Illinois Workers' Compensation Commission

REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY ON THE ILLINOIS WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

January 1, 2010

Pat Quinn
Governor

Amy J. Masters
Acting Chairman

Table of Contents

Dear Governor Quinn,
Members of the General Assembly,
and Citizens of Illinois:

We submit this report on the implementation of the first workers' compensation medical fee schedule in Illinois, as directed by Section 8.2(f) of the Illinois Workers' Compensation Act.

We are grateful to the members of the Workers' Compensation Medical Fee Advisory Board (WCMFAB)—

EMPLOYEE REPRESENTATIVES	EMPLOYER REPRESENTATIVES	MEDICAL REPRESENTATIVES
Eric Dean Int'l. Assoc. of Ironworkers	Maddy Bowling Maddy Bowling and Associates	Dr. Jesse Butler Illinois Bone and Joint Institute
Roger Poole Int'l. Assoc. of Machinists	Kim Moreland Rising Medical Solutions	Dr. Edward Sclamberg Orthopedics of the North Shore
Ronald Powell United Food & Commercial Workers	John Smolk United Airlines	*Elena Butkus (former member)* *Illinois Hospital Association*

—who have collaborated over the last several years to make the fee schedule work. The fee schedule is saving money by reducing the growth of Illinois' medical costs, without harming workers' access to medical care.

The WCMFAB helped to write this report. We hope it will inform legislators of the public policy issues involved. We recognize the fee schedule affects business, labor, insurers, and providers across the state, in every legislative district. We are committed to work together to continue to improve it.

We commend the agreed-bill negotiators and legislators for directing us to write this report, because it has caused all parties to reflect on the strengths and weaknesses of the new law, and discuss possible improvements. This report will guide future deliberations.

Amy J. Masters, Acting Chairman

Mario Basurto, Commissioner

David L. Gore, Commissioner

Molly Mason, Commissioner

Yolaine Dauphin, Commissioner

Kevin Lamborn, Commissioner

Paul W. Rink, Commissioner

James F. DeMunno, Commissioner

Nancy Lindsay, Commissioner

Barbara A. Sherman, Commissioner

Bertha E. Parker, Acting Secretary
of Commission

SUMMARY

When the legislature enacted the first workers' compensation medical fee schedule in Illinois, it also directed the Commission to report on its implementation by January 1, 2010. This report is offered in response to that mandate.

For decades, changes to Illinois workers' compensation law have been made through an agreed-bill process. Business and labor representatives negotiate and draft the precise terms of a bill, and jointly present it to the legislature for approval. After nearly two years of negotiations, HB2137 passed the House 113-2 and the Senate 49-4. PA094-0277 took effect July 20, 2005.

In brief, HB2137 gave the business community cost savings, mainly through the fee schedule, and it gave the labor community increases in benefit payments, especially for permanent partial disability. It was estimated that the bill would bring 6.5% cost savings and 5% benefit increases, for a net savings to the system of 1.5%.

The law also created a Workers' Compensation Medical Fee Advisory Board (WCMFAB), composed of employee, employer, and medical representatives, to advise the Commission on the fee schedule. The WCMFAB has been involved throughout the development of the fee schedule, and has served as a forum in which issues may be discussed among people with divergent interests.

Since 2005, the Commission has worked intensely with the WCMFAB and other interested parties to create, implement, and refine the fee schedule. We have reason to believe the efforts are saving employers money without harming workers' ability to get good medical care. At the same time, there are areas of concern, which are noted in this report.

The experience of other states indicates that fee schedules are never perfect, and they require continuing adjustment. We will continue to work with all interested parties to address the needs of the employee, employer, and medical communities.

