



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB2840

Introduced 2/6/2025, by Rep. Dan Ugaste

SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

Amends the Workers' Compensation Act. Makes existing medical fee schedules inoperative after August 31, 2026. Provides that the Illinois Workers' Compensation Commission shall establish new medical fee schedules applicable on and after September 1, 2026 in accordance with specified criteria. Provides for 4 non-hospital fee schedules and 14 hospital fee schedules applicable to different geographic areas of the State. Sets forth a procedure for petitioning the Commission if a maximum fee causes a significant limitation on access to quality health care in either a specific field of health care services or a specific geographic limitation on access to health care. Effective immediately.

LRB104 11298 SPS 21384 b

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 The provisions of this subsection (a), other than this
19 sentence, are inoperative after August 31, 2026.

20 (a-1) Notwithstanding the provisions of subsection (a) and
21 unless otherwise indicated, the following provisions shall
22 apply to the medical fee schedule starting on September 1,
23 2011:

24 (1) The Commission shall establish and maintain fee
25 schedules for procedures, treatments, products, services,
26 or supplies for hospital inpatient, hospital outpatient,

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

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

12 (i) Cook County;

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

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

17 (iv) All other counties of the State.

18 (B) Fourteen regions for hospital fee schedule
19 amounts shall be utilized:

20 (i) Cook, DuPage, Will, Kane, McHenry, DeKalb,
21 Kendall, and Grundy Counties;

22 (ii) Kankakee County;

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

25 (iv) Winnebago and Boone Counties;

26 (v) Peoria, Tazewell, Woodford, Marshall, and

1 Stark Counties;

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

3 (vii) Rock Island, Henry, and Mercer Counties;

4 (viii) Sangamon and Menard Counties;

5 (ix) McLean County;

6 (x) Lake County;

7 (xi) Macon County;

8 (xii) Vermilion County;

9 (xiii) Alexander County; and

10 (xiv) All other counties of the State.

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

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

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

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

1 consistent manner.

2 (6) The Commission shall automatically update all
3 codes and associated rules with the version of the codes
4 and rules valid on January 1 of that year.

5 The provisions of this subsection (a-1), other than this
6 sentence, are inoperative after August 31, 2026.

7 (a-1.5) The following provisions apply to procedures,
8 treatments, services, products, and supplies covered under
9 this Act and rendered or to be rendered on or after September
10 1, 2026:

11 (1) In this Section:

12 "CPT code" means each Current Procedural Terminology
13 code, for each geographic region specified in subsection
14 (b) of this Section, included on the most recent medical
15 fee schedule established by the Commission pursuant to
16 this Section.

17 "DRG code" means each current diagnosis related group
18 code, for each geographic region specified in subsection
19 (b) of this Section, included on the most recent medical
20 fee schedule established by the Commission pursuant to
21 this Section.

22 "Geozip" means a three-digit zip code based on data
23 similarities, geographical similarities, and frequencies.

24 "Health care services" means those CPT and DRG codes
25 for procedures, treatments, products, services or supplies
26 for hospital inpatient, hospital outpatient, emergency

1 room, ambulatory surgical treatment centers, accredited
2 ambulatory surgical treatment facilities, and professional
3 services. "Health care services" does not include codes
4 classified as healthcare common procedure coding systems
5 or dental.

6 "Medicare maximum fee" means, for each CPT and DRG
7 code, the current maximum fee for that CPT or DRG code
8 allowed to be charged by the Centers for Medicare and
9 Medicaid Services for Medicare patients in that geographic
10 region. The Medicare maximum fee shall be the greater of
11 (i) the current maximum fee allowed to be charged by the
12 Centers for Medicare and Medicaid Services for Medicare
13 patients in the geographic region or (ii) the maximum fee
14 charged by the Centers for Medicare and Medicaid Services
15 for Medicare patients in the geographic region on January
16 1, 2026.

