

School Based Health Clinic

Fee Schedule Key

Effective 04/01/2026 Updated 07/21/2026

Instructions For Billing Multiples	
Note is A	<u>For providers listed above with the exception of Portable X-ray Companies and Independent Laboratories:</u> ➤ Quantity up to and including 5: • Claim must be submitted electronically** • Enter the number of tests performed on a single date of service in the days/units field ➤ Quantity greater than 5: • Claim must be submitted electronically** • Enter in the days/units field the number of tests performed on a single date of service • Test results must be uploaded through the Attachment Upload Portal prior to submitting the claim electronically**
Note is B or C, any of the above providers	<u>NOTE: The number listed in the days/units field must be "1" and procedures are:</u> <u>Bilateral:</u> • Enter the procedure code with modifier RT and quantity '1' in days/units field • Enter the procedure code with modifier LT and quantity '1' in days/units field on the subsequent service section <u>Not Bilateral:</u> • Enter the specific procedure code on one service section • Enter the unlisted procedure code for quantities greater than one in the next service section • List the total number and name of additional tests in the description/note field***. • Documentation for all tests must be uploaded through the Attachment Upload Portal prior to submitting the claim electronically**
Note is H	• Claim must be submitted electronically** • Enter the specific procedure code and the number of tests performed on a single date of service, up to the max quantity, in the days/units field
Maximum Quantity is greater than 1	Submit the number of units performed or dispensed on a single date of service, up to the listed max quantity, in the days/units field.
HP=Y	<u>NOTE: The number listed in the days/units field must be "1"</u> <u>Practitioner purchased and administered drugs:</u> • Claim must be submitted electronically** • Enter the name of the drug, strength of the drug, and the amount given in the description/note field*** according to NDC billing guidelines found in the Handbook Supplement on the Provider Handbooks webpage

HP = N; Max qty is "1" or blank, and note fields are blank, and procedures	<u>Bilateral:</u> • Enter the procedure code with modifier RT and quantity '1' in days/units field in one service section • Enter the same procedure code with modifier LT and quantity '1' in the days/units field in the next service section <u>Not Bilateral:</u> • Enter the specific procedure code on one service section • Enter the unlisted procedure code for quantities greater than one in the next service section and list the total number and name of additional tests in the description/note field***

Column HEADING	Column Description
HCPCS	CPT-4 or HCPCS procedure code.
Note:	Special billing information applies to the code.
A	Professional and technical components are each reimbursed at 50% of the state maximum.
B	Professional and technical components are each reimbursed at 50% of the state maximum, rounded to the nearest cent.
C	Reimbursements for professional and technical components split at a rate other than 50%.
D	Code is billable by encounter rate clinic only. Reimbursement for 90845 (as a detail code to T1015) is the provider-specific encounter rate. Reimbursement for S5190 is \$0.00.
E	Vaccine is supplied through the Vaccines For Children (VFC) program for children age 0 through 18.
F	Vaccine is not available through the VFC program. Additional <i>Unit Price</i> reimbursement is not applicable.
H	• Reimbursements for professional and technical components split at the rates shown in Columns M1 and M2 • Multiples are allowed up to the posted Max Qty
J	• Covered only when specimen is obtained and submitted to IDPH for processing for blood lead analysis as a Healthy Kids service for ages 0-20 years • Must be billed with the U1 modifier as documentation that the service meets this description • Billing guidelines are available in the Practitioner Handbook.
M	• Enter name of vaccine in the description/note field*** • The EPSDT indicator is required to identify as a preventive service • Vaccine restricted to the CDC's ACIP recommended ages • Vaccine is supplied through the VFC program for children through 18 years of age Obstetric/Gynecology providers are reimbursed for the HPV vaccine product for the CDC's ACIP recommended ages as shown in the State Max column when billed with SL modifier
N	Prior approval (PA) required for practitioner-purchased and administered drugs. Please reference the Pharmacy webpage for PA guidelines. Drug PA is obtained through Pharmacy.
T	A \$12.00 dispensing fee is allowed for 340B enrolled providers when billed with the "UD" modifier. The dispensing fee must be billed as CPT code 99070 in accordance with the November 18, 2021 provider notice .