OVERVIEW OF FEE SCHEDULE PROVISIONS

Section 8.2 of the Act directed the Commission to establish a fee schedule for treatment on or after February 1, 2006 in the following manner:

- Find a database containing at least 12 million Illinois line-item medical charges from August 1, 2002 through August 1, 2004.
- Calculate a fee schedule amount for each procedure in each three-digit zip code. There are 29 "geozips" in Illinois, and therefore 29 fees for each procedure.
- Find at least nine bills for each procedure in a geozip. If the database did not have nine bills, bills from up to four other geozips could be combined. If the database still could not produce nine bills, reimbursement defaulted to 76% of charge (POC76).
- Calculate the fee schedule amount at 90% of the 80th percentile of actual charges. (For example, if you had 10 bills, you would arrange them from the lowest to the highest, select the 8th bill, and then multiply it by 90% to calculate the fee schedule amount.)

The fee schedule amount represents the maximum payment. Payment shall be the lesser of the fee schedule amount or the actual charge. The law allows providers and employers/insurers to contract for different reimbursement levels, and any contract prevails over the fee schedule.

To contain costs, the fees are adjusted each year by the percentage change in the Consumer Price Index-U, all urban consumers, U.S. city average, all items, 1982-84=100, for the 12-month period ending August 31 of that year. Because medical costs usually rise more rapidly than general inflation, this measure was expected to produce significant savings over time.

DEVELOPMENT OF FEE SCHEDULE

With six months to create a fee schedule, and no medical experts on staff, the Commission contracted with an experienced workers' compensation medical expert. Glen Boyle of True Course MDCS, who developed workers' compensation medical databases for the State of Wisconsin, has served as project manager since 2005.

The law specified that the fees were to be calculated using a database that contained at least 12 million Illinois line-item charges. Only one database in the country was found to exist: it is owned by Ingenix, a subsidiary of UnitedHealth Group. Ingenix had data for three areas—Anesthesia, Healthcare Common Procedure Coding System (HCPCS), and Professional Services—and it created fee schedules for those categories. Ingenix created and continues to host a website on which all fees are listed. This was the first workers' compensation fee schedule in the country to be published online, available at no charge to the users. Mr. Boyle created the Hospital Inpatient fee schedule, using data obtained from the Illinois Department of Public Health.

The Commission could not find appropriate data for other areas: Ambulatory Surgical Treatment Centers (ASTCs), Dental, Emergency Room Facility, or Hospital Outpatient services. The billing practices associated with these service types are complex, and suitable databases were difficult to identify and assemble. Because the Commission did not have data with which to create fee schedules, by law, reimbursement defaulted to 76% of charge (aka POC76).

Once the fee schedules were posted, business representatives expressed concern that too many areas defaulted to POC76, and they asked the Commission to search for data with which fee schedules could be created. In addition, medical representatives asked for a fee schedule for three high-cost rehabilitation hospitals, because their services are much more intense than other hospitals. The Commission and the WCMFAB agreed. For two years, the Commission worked with the WCMFAB to create the new fee schedules, which took effect on February 1, 2009.

Ingenix created the fee schedules for Hospital Outpatient procedures for radiology, pathology and laboratory, physical medicine and rehabilitation. Mr. Boyle used IDPH data to create the fee schedules for Hospital Outpatient Surgical Facility procedures, ASTC procedures, and three designated Rehabilitation Hospitals.

Finally, because Medicare changed its coding system for Hospital Inpatient services, the Commission had to convert its Hospital Inpatient fee schedule. To stay within the direction of the Illinois law, Mr. Boyle took the same 2002-2004 bills, removed the charges from the rehabilitation hospitals, and regrouped the charges into the new code categories. The new Hospital Inpatient fee schedule took effect 6/30/09.

EFFECT OF FEE SCHEDULE: ANALYSIS OF INDIVIDUAL PROVISIONS

The fee schedule affects costs in several ways: initially, it sets a fee schedule amount for each procedure; it adjusts the fee each year; and it adopts modifiers and bundling edits that direct how services are billed. Experts agree that it is not possible to separate and measure the effect of each provision, but this section will explain how each each provision can constrain costs.

