

HB4872



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4872

by Rep. Lou Lang

SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

Amends the Workers' Compensation Act. Provides that when a patient notifies a provider that the patient is seeking treatment for a work-related injury, the provider shall bill the employer or its designee directly (currently only bill employer directly). Provides for the payment of interest to providers. Effective immediately.

LRB100 19187 JLS 34452 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 hospital
16 charges and fees as of August 1, 2004 but not earlier than
17 August 1, 2002. These charges and fees are provider billed
18 amounts and shall not include discounted charges. The 80th
19 percentile is the point on an ordered data set from low to high
20 such that 80% of the cases are below or equal to that point and
21 at most 20% are above or equal to that point. The Commission
22 shall adjust these historical charges and fees as of August 1,
23 2004 by the Consumer Price Index-U for the period August 1,

1 2004 through September 30, 2005. The Commission shall establish
2 fee schedules for procedures, treatments, or services for
3 hospital inpatient, hospital outpatient, emergency room and
4 trauma, ambulatory surgical treatment centers, and
5 professional services. These charges and fees shall be
6 designated by geozip or any smaller geographic unit. The data
7 shall in no way identify or tend to identify any patient,
8 employer, or health care provider. As used in this Section,
9 "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 the
17 geozip with up to 4 other geozips that are demographically and
18 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 that

1 state's fee schedule amount or the fee schedule amount for the
2 region in which the employee resides. If no fee schedule exists
3 in that state, the provider shall be reimbursed at the lesser
4 of the actual charge or the fee schedule amount for the region
5 in which the employee resides. Not later than September 30 in
6 2006 and each year thereafter, the Commission shall
7 automatically increase or decrease the maximum allowable
8 payment for a procedure, treatment, or service established and
9 in effect on January 1 of that year by the percentage change in
10 the Consumer Price Index-U for the 12 month period ending
11 August 31 of that year. The increase or decrease shall become
12 effective on January 1 of the following year. As used in this
13 Section, "Consumer Price Index-U" means the index published by
14 the Bureau of Labor Statistics of the U.S. Department of Labor,
15 that measures the average change in prices of all goods and
16 services purchased by all urban consumers, U.S. city average,
17 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 forth
11 in this Section, then the Commission shall average or
12 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 than
15 9 charges or fees for a procedure, treatment, product,
16 supply, or service or where the fee schedule amount cannot
17 be determined by the non-discounted charge data,
18 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 with
24 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 the
13 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 chagemaster. A standard chagemaster 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 be
6 70% of the fee schedule amounts, which shall be adjusted yearly
7 by the Consumer Price Index-U, as described in subsection (a)
8 of this Section.

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

15 (b) Notwithstanding the provisions of subsection (a), if
16 the Commission finds that there is a significant limitation on
17 access to quality health care in either a specific field of
18 health care services or a specific geographic limitation on
19 access to health care, it may change the Consumer Price Index-U
20 increase or decrease for that specific field or specific
21 geographic limitation on access to health care to address that
22 limitation.

23 (c) The Commission shall establish by rule a process to
24 review those medical cases or outliers that involve
25 extra-ordinary treatment to determine whether to make an
26 additional adjustment to the maximum payment within a fee

1 schedule for a procedure, treatment, or service.

2 (d) When a patient notifies a provider that the treatment,
3 procedure, or service being sought is for a work-related
4 illness or injury and furnishes the provider the name and
5 address of the responsible employer, the provider shall bill
6 the employer or its designee directly. The employer or its
7 designee shall make payment for treatment directly to the
8 provider in accordance with the provisions of this Section.
9 Providers ~~and providers~~ shall submit bills and records in
10 accordance with the provisions of this Section.

11 (1) All payments to providers for treatment provided
12 pursuant to this Act shall be made within 30 days of
13 receipt of the bills as long as the bill ~~claim~~ contains
14 substantially all the required data elements necessary to
15 adjudicate the bill ~~bills~~.

16 (2) If the bill ~~claim~~ does not contain substantially
17 all the required data elements necessary to adjudicate the
18 bill, or the claim is denied for any other reason, in whole
19 or in part, the employer or its insurer shall provide
20 written notification, explaining the basis for the denial
21 and describing any additional necessary data elements, to
22 the provider within 30 days of receipt of the bill.

23 (3) In the case of nonpayment to a provider within 30
24 days of receipt of the bill which contained substantially
25 all of the required data elements necessary to adjudicate
26 the bill or nonpayment to a provider of a portion of such a

1 ~~bill up to the lesser of the actual charge or the payment~~
2 ~~level set by the Commission in the fee schedule established~~
3 ~~in this Section, the bill, or portion of the bill up to the~~
4 lesser of the actual charge or the payment level set by the
5 Commission in the fee schedule established in this Section,
6 shall incur interest at a rate of 1% per month payable by
7 the employer to the provider. Any required interest
8 payments shall be made by the employer or its insurer to
9 the provider not later than ~~within~~ 30 days after payment of
10 the bill.

11 (4) If the employer or its insurer fails to make an
12 interest payment required pursuant to this Section, the
13 provider may enforce the provisions of this Section
14 directly against the employer, its insurer, or both.
15 Interest under this Section is payable only to the
16 provider. An employee is not responsible for the payment of
17 interest under this Section.

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 the
25 employee participates in a group health plan, the provider may
26 submit a claim for services to the group health plan. If the

1 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 provider
5 shall not bill or otherwise attempt to recover from the
6 employee the difference between the provider's charge and the
7 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 under
12 this Act, the provider may seek payment of the provider's
13 actual charges from the employee for any procedure, treatment,
14 or service rendered. Once an employee informs the provider that
15 there is an application filed with the Commission to resolve a
16 dispute over payment of such charges, the provider shall cease
17 any and all efforts to collect payment for the services that
18 are the subject of the dispute. Any statute of limitations or
19 statute of repose applicable to the provider's efforts to
20 collect payment from the employee shall be tolled from the date
21 that the employee files the application with the Commission
22 until the date that the provider is permitted to resume
23 collection efforts under the provisions of this Section.

24 (e-10) If an employer notifies a provider that the employer
25 will pay only a portion of a bill for any procedure, treatment,
26 or service rendered in connection with a compensable illness or

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

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

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

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

1 have agreed otherwise in writing. Services not covered or not
2 compensable under this Act are not subject to the fee schedule
3 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 regarding
10 the implementation of the medical fee schedule and the index
11 used for annual adjustment to that schedule as described in
12 this Section.

13 (Source: P.A. 97-18, eff. 6-28-11.)

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