U	A \$35.00 dispensing fee is allowed when billed with the “UD” modifier for highly effective birth control methods purchased through the 340B federal Drug Pricing Program. The \$35.00 dispensing fee is also allowed to 340B providers for the following unclassified/NEC procedure codes: • J3490 when billing Depo-SubQ Provera 104mg Injection • J8499 when billing Emergency Contraceptives (ECPs), effective June 1, 2016 The dispensing fee must be billed as CPT code 99070 in accordance with the November 18, 2021 provider notice.
V	Smoking cessation counseling services are reimbursable when provided to pregnant and post-partum women, as well as children age 2-21 years under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), in accordance with the August 26, 2014 provider notice .
W	Reimbursable only to a designated eligible/approved facility by the Department. The CPT code must be billed by the eligible/approved rendering practitioner with the FP modifier, and the facility must be designated as the billing provider/payee on the claim.
CC	Effective 10/01/2023, the U5 modifier must be used with an appropriate level evaluation and management visit code in the range 99202-99215 when billing a subsequent prenatal care visit in accordance with the ‘Billing Guidelines for Changes to Maternity Care Reimbursement’ document on the NIPS webpage. The U5 modifier will distinguish these prenatal care services from other types of visits and also derive a rate of \$104.96, mirroring the rate for 0502F that was formerly used to bill subsequent prenatal care visits prior to 10/01/2023.
DD	<<Correction to previous description of Note DD>> Retroactive to the 9/30/2023 Practitioner Fee Schedule and Practitioner Fee Schedule Key, prior approval for CPT 90678 is NOT required for pregnant customers with a gestational age of 32-36 weeks. Previous instructions were to attach the HFS 1624 Override Request Form for an age override of the R17 error so the PA could be verified. System changes have been made to not reject these claims with the R17 error. Providers who had claims previously reject with the R17 error code may resubmit, with a request for time override when applicable using the HFS 1624 Override Request Form.
EE	The Department will reimburse the “initial prenatal care visit”, 0500F when billed in conjunction with the U4 modifier when not billing a global maternity code in accordance with the ‘Billing Guidelines for Changes to Maternity Care Reimbursement’ document on the NIPS webpage. *Note: 0502F and 0503F were discontinued effective 10/1/2023 in accordance with these changes.
II	CPT code will require either the U1 or U2 modifier, but not both, and can be combined with other applicable modifiers, effective 8/1/26. If the U1 or U2 is not used on this code for DOS on/after 8/1/26, the claim will reject L54. Coding Updates reimbursable in accordance with the Provider Notice issued 07/07/2026
Eff Date (Effective Date)	Effective date of codes added on or after 01/01/07 <i>or</i> date of change in payment policy.
HP (Hand Priced Indicator)	If “Y”, special pricing methodology is applied: Practitioner purchased and administered drugs: <i>The number listed in the days/units field must be “1”.</i> Claims must be submitted electronically**. The name of the drug, strength of the drug, and the amount given must be shown in the description/note field*** and must be billed according to NDC billing guidelines found in the Handbook Supplement on the Provider Handbooks webpage. Medical/surgical procedures: <i>The number listed in the days/units field must be “1”.</i> Claims must be submitted electronically**. The specific name of the procedure and the total number of times performed must be submitted in the description/note field***. Supporting documentation

	must be uploaded through the Attachment Upload Portal prior to submitting the claim electronically**.
NDC Ind (NDC indicator)	If “Y”, the 11-digit NDC must be billed according to NDC billing guidelines available in the Handbook Supplement .
AV (Anesthesia Value)	Value assigned by the Department and used in the calculation of the anesthesia formula, which is found in the Handbook Supplement .
M1 (Modifier 1) 26	Rate paid for the professional component of the procedure.
M2 (Modifier 2) TC	Rate paid for the technical component of the procedure.
Assist Surg (Assistant Surgeon)	“Y” indicates services of an assistant at surgery may be paid.
CoSurg (Co-Surgeon)	“Y” indicates services of a co-surgeon may be paid.
Unit Price	Price for each unit when multiple quantities are billable, or reimbursement for VFC-obtained vaccine administered to a child age 0-18.
Max Qty (Maximum Quantity)	The maximum number of units payable for the code.
State Max (State Maximum)	The maximum allowable reimbursement. This amount reflects combined professional and technical components where applicable, or the maximum reimbursement for a vaccine administered to an adult age 19+ when applicable for a vaccine code.
Add-On	<u>Surg</u> The amount added to the state maximum when the procedure is performed in the practitioner’s office. This amount covers such items as casting and surgical supplies. <u>Child</u> The amount added to the state maximum for services rendered by practitioners enrolled in the Maternal Child Health program. <u>Adult</u> The amount added to the state maximum for services rendered by practitioners enrolled in the Maternal Child Health program.

**Please refer to the [November 24, 2021 provider notice](#) regarding final phase-out of paper claim billing, and for instructions regarding the Attachment Upload Portal. Effective with claims received on and after December 15, 2021, the Department will no longer accept paper claims.

***The description/note field is the “procedure literal description” field for MEDI DDE claims, or the Loop 2400 NTE segment on electronic transactions.