Original fee calculation

Early external studies reported that the Illinois fee schedule is one of the highest in the nation. Because Illinois costs had been among the highest in the nation, and the law directed the fee schedule to be based on historical charges, the fact that Illinois costs are still among the highest is not surprising. In addition, because some proportion of the market was under contract that provided for discounted payments, a fee schedule based on charges could cause fee schedule amounts to be greater than previously contracted rates. Some providers that were not used to having their bills reduced did complain about the fee schedule. Overall, however, providers concede, and external studies agree, that the initial reimbursement levels were higher than in most other states.

Annual adjustment to fees

To contain costs, the fees are adjusted each year by the percentage change in the general Consumer Price Index-U. Because medical costs usually rise more rapidly than general inflation, this measure was expected to produce significant savings as the years go on. As the chart below shows, the fee schedule has produced 5% savings compared to medical inflation. Parties were surprised when it was announced that fees will actually decrease in 2010.

CPI ADJUSTMENTS TO MEDICAL FEES		
EFFECTIVE DATE	CPI-U	CPI-M
2/1/06	4.90%	4.37%
1/1/07	3.80%	4.26%
1/1/08	1.97%	4.52%
1/1/09	5.37%	3.26%
1/1/10	-1.48%	3.31%
Total	14.56%	19.72%
		|----5% savings--|

CPI-U: average percentage change in prices paid by urban consumers for a market basket of goods and services.
CPI-M: average percentage change in prices paid by for medical services.

Modifiers

The Commission adopted modifiers published by the American Medical Association (AMA), which provide guidelines for payments in various situations. The adoption of modifiers represents significant savings. For example, during a surgery, a doctor might perform several procedures. Before the fee schedule, it was common practice to pay each procedure at 100%. Since the adoption of the multiple procedure modifier, the 1st procedure is paid at 100% and subsequent procedures are paid at 50%.

Bundling edits

The Commission adopted bundling edits, which prescribe which procedures may be billed separately and which are included in more comprehensive procedures, e.g., hot and cold packs are considered part of physical therapy procedures and may not be billed separately; a diagnostic arthroscopy is considered part of a shoulder surgery and cannot be billed separately. Before the fee schedule, such charges could, in effect, be double-billed.

Payment guidelines

The Commission adopted payment guidelines that contain rules surrounding global periods for surgical procedures (e.g., office visits within 30-90 days after surgery are included in the price of the surgery), as well as billing rules for multiple procedures, bilateral procedures, assistant surgeons, co-surgery, and team surgery. Prior to the adoption of this provision, providers were unhindered in billing for procedures that are normally excluded in other health care payment systems.

Pass-through charges

The Commission adopted a rule that the following items, when billed by hospitals or ASTCs, shall be paid at 65% of charges:

- 0274 (prosthetics/orthotics)
- 0275 (pacemaker)
- 0276 (lens implants)
- 0278 (implants)
- 0540 and 545 (ambulance)
- 0624 (investigational devices)
- 0636 (drugs requiring detailed coding)

Before the fee schedule, many payers negotiated discounts for these items, but providers were often paid at 100% for these items because payers would end up paying the full amount if the injured worker was billed for the remaining balance.

Standardization of billing

Before the fee schedule regulations took effect, workers' compensation billing practices were completely unregulated. Payers often paid 100% of charges on bills that would be significantly reduced in other systems. The modifiers, billing edits, payment guidelines, pass-through charges, etc., have made billing in workers' compensation more uniform and predictable, and will undoubtedly save payers money in costs and administration.

Balance billing

Balance billing is the attempt by medical providers to bill injured workers for unpaid medical bills. For years, Illinois was one of the only states in the country that did not prohibit this practice. Workers were pursued by collection agencies, and their credit records damaged, for bills that were never their responsibility. Both business and labor groups supported a prohibition on balance billing, which is now part of the fee schedule law.

EFFECT OF FEE SCHEDULE: OVERALL EFFECT

Business representatives have expressed concern that the fee schedule is too generous. The real issue is whether the law has produced the negotiators' anticipated savings. The law was expected to yield a 6.5% cost savings through the fee schedule as well as other provisions authorizing utilization review, a workers' compensation fraud unit, etc. Were these expectations met?

