# HB4079

LRB10332159SPS61248b

## 103RD GENERAL ASSEMBLY

## State of Illinois

## 2023 and 2024

### HB4079

Introduced 5/10/2023, by Rep. Dan Ugaste

## SYNOPSIS AS INTRODUCED:

820 ILCS 305/8.2

Amends the Workers' Compensation Act. Provides that the Illinois Workers' Compensation Commission shall establish new medical fee schedules applicable on and after September 1, 2024 in accordance with specified criteria. Makes existing medical fee schedules inoperative after August 31, 2024. Provides that a provider may prescribe a one-time 7-day supply unless a prescription for more than 7 days is preauthorized by the employer. Provides for non-hospital fee schedules and 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. Provides that by September 1, 2023, the Commission, in consultation with the Workers' Compensation Medical Fee Advisory Board, shall adopt by rule an evidence-based drug formulary and any rules necessary for its administration. Provides that prescriptions prescribed for workers' compensation cases shall be limited to the prescription drugs and doses on the closed formulary. Provides that a custom compound medication for longer than the one-time 7-day supply shall be approved for payment only if the compound meets specified standards. Provides for charges for custom compound medications. Effective immediately.

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A BILL FOR

AN ACT concerning employment.

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

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

(820 ILCS 305/8.2)

Sec. 8.2. Fee schedule.

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

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

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

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

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

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

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

(i) Cook County;

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

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

(iv) All other counties of the State.

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

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

(ii) Kankakee County;

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

(iv) Winnebago and Boone Counties;

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

(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.

(2) If a geozip, as defined in subsection (a) of this Section, overlaps into one or more of the regions set forth in this Section, 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) In cases where the compiled data contains less than 9 charges or fees for a procedure, treatment, product, supply, or service or where the fee schedule amount cannot be determined by the non-discounted charge data, non-Medicare relative values and conversion factors derived from established fee schedule amounts, coding crosswalks, or other data as determined by the Commission, reimbursement shall occur at 76% of charges and fees until September 1, 2011 and 53.2% of charges and fees thereafter as determined by the Commission in a manner consistent with the provisions of this paragraph.

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

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

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

(6) The Commission shall automatically update all

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

(a-1.5) The following provisions apply to procedures, treatments, services, products, and supplies covered under this Act and rendered or to be rendered on or after September 1, 2024:

(1) In this Section:

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

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

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

"Health care services" means those CPT and DRG codes for procedures, treatments, products, services, or supplies for hospital inpatient, hospital outpatient, emergency room, ambulatory surgical treatment centers, accredited ambulatory surgical treatment facilities, and professional services.

"Health care services" does not include codes classified as healthcare common procedure coding systems or dental.

"Medicare maximum fee" means, for each CPT and DRG code, the current maximum fee for that CPT or DRG code allowed to be charged by the Centers for Medicare and Medicaid Services for Medicare patients in that geographic region. The Medicare maximum fee shall be the greater of (i) the current maximum fee allowed to be charged by the Centers for Medicare and Medicaid Services for Medicare patients in the geographic region or (ii) the maximum fee charged by the Centers for Medicare and Medicaid Services for Medicare patients in the geographic region on January 1, 2024.

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

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

(2) The Commission shall establish and maintain fee schedules for procedures, treatments, products, services, or supplies for hospital inpatient, hospital outpatient, emergency room, ambulatory surgical treatment centers,

accredited ambulatory surgical treatment facilities, prescriptions filled and dispensed outside of a licensed pharmacy, dental services, and professional services. These fee schedule amounts shall be grouped into geographic regions in the following manner:

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

(i) Cook County;

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

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

(iv) all other counties of the State.

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

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

(ii) Kankakee County;

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

(iv) Winnebago and Boone Counties;

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

(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, 2024 shall be determined as follows:

(A) Within 45 days after the effective date of this amendatory Act of the 103rd 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 Commission shall determine an adjustment to be made to

the workers' compensation maximum fee for each CPT and DRG code as follows:

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

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

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

(iv) if the Medicare percentage amount for that CPT or DRG code is greater than 225% but less than or equal to 428.57%, then the workers' compensation maximum fee for that CPT or DRG code shall be adjusted so that it equals the greater of

(I) 191.25% of the most recent Medicare maximum fee for that CPT or DRG code or (II) 70% of the most recent workers' compensation maximum amount for that CPT or DRG code; or

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

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

(C) The initial workers' compensation maximum fee for each CPT and DRG code as of September 1, 2024 shall be equal to the workers' compensation maximum fee for that code as determined and adjusted pursuant to subparagraph (B), subject to any further adjustments under paragraph (5) of this subsection.

