issued an explanation of benefits for a bill,
18 the bill, or portion of the bill up to the lesser of the
19 actual charge or the payment level set by the Commission
20 in the fee schedule established in this Section, shall
21 incur interest at a rate of 1% per month payable by the
22 employer to the provider. Any required interest payments
23 shall be made by the employer or its insurer to the
24 provider within 30 days after payment of the bill.

25 (4) If the employer or its insurer fails to pay
26 interest within 30 days after payment of the bill as

1 required pursuant to paragraph (3), the provider may bring
2 an action in circuit court for the sole purpose of seeking
3 payment of interest pursuant to paragraph (3) against the
4 employer or its insurer responsible for insuring the
5 employer's liability pursuant to item (3) of subsection
6 (a) of Section 4. The circuit court's jurisdiction shall
7 be limited to enforcing payment of interest pursuant to
8 paragraph (3). Interest under paragraph (3) is only
9 payable to the provider. An employee is not responsible
10 for the payment of interest under this Section. The right
11 to interest under paragraph (3) shall not delay, diminish,
12 restrict, or alter in any way the benefits to which the
13 employee or his or her dependents are entitled under this
14 Act.

15 The changes made to this subsection (d) by this amendatory
16 Act of the 100th General Assembly apply to procedures,
17 treatments, and services rendered on and after the effective
18 date of this amendatory Act of the 100th General Assembly.

19 (e) Except as provided in subsections (e-5), (e-10), and
20 (e-15), a provider shall not hold an employee liable for costs
21 related to a non-disputed procedure, treatment, or service
22 rendered in connection with a compensable injury. The
23 provisions of subsections (e-5), (e-10), (e-15), and (e-20)
24 shall not apply if an employee provides information to the
25 provider regarding participation in a group health plan. If
26 the employee participates in a group health plan, the provider

1 may submit a claim for services to the group health plan. If
2 the claim for service is covered by the group health plan, the
3 employee's responsibility shall be limited to applicable
4 deductibles, co-payments, or co-insurance. Except as provided
5 under subsections (e-5), (e-10), (e-15), and (e-20), a
6 provider shall not bill or otherwise attempt to recover from
7 the employee the difference between the provider's charge and
8 the amount paid by the employer or the insurer on a compensable
9 injury, or for medical services or treatment determined by the
10 Commission to be excessive or unnecessary.

11 (e-5) If an employer notifies a provider that the employer
12 does not consider the illness or injury to be compensable
13 under this Act, the provider may seek payment of the
14 provider's actual charges from the employee for any procedure,
15 treatment, or service rendered. Once an employee informs the
16 provider that there is an application filed with the
17 Commission to resolve a dispute over payment of such charges,
18 the provider shall cease any and all efforts to collect
19 payment for the services that are the subject of the dispute.
20 Any statute of limitations or statute of repose applicable to
21 the provider's efforts to collect payment from the employee
22 shall be tolled from the date that the employee files the
23 application with the Commission until the date that the
24 provider is permitted to resume collection efforts under the
25 provisions of this Section.

26 (e-10) If an employer notifies a provider that the

1 employer will pay only a portion of a bill for any procedure,
2 treatment, or service rendered in connection with a
3 compensable illness or disease, the provider may seek payment
4 from the employee for the remainder of the amount of the bill
5 up to the lesser of the actual charge, negotiated rate, if
6 applicable, or the payment level set by the Commission in the
7 fee schedule established in this Section. Once an employee
8 informs the provider that there is an application filed with
9 the Commission to resolve a dispute over payment of such
10 charges, the provider shall cease any and all efforts to
11 collect payment for the services that are the subject of the
12 dispute. Any statute of limitations or statute of repose
13 applicable to the provider's efforts to collect payment from
14 the employee shall be tolled from the date that the employee
15 files the application with the Commission until the date that
16 the provider is permitted to resume collection efforts under
17 the provisions of this Section.

18 (e-15) When there is a dispute over the compensability of
19 or amount of payment for a procedure, treatment, or service,
20 and a case is pending or proceeding before an Arbitrator or the
21 Commission, the provider may mail the employee reminders that
22 the employee will be responsible for payment of any procedure,
23 treatment or service rendered by the provider. The reminders
24 must state that they are not bills, to the extent practicable
25 include itemized information, and state that the employee need
26 not pay until such time as the provider is permitted to resume

1 collection efforts under this Section. The reminders shall not
2 be provided to any credit rating agency. The reminders may
3 request that the employee furnish the provider with
4 information about the proceeding under this Act, such as the
5 file number, names of parties, and status of the case. If an
6 employee fails to respond to such request for information or
7 fails to furnish the information requested within 90 days of
8 the date of the reminder, the provider is entitled to resume
9 any and all efforts to collect payment from the employee for
10 the services rendered to the employee and the employee shall
11 be responsible for payment of any outstanding bills for a
12 procedure, treatment, or service rendered by a provider.

13 (e-20) Upon a final award or judgment by an Arbitrator or
14 the Commission, or a settlement agreed to by the employer and
15 the employee, a provider may resume any and all efforts to
16 collect payment from the employee for the services rendered to
17 the employee and the employee shall be responsible for payment
18 of any outstanding bills for a procedure, treatment, or
19 service rendered by a provider as well as the interest awarded
20 under subsection (d) of this Section. In the case of a
21 procedure, treatment, or service deemed compensable, the
22 provider shall not require a payment rate, excluding the
23 interest provisions under subsection (d), greater than the
24 lesser of the actual charge or the payment level set by the
25 Commission in the fee schedule established in this Section.
26 Payment for services deemed not covered or not compensable

1 under this Act is the responsibility of the employee unless a
2 provider and employee have agreed otherwise in writing.
3 Services not covered or not compensable under this Act are not
4 subject to the fee schedule in this Section.

5 (f) Nothing in this Act shall prohibit an employer or
6 insurer from contracting with a health care provider or group
7 of health care providers for reimbursement levels for benefits
8 under this Act different from those provided in this Section.

9 (g) On or before January 1, 2010 the Commission shall
10 provide to the Governor and General Assembly a report
11 regarding the implementation of the medical fee schedule and
12 the index used for annual adjustment to that schedule as
13 described in this Section.

14 (Source: P.A. 100-1117, eff. 11-27-18; 100-1175, eff.
15 1-11-19.)

16 Section 99. Effective date. This Act takes effect upon
17 becoming law.