

Portions of the Illinois Workers' Compensation Act Related to Medical Care
As of 6/28/11
820ILCS305

§8: Medical care

Section 8. The amount of compensation which shall be paid to the employee for an accidental injury not resulting in death is:

- (a) The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury, even if a health care provider sells, transfers, or otherwise assigns an account receivable for procedures, treatments, or services covered under this Act. If the employer does not dispute payment of first aid, medical, surgical, and hospital services, the employer shall make such payment to the provider on behalf of the employee. The employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto. If as a result of the injury the employee is unable to be self-sufficient the employer shall further pay for such maintenance or institutional care as shall be required.

Employee Choice/Panel of Physicians

The employee may at any time elect to secure his own physician, surgeon and hospital services at the employer's expense, or,

Upon agreement between the employer and the employees, or the employees' exclusive representative, and subject to the approval of the Illinois Workers' Compensation Commission, the employer shall maintain a list of physicians, to be known as a Panel of Physicians, who are accessible to the employees. The employer shall post this list in a place or places easily accessible to his employees. The employee shall have the right to make an alternative choice of physician from such Panel if he is not satisfied with the physician first selected. If, due to the nature of the injury or its occurrence away from the employer's place of business, the employee is unable to make a selection from the Panel, the selection process from the Panel shall not apply. The physician selected from the Panel may arrange for any consultation, referral or other specialized medical services outside the Panel at the employer's expense. Provided that, in the event the Commission shall find that a doctor selected by the employee is rendering improper or inadequate care, the Commission may order the employee to select another doctor certified or qualified in the medical field for which treatment is required. If the employee refuses to make such change the Commission may relieve the employer of his obligation to pay the doctor's charges from the date of refusal to the date of compliance.

Vocational Rehabilitation Counselors Need Certification

Any vocational rehabilitation counselors who provide service under this Act shall have appropriate certifications which designate the counselor as qualified to render opinions relating to vocational rehabilitation. Vocational rehabilitation may include, but is not limited to, counseling for job searches, supervising a job search program, and vocational retraining including education at an accredited learning institution. The employee or employer may petition to the Commission to decide disputes relating to vocational rehabilitation and the Commission shall resolve any such dispute, including payment of the vocational rehabilitation program by the employer.

Maintenance; TPD

The maintenance benefit shall not be less than the temporary total disability rate determined for the employee. In addition, maintenance shall include costs and expenses incidental to the vocational rehabilitation program.

When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits. Temporary partial disability benefits shall be equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and the gross amount

which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working.

Access to Medical Reports

Every hospital, physician, surgeon or other person rendering treatment or services in accordance with the provisions of this Section shall upon written request furnish full and complete reports thereof to, and permit their records to be copied by, the employer, the employee or his dependents, as the case may be, or any other party to any proceeding for compensation before the Commission, or their attorneys.

Medical Care

Notwithstanding the foregoing, the employer's liability to pay for such medical services selected by the employee shall be limited to:

- (1) all first aid and emergency treatment; plus
- (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus
- (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection. At any time the employee may obtain any medical treatment he desires at his own expense. This paragraph shall not affect the duty to pay for rehabilitation referred to above.
- (4) The following shall apply for injuries occurring on or after the effective date of this amendatory Act of the 97th General Assembly and only when an employer has an approved preferred provider program pursuant to Section 8.1a on the date the employee sustained his or her accidental injuries:
 - (A) The employer shall, in writing, on a form promulgated by the Commission, inform the employee of the preferred provider program;
 - (B) Subsequent to the report of an injury by an employee, the employee may choose in writing at any time to decline the preferred provider program, in which case that would constitute one of the two choices of medical providers to which the employee is entitled under subsection (a)(2) or (a)(3); and
 - (C) Prior to the report of an injury by an employee, when an employee chooses non-emergency treatment from a provider not within the preferred provider program, that would constitute the employee's one choice of medical providers to which the employee is entitled under subsection (a)(2) or (a)(3).