(4) The Commission, as of September 1, 2025 and September 1 of each year thereafter, shall adjust the workers' compensation maximum fee for each CPT or DRG code to exactly half of the most recent annual increase in the Consumer Price Index-U.

(5) A person who believes that the workers' compensation maximum fee for a CPT or DRG code, as

otherwise determined pursuant to this subsection, creates or would create upon implementation 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 may petition the Commission to modify the workers' compensation maximum fee for that CPT or DRG code so as to not create that significant limitation.

The petitioner bears the burden of demonstrating, by a preponderance of the credible evidence, that the workers' compensation maximum fee that would otherwise apply would create 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. Petitions shall be made publicly available. Such credible evidence shall include empirical data demonstrating a significant limitation on access to quality health care. Other interested persons may file comments or responses to a petition within 30 days after the filing of a petition.

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

compensation maximum fee for that CPT or DRG code by the amount minimally necessary to avoid creating 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. The increased workers' compensation maximum fee shall take effect upon entry of the Commission's final action.

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

(a-2.5) Subsections (a), (a-1), and (a-2) are inoperative on and after August 31, 2024.

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

(a-3.5) By September 1, 2023, the Commission, in consultation with the Workers' Compensation Medical Fee Advisory Board, shall adopt by rule an evidence-based drug formulary and any rules necessary for its administration. Prescriptions prescribed for workers' compensation cases shall

be limited to the prescription drugs and doses on the closed formulary.

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

(a-4) As used in this Section, "custom compound medication" means a customized medication prescribed or ordered by a duly licensed prescriber for a specific patient that is prepared in a pharmacy by a licensed pharmacist in response to a licensed prescriber's prescription or order by combining, mixing, or altering of ingredients, but not reconstituting, to meet the unique needs of a specific patient.

(a-5) A custom compound medication for longer than the one-time 7-day supply described in subsection (a-6) shall be approved for payment only if the compound meets all of the following standards:

(1) there is no readily available commercially manufactured equivalent product;

(2) no other Food and Drug Administration-approved alternative drug is appropriate for the patient;

(3) the active ingredients of the compound each have a National Drug Code number, are components of drugs approved by the Food and Drug Administration, and the active ingredients in the custom compound medication are being used for diagnosis or conditions approved use by the Food and Drug Administration and not being used for

off-label use;

(4) the drug has not been withdrawn or removed from the market for safety reasons; and

(5) the prescriber is able to demonstrate to the payer that the compound medication is clinically appropriate for the intended use.

(a-6) Custom compound medications shall be charged using the specific amount of each component drug and its original manufacturer's National Drug Code number included in the compound. Charges shall be based on a maximum charge of the average wholesale price based upon the original manufacturer's National Drug Code number, as published by Red Book or Medi-Span and prorated for each component amount used. If the National Drug Code for the compound ingredient is a repackaged drug, the maximum allowable fee for the repackaged drug shall be determined by the National Drug Code and the average wholesale price of the underlying original manufacturer. Components without National Drug Code numbers shall not be charged. A single dispensing fee for a custom compound medication as determined by the Commission based on the actual costs of preparing and dispensing the custom compound medication shall be paid. The dispensing fee for a compound prescription shall be billed with code WC 700-C. The provider may prescribe a one-time 7-day supply. Any custom compound medication prescriptions for more than 7 days shall be preauthorized by the employer. Under all circumstances, if the

compound medication meets the requirements in subsection (a-5), a 7-day supply shall be covered.

(a-7) This Section is subject to the other provisions of this Act, including, but not limited to, Section 8.7.

(b) Notwithstanding the provisions of subsection (a), if the Commission finds that there is 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, it may change the Consumer Price Index-U increase or decrease for that specific field or specific geographic limitation on access to health care to address that limitation.

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

(d) When a patient notifies a provider that the treatment, procedure, or service being sought is for a work-related illness or injury and furnishes the provider the name and address of the responsible employer, the provider shall bill the employer or its designee directly. The employer or its designee shall make payment for treatment in accordance with the provisions of this Section directly to the provider, except that, if a provider has designated a third-party billing entity to bill on its behalf, payment shall be made

directly to the billing entity. Providers shall submit bills and records in accordance with the provisions of this Section.