Unfortunately, this is a difficult question to answer precisely. There are a number of reasons negotiators were unable to calculate expected savings precisely:

- Workers' compensation cases are often closed by lump-sum settlements that do not delineate medical costs;
- Before 2005, workers could be billed for the balance of unpaid medical services, so that the actual payment for a service was unknown;
- Some segment of the market (perhaps 25% or more) was and continues to be under contract for different payment amounts;
- The Commission does not have a database of medical information;
- Much medical information is considered private or proprietary; and
- Injury rates and the severity of injuries vary from year to year, which affects aggregate medical costs.

Just as it was hard to define expectations for the fee schedule law, it is hard to identify results. The information reported below is the latest data published, but it only represents the first year or so of the fee schedule. Stakeholders on all sides have indicated that their current experience may vary from the data presented below. The Commission and WCMFAB will monitor new data as it becomes available. While perspectives vary on the savings produced by the fee schedule, there is an agreement among the stakeholders that the growth rate of medical costs was significantly reduced as a result of the fee schedule.

The National Council on Compensation Insurance (NCCI), a private organization that issues advisory insurance rates for Illinois, initially estimated the fee schedule would produce insignificant savings. The NCCI *Annual Statistical Bulletins*, however, show a sharp decline in the growth of medical costs in the first year after the fee schedule was implemented.[1]

Average Medical Cost Per Case In Illinois

Policy Year	All Injuries	% Change
2000	$3,538	16.4%
2001	$3,942	11.4%
2002	$4,839	22.8%
2003	$5,779	19.4%
2004	$6,695	15.9%
2005	$7,735	15.5%
2006	$8,234	6.5%

We asked the NCCI to go back and review its calculations for past years to more precisely identify the effect of the fee schedule, but it was unable to do so in time for this report.

The Workers' Compensation Research Institute (WCRI), an organization funded primarily by insurers, used a different method—it analyzed only those cases involving more than seven lost workdays—and it also found that the growth rate of Illinois medical payments per claim sharply declined in the first year of the fee schedule. Note that, before the fee schedule, cost growth in Illinois had been outpacing other study states, but post-fee schedule, it grew at a much slower rate than other states. [2]

Growth in Average Medical Payment per Claim
With More Than 7 Days of Lost Work Time

Policy Year	Illinois	14-State Median
2002 – 2003	13.3%	10.7%
2003 – 2004	11.5%	6.7%
2004 – 2005	7.6%	7.0%
2005 – 2006	16.5%	8.4%
2006 – 2007	1.3%	6.3%

In addition, the WCRI found that nonfacility fees had been increasing 4.5 – 8% per year from 2001 – 2005, but fell 2% in the first year after implementation. Taken together, this indicates nonfacility savings of 6.5% - 10% in the first year.[3]

The WCRI also found that the growth rate for the utilization of services leveled off. Utilization is defined as the composite of the number of visits per claim, number of services per visit, and the resource intensity of services provided. Again, Illinois had been outpacing other study states, but the rate sharply declined in the first year of the fee schedule.[4]

Utilization of Nonhospital Providers
For Claims With More Than 7 Days of Lost Work Time
Annual Percentage Change

Policy Year	Illinois	14-State Median
2002 – 2003	6.6%	5.7%
2003 – 2004	5.7%	3.2%
2004 – 2005	2.5%	2.6%
2005 – 2006	10.1%	2.9%
2006 – 2007	0.7%	1.7%

In an effort to learn more of the effect of the law, the Commission invited any and all providers and payers to present their experiences to the WCMFAB. Representatives of various medical providers and payers, including some board members, made presentations, and their reported experiences vary widely. Two examples give a sense of the range of the reports:

- Board member Kim Moreland of Rising Medical Solutions, a statewide bill review company, reported that the fee schedule has reduced medical payments by 16%.
- Board member John Smolk of United Airlines, a self-insured employer large enough to have negotiated deep discounts before the fee schedule was enacted, claimed United has experienced little savings.