When an employer and employee so agree in writing, nothing in this Act prevents an employee whose injury or disability has been established under this Act, from relying in good faith, on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by a duly accredited practitioner thereof, and having nursing services appropriate therewith, without suffering loss or diminution of the compensation benefits under this Act. However, the employee shall submit to all physical examinations required by this Act. The cost of such treatment and nursing care shall be paid by the employee unless the employer agrees to make such payment.

Where the accidental injury results in the amputation of an arm, hand, leg or foot, or the enucleation of an eye, or the loss of any of the natural teeth, the employer shall furnish an artificial of any such members lost or damaged in accidental injury arising out of and in the course of employment, and shall also furnish the necessary braces in all proper and necessary cases. In cases of the loss of a member or members by amputation, the employer shall, whenever necessary, maintain in good repair, refit or replace the artificial limbs during the lifetime of the employee. Where the accidental injury accompanied by physical injury results in damage to a denture, eye glasses or contact eye lenses, or where the accidental injury results in damage to an artificial member, the employer shall replace or repair such denture, glasses, lenses, or artificial member.

The furnishing by the employer of any such services or appliances is not an admission of liability on the part of the employer to pay compensation.

The furnishing of any such services or appliances or the servicing thereof by the employer is not the payment of compensation.

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§8(j): Benefits Received Under Group Health Plan

(j)

1. In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments. This paragraph does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act. Any employer receiving such credit shall keep such employee safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit.

Any excess benefits paid to or on behalf of a State employee by the State Employees' Retirement System under Article 14 of the Illinois Pension Code on a death claim or disputed disability claim shall be credited against any payments made or to be made by the State of Illinois to or on behalf of such employee under this Act, except for payments for medical expenses which have already been incurred at the time of the award. The State of Illinois shall directly reimburse the State Employees' Retirement System to the extent of such credit.

2. Nothing contained in this Act shall be construed to give the employer or the insurance carrier the right to credit for any benefits or payments received by the employee other than compensation payments provided by this Act, and where the employee receives payments other than compensation payments, whether as full or partial salary, group insurance benefits, bonuses, annuities or any other payments, the employer or insurance carrier shall receive credit for each such payment only to the extent of the compensation that would have been payable during the period covered by such payment.
3. The extension of time for the filing of an Application for Adjustment of Claim as provided in paragraph 1 above shall not apply to those cases where the time for such filing had expired prior to the date on which payments or benefits enumerated herein have been initiated or resumed. Provided however that this paragraph 3 shall apply only to cases wherein the payments or benefits herein above enumerated shall be received after July 1, 1969.

(Source: P.A. 93-721, eff. 1-1-05; 94-277, eff. 7-20-05; 94-695, eff. 11/16/05.)

§8.1a: Preferred Provider Program

Section 8.1a. Preferred provider programs. Starting on the effective date of this amendatory Act of the 97th General Assembly, to satisfy its liabilities under this Act for the provision of medical treatment to injured employees, an employer may utilize a preferred provider program approved by the Illinois Department of Insurance as in compliance with Sections 370k, 370l, 370m, and 370p of Article XX-1/2 of the Illinois Insurance Code. For the purposes of compliance with these Sections, the employee shall be considered the "beneficiary" and the employer shall be considered the "insured". Employers and insurers contracting directly with providers or utilizing multiple preferred provider programs to implement a preferred provider program providing workers' compensation benefits shall be subject to the above requirements of Article XX-1/2 applicable to administrators with regard to such program, with the exception of Section 370l of the Illinois Insurance Code.

- (a) In addition to the above requirements of Article XX-1/2 of the Illinois Insurance Code, all preferred provider programs under this Section shall meet the following requirements:
 - (1) The provider network shall include an adequate number of occupational and non-occupational providers.

