AN ACT concerning government.

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

Section 5. The State Employees Group Insurance Act of 1971 is amended by adding Section 6.11A as follows:

(5 ILCS 375/6.11A new)

Sec. 6.11A. Physical therapy and occupational therapy.

(a) The program of health benefits provided under this Act shall provide coverage for medically necessary physical therapy and occupational therapy ordered or referred by a physician licensed under the Medical Practice Act of 1987, a physician's assistant licensed under the Physician's Assistant Practice Act of 1987, or an advanced practice nurse licensed under the Nurse Practice Act.

(b) For the purpose of this Section, "medically necessary" means any care, treatment, intervention, service, or item that will or is reasonably expected to:

(i) prevent the onset of an illness, condition, injury, disease, or disability;

(ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, disease, or disability; or

(iii) assist the achievement or maintenance of

maximum functional activity in performing daily activities.

(c) The coverage required under this Section shall be subject to the same deductible, coinsurance, waiting period, cost sharing limitation, treatment limitation, calendar year maximum, or other limitations as provided for other physical or rehabilitative or occupational therapy benefits covered by the policy.

(d) Upon request of the reimbursing insurer, the provider of the physical therapy or occupational therapy shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued treatment is medically necessary and is resulting in approved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of the diagnosis, proposed treatment by type, proposed frequency of treatment, anticipated duration of treatment, anticipated outcomes stated as goals, and proposed frequency of updating the treatment plan.

(e) When making a determination of medical necessity for treatment, an insurer must make the determination in a manner consistent with the manner in which that determination is made with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity may be viewed as reasonable only if the review includes a licensed health care

professional with the same category of license as the professional who ordered or referred the service in question and with expertise in the most current and effective treatment.