ISSUES OF CONCERN: ISSUES GOVERNED UNDER THE RULES

The Commission and the WCMFAB have discussed all of the following issues, and they will continue to try to develop solutions. If parties agree on a solution, a rule change would be required to implement it. Each change to the fee schedule may create an administrative burden with additional cost and effort for providers, payers, employers, and the Commission to implement and achieve compliance. New rules must be carefully considered with thought to the impact upon all stakeholders and the Commission.

Access to Care

Ideally, a fee schedule will reduce medical costs without harming workers' access to medical care. Section 8.2(b) of the Act does authorize the Commission to adjust fees if it finds there is a "significant limitation" to care. To date, the fee schedule does not appear to have harmed workers' access to care.

Only one provider has stepped forward and claimed an access problem. In 2007, a Jacksonville medical provider appeared before the WCMFAB and claimed that reimbursement for physical therapy in its geozip was so low—actually below Medicare rates—that it would stop treating injured workers in that area. That provider did close its facility, but board members were not persuaded that the closure was due to the fee schedule.

Action: The situation prompted the WCMFAB to discuss how the Commission might handle an access-to-care claim. The Commission and WCMFAB are working on drafts of a possible rule.

Ambulatory Surgical Treatment Centers (ASTCs): Payment of facility fees

By rule, only Ambulatory Surgical Treatment Centers (ASTCs) licensed by the Illinois Department of Public Health come under the ASTC fee schedule. Roughly 140 ASTCs are licensed by IDPH, and, according to IDPH criteria, there is no need for more.

The intention of the licensing provision was to discourage surgeries from being performed in unsafe and unregulated settings. It has the effect of eliminating the payment of facility fees to doctors' surgical suites, but also to unlicensed-but-accredited facilities. A representative of an unlicensed facility that has several Medicare-related accreditations asked the WCMFAB to consider those accreditations as alternative indications of safety and quality. This provider also reported that they now perform their surgeries in a hospital, which results in a higher charge to the employer.

Action: The WCMFAB has discussed expanding the fee schedule to include ASTCs with certain Medicare-related accreditations.

Equipment/Implants

Because of the variability of coding and charges for some equipment— implants, prosthetics, orthotics, and some other devices—the Commission promulgated rules providing that these items shall be paid at 65% of the charged amount. The Commission and WCMFAB understood that these items would be billed at the same rates as those charged to group health or Medicare, since hospitals must follow a chargemaster that lists the charge for each service provided by each hospital.

Individuals have reported, however, that some hospitals have chosen to exclude some implants from the chargemaster, and are charging substantially more under workers' compensation. Some business representatives claim that providers have raised rates not only to offset the 65% discount, but also to result in a significantly higher payment amount than before the fee schedule existed.

Payers have reported that they have said subpoenaed charge information, and hospitals have refused to comply. We await the outcome of such cases and for precedent to be set.

In other states, payment is more limited. Examples:

California	120% of Medicare.[5]
New York	Pay cost plus 10%, not to exceed $350. [6]
Oregon	Pay greater of 85% of manufacturer's suggested retail price or 140% of actual cost.[7]

Action: It appears clear that the 65%-of-charge provision in Illinois has led to excessive charges. A regulation that relies on a chargemaster will not prevent abuse. The Commission and the WCMFAB plan to draft a new rule that will establish a more reasonable provision based on implant costs.

Historical Charge Data

Most fee schedules refer to Medicare and either establish payment at a percentage above Medicare or set fees based on the cost of services (RBRVS). During the legislative negotiations, labor representatives were opposed to a Medicare-based fee schedule, fearing that the lower Medicare payments would hurt workers' access to care. Instead, negotiators agreed on a unique fee schedule based on historical charges between 2002-2004. (Charge data was used because payment data is usually proprietary and therefore unavailable.)

A charge-based fee schedule presents at least two issues: 1) it creates some anomalies in the fee schedule; and 2) it can make the administration of the fee schedule difficult.