- (2) The provider network shall include an adequate number and type of physicians or other providers to treat common injuries experienced by injured workers in the geographic area where the employees reside.
 - (3) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees.
 - (4) Physician compensation shall not be structured in order to achieve the goal of inappropriately reducing, delaying, or denying medical treatment or restricting access to medical treatment.
 - (5) Before entering into any agreement under this Section, a program shall establish terms and conditions that must be met by noninstitutional providers wishing to enter into an agreement with the program. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers. Neither difference in prices among noninstitutional providers produced by a process of individual negotiation nor price differences among other noninstitutional providers in different geographical areas or different specialties constitutes unreasonable discrimination.
- (b) The administrator of any preferred provider program under this Act that uses economic evaluation shall file with the Director of Insurance a description of any policies and procedures related to economic evaluation utilized by the program. The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The Director of Insurance may deny approval of any preferred provider program that uses any policy or procedure of economic evaluation to inappropriately reduce, delay or deny medical treatment, or to restrict access to medical treatment. Evaluation of providers based upon objective medical quality and patient outcome measurements, appropriate use of best clinical practices and evidence based medicine, and use of health information technology shall be permitted. If approved, the employer shall provide a copy of the filing to all participating providers.
- (1) The Director of the Department of Insurance shall make each administrator's filing available to the public upon request. The Director of the Department of Insurance may not publicly disclose any information submitted pursuant to this Section that is determined by the Director of the Department of Insurance to be confidential, proprietary, or trade secret information pursuant to State or federal law.
 - (2) For the purposes of this subsection (b), "economic evaluation" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association. Economic evaluation shall not include negotiated rates with a provider.
- (c) Except for the provisions of subsection (a)(4) of Section 8 and for injuries occurring on or after the effective date of this amendatory Act of the 97th General Assembly, an employee of an employer utilizing a preferred provider program shall only be allowed to select a participating network provider from the network. An employer shall be responsible for:
- (i) all first aid and emergency treatment;
 - (ii) all medical, surgical, and hospital services provided by the participating network provider initially selected by the employee or by any other participating network provider recommended by the initial participating network provider or any subsequent participating network provider in the chain of referrals from the initial participating network provider; and
 - (iii) all medical, surgical, and hospital services provided by the participating network provider subsequently chosen by the employee or by any other participating network provider recommended by the subsequent participating network provider or any subsequent participating network provider in the chain of referrals from the second participating network provider. An employer shall not be liable for services determined by the Commission not to be compensable. An employer shall not be liable for medical services provided by a non-authorize provider when proper notice is provided to the injured worker.
- (1) When the injured employee notifies the employer of the injury or files a claim for workers' compensation with the employer, the employer shall notify the employee of his or her right to be treated by a physician of his or her choice from the preferred provider network established pursuant to this Section, and the method by which the list of participating network providers may be accessed by the employee, except as provided in subsection (a)(4) of Section 8.
 - (2) Consistent with Article XX-1/2 of the Illinois Insurance Code, treatment by a specialist who is not a member of the preferred provider network shall be permitted on a case-by-case basis if the medical provider network does not contain a physician who can provide the approved treatment, and if the

employee has complied with any pre-authorization requirements of the preferred provider network. Consent for the employee to visit an out-of-network provider may not be unreasonably withheld. When a non-network provider is authorized pursuant to this subparagraph (2), the non-network provider shall not hold an employee liable for costs except as provided in subsection (e) of Section 8.2.

- (3) The Director shall not approve, and may withdraw prior approval of, a preferred provider program that fails to provide an injured employee with sufficient access to necessary treating physicians, surgeons, and specialists.
 - (d) Except as provided in subsection (a)(4) of Section 8, upon a finding by the Commission that the care being rendered by the employee's second choice of provider within the employer's network is improper or inadequate, the employee may then choose a provider outside of the network at the employer's expense. The Commission shall issue a decision on any petition filed pursuant to this Section within 5 working days.
 - (e) The Director of the Department of Insurance may promulgate such rules as are necessary to carry out the provisions of this Section relating to approval and regulation of preferred provider programs.
- (Source: P.A. 97-18, eff. 6-28-11.)

§8.1b: AMA Guides

Sec. 8.1b. Determination of permanent partial disability.