17 "Medicare percentage amount" means, for each CPT and
18 DRG code, the workers' compensation maximum fee as a
19 percentage of the Medicare maximum fee.

20 "Workers' compensation maximum fee" means, for each
21 CPT and DRG code, the current maximum fee allowed to be
22 charged under the medical fee schedule established by the
23 Commission for that CPT or DRG code in that geographic
24 region.

25 (2) The Commission shall establish and maintain fee
26 schedules for procedures, treatments, products, services,

1 or supplies for hospital inpatient, hospital outpatient,
2 emergency room, ambulatory surgical treatment centers,
3 accredited ambulatory surgical treatment facilities,
4 prescriptions filled and dispensed outside of a licensed
5 pharmacy, dental services, and professional services.
6 These fee schedule amounts shall be grouped into
7 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;

(vii) Rock Island, Henry, and Mercer Counties;

(viii) Sangamon and Menard Counties;

(ix) McLean County;

(x) Lake County;

(xi) Macon County;

(xii) Vermilion County;

(xiii) Alexander County; and

(xiv) all other counties of the State.

If a geozip overlaps into one or more of the regions set forth in this subsection, then the Commission shall average or repeat the charges and fees in a geozip in order to designate charges and fees for each region.

(3) The initial workers' compensation maximum fee for each CPT and DRG code as of September 1, 2026 shall be determined as follows:

(A) Within 45 days after the effective date of this amendatory Act of the 104th General Assembly, the Commission shall determine the Medicare percentage amount for each CPT and DRG code using the most recent data available.

CPT or DRG codes which have a value, but are not covered expenses under Medicare, are still compensable under the medical fee schedule according to the rate described in subparagraph (B).

(B) Within 30 days after the Commission makes the determinations required under subparagraph (A), the

1 Commission shall determine an adjustment to be made to
2 the workers' compensation maximum fee for each CPT and
3 DRG code as follows:

4 (i) if the Medicare percentage amount for that
5 CPT or DRG code is equal to or less than 125%, then
6 the workers' compensation maximum fee for that CPT
7 or DRG code shall be adjusted so that it equals
8 125% of the most recent Medicare maximum fee for
9 that CPT or DRG code;

10 (ii) if the Medicare percentage amount for
11 that CPT or DRG code is greater than 125% but less
12 than 150%, then the workers' compensation maximum
13 fee for that CPT or DRG code shall not be adjusted;

14 (iii) if the Medicare percentage amount for
15 that CPT or DRG code is greater than 150% but less
16 than or equal to 225%, then the workers'
17 compensation maximum fee for that CPT or DRG code
18 shall be adjusted so that it equals the greater of
19 (I) 150% of the most recent Medicare maximum fee
20 for that CPT or DRG code or (II) 85% of the most
21 recent workers' compensation maximum amount for
22 that CPT or DRG code;

23 (iv) if the Medicare percentage amount for
24 that CPT or DRG code is greater than 225% but less
25 than or equal to 428.57%, then the workers'
26 compensation maximum fee for that CPT or DRG code

1 shall be adjusted so that it equals the greater of
2 (I) 191.25% of the most recent Medicare maximum
3 fee for that CPT or DRG code or (II) 70% of the
4 most recent workers' compensation maximum amount
5 for that CPT or DRG code; or

6 (v) if the Medicare percentage amount for that
7 CPT or DRG code is greater than 428.57%, then the
8 workers' compensation maximum fee for that CPT or
9 DRG code shall be adjusted so that it equals 300%
10 of the most recent Medicare maximum fee for that
11 CPT or DRG code.

12 The Commission shall promptly publish on its
13 website the adjustments determined pursuant to this
14 subparagraph (B).

15 (C) The initial workers' compensation maximum fee
16 for each CPT and DRG code as of September 1, 2026 shall
17 be equal to the workers' compensation maximum fee for
18 that code as determined and adjusted pursuant to
19 subparagraph (B), subject to any further adjustments
20 under paragraph (5) of this subsection.