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

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

(3) In the case (i) of nonpayment to a provider within 30 days of receipt of the bill which contained substantially all of the required data elements necessary to adjudicate the bill, (ii) of nonpayment to a provider of a portion of such a bill, or (iii) where the provider has not been issued an explanation of benefits for a bill, the bill, or portion of the bill up to the lesser of the actual charge or the payment level set by the Commission

in the fee schedule established in this Section, shall incur interest at a rate of 1% per month payable by the employer to the provider. Any required interest payments shall be made by the employer or its insurer to the provider within 30 days after payment of the bill.

(4) If the employer or its insurer fails to pay interest within 30 days after payment of the bill as required pursuant to paragraph (3), the provider may bring an action in circuit court for the sole purpose of seeking payment of interest pursuant to paragraph (3) against the employer or its insurer responsible for insuring the employer's liability pursuant to item (3) of subsection (a) of Section 4. The circuit court's jurisdiction shall be limited to enforcing payment of interest pursuant to paragraph (3). Interest under paragraph (3) is only payable to the provider. An employee is not responsible for the payment of interest under this Section. The right to interest under paragraph (3) shall not delay, diminish, restrict, or alter in any way the benefits to which the employee or his or her dependents are entitled under this Act.

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

(e) Except as provided in subsections (e-5), (e-10), and

(e-15), a provider shall not hold an employee liable for costs related to a non-disputed procedure, treatment, or service rendered in connection with a compensable injury. The provisions of subsections (e-5), (e-10), (e-15), and (e-20) shall not apply if an employee provides information to the provider regarding participation in a group health plan. If the employee participates in a group health plan, the provider may submit a claim for services to the group health plan. If the claim for service is covered by the group health plan, the employee's responsibility shall be limited to applicable deductibles, co-payments, or co-insurance. Except as provided under subsections (e-5), (e-10), (e-15), and (e-20), a provider shall not bill or otherwise attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or the insurer on a compensable injury, or for medical services or treatment determined by the Commission to be excessive or unnecessary.

(e-5) If an employer notifies a provider that the employer does not consider the illness or injury to be compensable under this Act, the provider may seek payment of the provider's actual charges from the employee for any procedure, treatment, or service rendered. Once an employee informs the provider that there is an application filed with the Commission to resolve a dispute over payment of such charges, the provider shall cease any and all efforts to collect payment for the services that are the subject of the dispute.

Any statute of limitations or statute of repose applicable to the provider's efforts to collect payment from the employee shall be tolled from the date that the employee files the application with the Commission until the date that the provider is permitted to resume collection efforts under the provisions of this Section.

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

(e-15) When there is a dispute over the compensability of or amount of payment for a procedure, treatment, or service,

and a case is pending or proceeding before an Arbitrator or the Commission, the provider may mail the employee reminders that the employee will be responsible for payment of any procedure, treatment or service rendered by the provider. The reminders must state that they are not bills, to the extent practicable include itemized information, and state that the employee need not pay until such time as the provider is permitted to resume collection efforts under this Section. The reminders shall not be provided to any credit rating agency. The reminders may request that the employee furnish the provider with information about the proceeding under this Act, such as the file number, names of parties, and status of the case. If an employee fails to respond to such request for information or fails to furnish the information requested within 90 days of the date of the reminder, the provider is entitled to resume any and all efforts to collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider.

(e-20) Upon a final award or judgment by an Arbitrator or the Commission, or a settlement agreed to by the employer and the employee, a provider may resume any and all efforts to collect payment from the employee for the services rendered to the employee and the employee shall be responsible for payment of any outstanding bills for a procedure, treatment, or service rendered by a provider as well as the interest awarded

under subsection (d) of this Section. In the case of a procedure, treatment, or service deemed compensable, the provider shall not require a payment rate, excluding the interest provisions under subsection (d), greater than the lesser of the actual charge or the payment level set by the Commission in the fee schedule established in this Section. Payment for services deemed not covered or not compensable under this Act is the responsibility of the employee unless a provider and employee have agreed otherwise in writing. Services not covered or not compensable under this Act are not subject to the fee schedule in this Section.

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

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

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

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