During the rule-making process, some people raised concerns about some anomalous results produced by the fee schedule. An anomaly exists where there is a significant difference in the reimbursement rate for a procedure in one geozip compared to the rest of the state. As mentioned in the "Access to Care" section, physical therapy fees in the Jacksonville area seem unreasonably low. Meanwhile, some physical therapy fees paid to hospitals seem unreasonably high.

This is due to several factors. The law requires only nine bills in order to calculate a fee, and such a small number can create strange results. In addition, the law directed the Commission to use actual bills, which are subject to billing errors and varying billing practices.

The Joint Committee on Administrative Rules (JCAR) recommended that the Commission consider seeking a statutory amendment allowing the use of more recent data than the 2002-2004 data, and to continue to consider comments from interested parties on the validity of historical charge data. The Commission agreed with the recommendation.

In response, the project manager, Glen Boyle, proposed two statistical methods to the WCMFAB to smooth out anomalies. Under current law, the Commission does not have the authority to alter the fee schedule formulas, and board members did not agree on either method. If agreed-bill negotiators decide to address this issue, the Commission will provide information and support.

Secondly, a fee schedule based on historical data presents some administrative difficulty. When Medicare changed its hospital inpatient system from DRG to MS-DRG codes, it took the Commission 1 ½ years to promulgate rules, recalculate the bills, and adapt to the change. Parties were confused about how to translate from one set of codes to the other.

In addition, each year, dozens of codes are deleted and dozens are added. All codes that were created after 2/1/06 default to POC76. Over time, more and more codes default to POC76. The bulk of procedures performed in workers' compensation are still in current codes, but this can be expected to erode over time. Business groups are opposed to large areas of services defaulting to POC76.

Although the historical charge methodology is unusual, there is not widespread interest in replacing it. Instead, parties are focused on refining the method through rule changes. For example, one board member suggested the Commission could promulgate a rule authorizing a crosswalk between old and new codes, to reduce the use of POC76. The Commission and WCMFAB will work to draft a rule that will refine the method.

Resolution of Payment Disputes

Since the fee schedule was enacted, the Commission has received a large number of complaints from medical providers about insurance companies and third-party administrators. Providers claim that payers:

1. Pay less than the amount provided by the fee schedule;
2. Delay payments;
3. Refuse to pay the interest due on late payments, as authorized in Section 8.2(d) of the Act;
4. Fail to explain the basis of a denial or underpayment;
5. Tell the providers to call the Commission to find out why a bill was denied or reduced;
6. Unilaterally enroll providers, without their consent, in a network and then reduce payments accordingly;
7. After the fees increase each January 1, fail to pay the new fee schedule amounts;
8. Impose arbitrary requirements, e.g., while group health insurers generally allow providers to discuss several bills during one telephone call, a workers' compensation insurer only allows discussion of one bill per call, thereby making it more difficult to process bills.

Under the law, only employers and employees are authorized to petition the Commission for relief. Because the worker should not be billed for work-related medical treatment, the worker is disinclined to request a hearing before an arbitrator over an unpaid medical bill. Medical providers want a way to get their issues addressed.

At present, payment disputes are addressed inconsistently and inadequately. In an effort to minimize disputes, the Commission just completed a series of eight educational seminars around the state. The seminars cleared up a number of areas of confusion, and the project manager, Mr. Boyle, is now working to resolve some other issues that came to light during the discussions. The feedback from the seminar participants was very positive, and the Commission will continue to hold such seminars when changes are made to the fee schedule.

Action: The Commission and the WCMFAB are working with the Illinois Department of Insurance to establish a timely and objective process to resolve payment disputes that are beyond the jurisdiction of the Commission, such as those involving unilateral contracts and other improprieties.

In addition, to try to prevent disputes from occurring, the Commission and WCMFAB have agreed to draft a rule that will require payers to provide an Explanation of Benefits for every bill that clearly explains the basis of reductions or denials made by the payer.