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

- (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
- (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
 - (i) the reported level of impairment pursuant to subsection (a);
 - (ii) the occupation of the injured employee;
 - (iii) the age of the employee at the time of the injury;
 - (iv) the employee's future earning capacity; and
 - (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

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

§8.2: Medical Fee Schedule

Section 8.2. Fee schedule.

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-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-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 Medispan.
- (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 extraordinary 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 directly. The employer shall make payment and 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 claim contains substantially all the required data elements necessary to adjudicate the bills.
 - (2) If the claim 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, explaining the basis for the denial and describing any additional necessary data elements, to the provider within 30 days of receipt of the bill.
 - (3) In the case 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 or nonpayment to a provider of a portion of such a 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, the bill, or portion of the bill, shall incur interest at a rate of 1% per month payable to the provider. Any required interest payments shall be made within 30 days after payment.

§8.2(e): Balance Billing

- (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. 97-18, eff. 6-28-11.)

§8.2a: Electronic claims

Section 8.2a. Electronic claims.

- (a) The Director of Insurance shall adopt rules to do all of the following:
- (1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.
 - (2) Require acceptance by employers and insurers of electronic claims for payment of medical services.
 - (3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.
- (b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996 and standards adopted under the Illinois Health Information Exchange and Technology Act.
- (c) The rules requiring employers and insurers to accept electronic claims for payment of medical services shall be proposed on or before January 1, 2012, and shall require all employers and insurers to accept electronic claims for payment of medical services on or before June 30, 2012.
- (d) The Director of Insurance shall by rule establish criteria for granting exceptions to employers, insurance carriers, and health care providers who are unable to submit or accept medical bills electronically.

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

§8.3: Medical Fee Advisory Board

Section 8.3. Workers' Compensation Medical Fee Advisory Board. There is created a Workers' Compensation Medical Fee Advisory Board consisting of 9 members appointed by the Governor with the advice and consent of the Senate. Three members of the Advisory Board shall be representative citizens chosen from the employee class, 3 members shall be representative citizens chosen from the employing class, and 3 members shall be representative citizens chosen from the medical provider class. Each member shall serve a 4-year term and shall continue to serve until a successor is appointed. A vacancy on the Advisory Board shall be filled by the Governor for the unexpired term.

Members of the Advisory Board shall receive no compensation for their services but shall be reimbursed for expenses incurred in the performance of their duties by the Commission from appropriations made to the Commission for that purpose.

The Advisory Board shall advise the Commission on establishment of fees for medical services and accessibility of medical treatment.

(Source: P.A. 94-277, eff. 7-20-05.)

§8.7: Utilization Review

Section 8.7. Utilization review programs.

- (a) As used in this Section:
- "Utilization review" means the evaluation of proposed or provided health care services to determine the appropriateness of both the level of health care services medically necessary and the quality of health care services provided to a patient, including evaluation of their efficiency, efficacy, and appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. The evaluation must be accomplished by means of a system that identifies the utilization of health care services based on standards of care of nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence-based medicine based upon standards as provided in this Act. Utilization techniques may include prospective review, second opinions, concurrent review, discharge planning, peer review, independent medical examinations, and retrospective review (for purposes of this sentence, retrospective review shall be applicable to services rendered on or after July 20, 2005). Nothing in this Section applies to prospective review of necessary first aid or emergency treatment.
- (b) No person may conduct a utilization review program for workers' compensation services in this State unless once every 2 years the person registers the utilization review program with the Department of Insurance and

certifies compliance with the Workers' Compensation Utilization Management standards or Health Utilization Management Standards of URAC sufficient to achieve URAC accreditation or submits evidence of accreditation by URAC for its Workers' Compensation Utilization Management Standards or Health Utilization Management Standards. Nothing in this Act shall be construed to require an employer or insurer or its subcontractors to become URAC accredited.