21 (4) The Commission, as of September 1, 2027 and
22 September 1 of each year thereafter, shall adjust the
23 workers' compensation maximum fee for each CPT or DRG code
24 to exactly half of the most recent annual increase in the
25 Consumer Price Index-U.

26 (5) A person who believes that the workers'

1 compensation maximum fee for a CPT or DRG code, as
2 otherwise determined pursuant to this subsection, creates
3 or would create upon implementation a significant
4 limitation on access to quality health care in either a
5 specific field of health care services or a specific
6 geographic limitation on access to health care may
7 petition the Commission to modify the workers'
8 compensation maximum fee for that CPT or DRG code so as to
9 not create that significant limitation.

10 The petitioner bears the burden of demonstrating, by a
11 preponderance of the credible evidence, that the workers'
12 compensation maximum fee that would otherwise apply would
13 create a significant limitation on access to quality
14 health care in either a specific field of health care
15 services or a specific geographic limitation on access to
16 health care. Petitions shall be made publicly available.
17 Such credible evidence shall include empirical data
18 demonstrating a significant limitation on access to
19 quality health care. Other interested persons may file
20 comments or responses to a petition within 30 days after
21 the filing of a petition.

22 The Commission shall take final action on each
23 petition within 180 days after filing. The Commission may,
24 but is not required to, seek the recommendation of the
25 Medical Fee Advisory Board to assist with this
26 determination. If the Commission grants the petition, the

1 Commission shall further increase the workers'
2 compensation maximum fee for that CPT or DRG code by the
3 amount minimally necessary to avoid creating a significant
4 limitation on access to quality health care in either a
5 specific field of health care services or a specific
6 geographic limitation on access to health care. The
7 increased workers' compensation maximum fee shall take
8 effect upon entry of the Commission's final action.

9 (a-2) For procedures, treatments, services, or supplies
10 covered under this Act and rendered or to be rendered on or
11 after September 1, 2011, the maximum allowable payment shall
12 be 70% of the fee schedule amounts, which shall be adjusted
13 yearly by the Consumer Price Index-U, as described in
14 subsection (a) of this Section. The provisions of this
15 subsection (a-2), other than this sentence, are inoperative
16 after August 31, 2026.

17 (a-3) Prescriptions filled and dispensed outside of a
18 licensed pharmacy shall be subject to a fee schedule that
19 shall not exceed the Average Wholesale Price (AWP) plus a
20 dispensing fee of \$4.18. AWP or its equivalent as registered
21 by the National Drug Code shall be set forth for that drug on
22 that date as published in Medispan.

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

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

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

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

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

26 (2) If the bill does not contain substantially all the

1 required data elements necessary to adjudicate the bill,
2 or the claim is denied for any other reason, in whole or in
3 part, the employer or insurer shall provide written
4 notification to the provider in the form of an explanation
5 of benefits explaining the basis for the denial and
6 describing any additional necessary data elements within
7 30 days of receipt of the bill. The Commission, with
8 assistance from the Medical Fee Advisory Board, shall
9 adopt rules detailing the requirements for the explanation
10 of benefits required under this subsection.

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

24 (4) If the employer or its insurer fails to pay
25 interest within 30 days after payment of the bill as
26 required pursuant to paragraph (3), the provider may bring

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

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

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

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

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

25 (e-10) If an employer notifies a provider that the
26 employer will pay only a portion of a bill for any procedure,

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

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

1 be provided to any credit rating agency. The reminders may
2 request that the employee furnish the provider with
3 information about the proceeding under this Act, such as the
4 file number, names of parties, and status of the case. If an
5 employee fails to respond to such request for information or
6 fails to furnish the information requested within 90 days of
7 the date of the reminder, the provider is entitled to resume
8 any and all efforts to collect payment from the employee for
9 the services rendered to the employee and the employee shall
10 be responsible for payment of any outstanding bills for a
11 procedure, treatment, or service rendered by a provider.

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

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

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

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

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

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