ISSUES OF CONCERN: ISSUES SET IN LAW

The Commission and the WCMFAB have discussed all of the following issues, and they will continue to try to develop solutions. These issues would require legislation if changes were desired. We again remind all parties that each change to the fee schedule may create an administrative burden with additional cost and effort for providers, payers, employers, and the Commission to implement and achieve compliance. Amendments must be carefully considered with thought to the impact upon all stakeholders and the Commission.

Geozips

By law, there is a fee set for each procedure for each three-digit zip code in Illinois. Zip codes in Illinois range from 600-- to 629--, resulting in 29 different fees for each procedure. Payers have reported that some medical providers are gaming the system, providing care in nearby regions to obtain the highest payment. No other state in the country has so many regional w.c. fee schedules. Some states have a few regions, while most states have only one fee schedule for the entire state.

Action: The unusually large number of regional fee schedules produces anomalies in the fees, adds complexity to an already complicated system, and increases administrative and technical burdens. The Commission and WCMFAB will work to devise an appropriate map of fewer regions, and recommend it be enacted into law by the legislature.

Interest

Section 8.2(d) of the Act provides that payers shall pay medical bills 60 days after receipt of a complete bill, and authorizes medical providers to charge 1% per month interest after that time.

Providers widely report that payers are not paying the interest. One provider reported to the WCMFAB that payments for workers' compensation bills take 10 times longer than that for group health insurance, and there has been no improvement in the payment cycle since the interest provision was enacted. During the fee schedule seminars, the interest provision was explained and discussed. The Commission will continue to educate parties about this provision.

In addition, people disagree over what constitutes a "complete" bill. The International Association of Industrial Accident Boards and Commissions is studying the issue but has not reached agreement.

Action: The WCMFAB will invite payers to submit information about their policies, invite providers to share their concerns, and then draft a rule defining the documentation that should be included with a bill.

Utilization Review (UR)

Under Section 8.7 of the Act, utilization review is the evaluation of past, current, and/or future medical services to determine the appropriateness of the level and/or quality of care. UR addresses the necessity, appropriateness, setting, and intensity of the care. Utilization techniques may include second opinions, concurrent review, discharge planning, peer review, and independent medical examinations.

Utilization review is allowed but not required. If an employer wishes to conduct utilization review, it must use a professional who has registered with the Department of Insurance[8] and certifies compliance with URAC (national standards for the utilization review process). The review must be based on national standards of evidence-based medical care.

The Commission shall consider the UR report, along with all other evidence and in the same manner as all other evidence, in the determination of the reasonableness and necessity of the medical bills or treatment. If an employer denies payment or refuses to authorize treatment while relying on a proper UR program, there shall be a rebuttable presumption that the employer is not subject to penalties for the denial.

We have heard complaints that arbitrators and commissioners do not understand UR. In the fall of 2009, the Commission invited UR specialists and practicing attorneys to speak on UR at an IWCC judicial training program. A representative of a national standard of evidence-based medicine spoke on the background and use of evidence-based medicine, while a representative of a UR provider explained its processes, a doctor from the WCMFAB explained problems experienced while dealing with UR representatives, and practicing attorneys discussed issues that arise regarding the use of the UR evidence during a trial. The program increased the Commission's understanding of UR, and the Commission will continue to hold training programs as needed.

Another complaint is that the reviewing doctors are often out-of-state, which means they are often unfamiliar with Illinois law, and not subject to Illinois subpoena. Providers also complain that UR reviewers are hard to reach, which delays treatment, which can harm the patient and cost the employer. The Commission and WCMFAB will discuss the need for a rule requiring UR reviewers to be more accessible to providers and the IWCC hearing process.

Some concerns are due to unfamiliarity with the law, rather than with the law itself. Some providers have complained that payers are using UR improperly, e.g., their evaluation times exceed the URAC timelines, or that the UR professionals are hard to reach to discuss matters. Some providers complained that a doctor with one specialty reviewed treatment for a doctor with another specialty, e.g., a general practitioner turned down an orthopedic surgeon's recommendation for a spinal surgery. These practices are all prohibited by the URAC standards in the current law, but people may not realize that. The Commission will work to publicize the complaint avenues that are available to parties who encounter such problems.