- (c) In addition, the Director of Insurance may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (b).
- (d) This registration shall include submission of all of the following information regarding utilization review program activities:
 - (1) The name, address, and telephone number of the utilization review programs.
 - (2) The organization and governing structure of the utilization review programs.
 - (3) The number of lives for which utilization review is conducted by each utilization review program.
 - (4) Hours of operation of each utilization review program.
 - (5) Description of the grievance process for each utilization review program.
 - (6) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.
 - (7) Written policies and procedures for protecting confidential information according to applicable State and federal laws for each utilization review program.
- (e) A utilization review program shall have written procedures to ensure that patient-specific information obtained during the process of utilization review will be:
 - (1) kept confidential in accordance with applicable State and federal laws; and
 - (2) shared only with the employee, the employee's designee, and the employee's health care provider, and those who are authorized by law to receive the information. Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When making retrospective reviews, utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided.

- (f) If the Department of Insurance finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with the requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.
- (g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.
- (h) The Secretary of Insurance may by rule establish a registration fee for each person conducting a utilization review program.
- (i) Upon receipt of written notice that the employer or the employer's agent or insurer wishes to invoke the utilization review process, the provider of medical, surgical, or hospital services shall submit to the utilization review, following accredited procedural guidelines.
 - (1) The provider shall make reasonable efforts to provide timely and complete reports of clinical information needed to support a request for treatment. If the provider fails to make such reasonable efforts, the charges for the treatment or service may not be compensable nor collectible by the provider or claimant from the employer, the employer's agent, or the employee. The reporting obligations of providers shall not be unreasonable or unduly burdensome.
 - (2) Written notice of utilization review decisions, including the clinical rationale for certification or non-certification and references to applicable standards of care or evidence-based medical guidelines, shall be

furnished to the provider and employee.

- (3) An employer may only deny payment of or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section.
- (4) When a payment for medical services has been denied or not authorized by an employer or when authorization for medical services is denied pursuant to utilization review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review pursuant to subsection (a) is reasonably required to cure or relieve the effects of his or her injury.
- (5) The medical professional responsible for review in the final stage of utilization review or appeal must be available in this State for interview or deposition; or must be available for deposition by telephone, video conference, or other remote electronic means. A medical professional who works or resides in this State or outside of this State may comply with this requirement by making himself or herself available for an interview or deposition in person or by making himself or herself available by telephone, video conference, or other remote electronic means. The remote interview or deposition shall be conducted in a fair, open, and cost-effective manner. The expense of interview and the deposition method shall be paid by the employer. The deponent shall be in the presence of the officer administering the oath and recording the deposition, unless otherwise agreed by the parties. Any exhibits or other demonstrative evidence to be presented to the deponent by any party at the deposition shall be provided to the officer administering the oath and all other parties within a reasonable period of time prior to the deposition. Nothing shall prohibit any party from being with the deponent during the deposition, at that party's expense; provided, however, that a party attending a deposition shall give written notice of that party's intention to appear at the deposition to all other parties within a reasonable time prior to the deposition.

An admissible utilization review shall be considered by the Commission, along with all other evidence and in the same manner as all other evidence, and must be addressed along with all other evidence in the determination of the reasonableness and necessity of the medical bills or treatment. Nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment or employee choice of health care provider under Section 8(a) or the rights of employers to medical examinations under Section 12.

- (j) When an employer denies payment of or refuses to authorize payment of first aid, medical, surgical, or hospital services under Section 8(a) of this Act, if that denial or refusal to authorize complies with a utilization review program registered under this Section and complies with all other requirements of this Section, then there shall be a rebuttable presumption that the employer shall not be responsible for payment of additional compensation pursuant to Section 19(k) of this Act and if that denial or refusal to authorize does not comply with a utilization review program registered under this Section and does not comply with all other requirements of this Section, then that will be considered by the Commission, along with all other evidence and in the same manner as all other evidence, in the determination of whether the employer may be responsible for the payment of additional compensation pursuant to Section 19(k) of this Act.

The changes to this Section made by this amendatory Act of the 97th General Assembly apply only to health care services provided or proposed to be provided on or after September 1, 2011.

(Source: P.A. 94-277, eff. 7-20-05; 94-695, eff. 11/16/05; P.A. 97-18, eff. 6-28-11.)