As with any new law, it takes time for people to learn and make the best use of the UR provisions. Parties report that employers are using UR more and more, and better understanding its application. As precedents are set, and payers see which UR reports lead to successful outcomes, they will adjust their practices to their advantage. The Commission and the WCMFAB will discuss possible rule changes to make the URAC timelines and other provisions more clear.

By law, the Commission resolves workers' compensation disputes while the Illinois Department of Insurance has the authority to register and oversee the behavior of utilization review organizations (UROs). The Commission and WCMFAB clearly see the need for an audit process to make sure that UR organizations follow the URAC standards, as required by Section 8.7(b).

Action: The Commission is working with the Illinois Department of Insurance to promote enforcement of Section 8.7(f), which directs the IDOI to investigate complaints that a UR organization is not following URAC standards and, if necessary, issue a corrective action plan and, at last resort, a cease-and-desist order. In addition, the Commission and WCMFAB will continue to study UR regulations in other states.

CONCLUSION

Despite the limitations of the available data, the fee schedule appears to be responsible for positive trends in medical costs that are expected to continue, without harming workers' access to medical care. While perspectives vary, there is an agreement among the stakeholders that the growth rate of medical costs was significantly reduced as a result of the fee schedule.

This report has identified a number of possible improvements that could be made; the Commission and the Workers' Compensation Medical Fee Advisory Board will continue to work with all interested parties on these issues. This report will serve as an agenda for future board meetings.

The experience of other states indicates that fee schedules require continuing adjustment. Before any other major changes are made, however, reliable information should be obtained. Whenever the interested parties decide to reopen legislative negotiations, we strongly recommend that they allow the Commission the time and support to obtain good data first.

Finally, the Commission and WCMFAB would like to express appreciation to the agreed-bill negotiators and legislators for their foresight in directing the production of this report. It prompted all interested parties to engage in more focused discussions of the issues, which has resulted in greater understanding and commitment among the participants. We hope it will set the tone for future collaborations that will lead to improvements in the fee schedule.

Statutory citation: 820 ILCS 305/8(a) and 8.2 Rules: 50 Illinois Administrative Code 7110

The fee schedule is available at http://iwcc.ingenixonline.com/IWCC.asp/ .

HB2137 is available at http://www.ilga.gov/legislation/publicacts/94/094-0277.htm/. A summary of the bill is available at http://www.iwcc.il.gov/HB2137.pdf/.

In December 2009, 100 copies of this report were printed in-house by the authority of the State of Illinois. No printing order number was used. The report is available online at http://www.iwcc.il.gov/GAFSR.pdf/.

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[1] National Council on Compensation Insurance, *Annual Statistical Bulletin*, 1996-2009 editions, Exhibit XI ("First Report" data).

[2] Workers' Compensation Research Institute, *Monitoring the Impact of 2005 Reforms in Illinois: CompScope Medical Benchmarks, 9th Edition*, June 2009, pages 3, 77.

[3] WCRI, pages 3, 14.

[4] WCRI, page 82.

[5] California Department of Industrial Relations, " memo dated 6/25/09, found at http://www.dir.ca.gov/dwc/OMFS9904.htm#3/.

[6] New York's "Reimbursement to General Hospitals for Implantable Hardware and Instrumentation Utilized in Spinal Procedures," 1/31/07, found at http://www.wcb.state.ny.us/content/main/SubjectNos/sn046_166.jsp/.

[7] Oregon Administrative Rule 436-009-0080, found at http://wcd.oregon.gov/policy/rules/rules.html/.

[7] WCRI, pages 3, 17, 82.

[8] At the time Section 8.7 was enacted, the Department of Insurance was a division within the Department of Financial and Professional Regulation. It later became a self-standing agency. The IDOI is responsible for registering and ensuring compliance of utilization review organizations (UROs).