Healthcare and Family Services
Practitioner Fee Schedule Key
2/1/2010

For charges submitted by Physicians, Advanced Practice Nurses, Imaging Centers, Portable X-ray Companies, School-Based/Linked Health Centers, Local Health Departments, Encounter Rate Clinics, Independent Laboratories, Fee-For-Service Hospitals, and Optometrists and Dentists Providing Medical Services

Instructions for billing multiples	
Note is A:	Enter in the days/units field the number of tests performed on a single date of service. When the quantity exceeds 5, claim must be submitted on paper with all test results attached.
Note is B and Procedures:	-**are bilateral**, submit the procedure code once with modifier 50 and show quantity "1" in days/units field to represent two procedures performed. -**are not bilateral**, submit on paper with all test results attached. Submit the procedure code on one service section, and submit in the next service section the unlisted procedure code for any quantity beyond the first. List total number and name of additional tests in description field.
Note is C and procedures:	-**are bilateral**, submit the procedure code with modifier RT and quantity "1" in days/units field, and in the subsequent service section submit the same procedure code with modifier LT and quantity "1" in days/units field -**are not bilateral**, submit on paper with all test results attached. Submit the procedure code on one service section, and submit in the next service section the unlisted procedure code for any quantity beyond the first. List total number and name of additional tests in description field.
Maximum Quantity is greater than 1:	Submit in the days/units field the number of units performed or dispensed on a single date of service.
HP=Y:	***The number listed in the days/units field must be "1" -**Practitioner purchased and administered drugs**: May be submitted electronically or on paper. The claim must contain the name of the drug, strength of the drug, and the amount given shown in the description/note field and must be billed according to NDC billing guidelines available on our Web site at http://www.hfs.illinois.gov/assets/122107n.pdf -**Medical/surgical procedures**: Claims must be submitted on paper. The name of the procedure and total number of times performed must be submitted in the description/note field, and the procedure note must be attached.
HP = N; Max qty is "1" or blank, and note fields are blank, and procedures:	-**are bilateral**, submit the procedure code with modifier RT and quantity "1" in days/units field, and in the subsequent service section submit the same procedure code with modifier LT and quantity "1" in days/units field -**are not bilateral**, claims must be submitted on paper with procedure report attached. Submit the procedure code on one service section, and submit in the next service section the unlisted procedure code for any quantity beyond the first. List total number and name of additional tests in description field.

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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.
E	Vaccine is supplied through the Vaccines For Children (VFC) program. The department reimburses for the administrative cost (practice expense) of the vaccine only, for ages 0-19 years, as shown in the Unit Price column.
F	Vaccine is not available through the VFC. The department reimburses for the vaccine when it is medically necessary.
G	Vaccine is supplied for children, but not adults, through the VFC. The department reimburses for the administrative cost (practice expense) of the vaccine for ages 0-18 years as shown in the Unit Price column. The department reimburses for the vaccine for adults, ages 19 and older, as shown in the State Max column when medically necessary.
H *Removed*	
I *Removed*	
J	Covered only for blood lead draws as a Healthy Kids service for ages 0-20 years, and must be billed with the U1 modifier as documentation that the service meets this description.
M	Age restricted to 9-26 years. Vaccine is supplied through the VFC program for ages 9-18 years. The department reimburses VFC-enrolled providers for administrative cost (practice expense) as shown in the Unit Price column. The department reimburses for the vaccine for ages 19-26 years, and ages 9-26 years for non-VFC providers, as shown in the State Max column. Additional information is provided at http://www.hfs.illinois.gov/physicians/.
N	Prior approval required for physician-purchased and administered drug. Prior approval guidelines are provided at http://www.hfs.illinois.gov/pharmacy/guidelines.html.
P	Add-on applies only when the Primary Care Physician provides services.
Q	State maximum amount now includes the Maternal Child Health Add-on amount for all providers.
R	Covered only for ages 0-20 years. Reimbursement for professional and technical components splits at a rate other than 50%.

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S	© indicates child professional and technical components, (A) indicates adult professional and technical components
Prog Cov (Program Coverage)	**02**-Title XIX coverage only (limited Transitional Assistance coverage) **04**-Medicaid covered services **09**-Qualified Medicare Beneficiary (QMB) coverage only (See Chap 100 Section 120.12, posted on our Web site at <http://www.hfs.illinois.gov/handbooks/chapter100.html
Eff Date (Effective Date)	Effective date of codes added on or after 01/01/07 or date of change in payment policy.
HP (Hand Priced Indicator)	If "Y", special pricing methodology is applied.
NDC Ind (NDC indicator)	If "Y", the 11-digit NDC must be billed according to NDC billing guidelines available on our Web site at http://www.hfs.illinois.gov/assets/122107n.pdf
Surg Ind (Surgery Indicator)	B = Obstetrical service N = Not considered surgical I = Incidental. Procedure may not pay separately when billed with other surgical codes. M = Major. Reimbursement for procedure includes 30-day postoperative care.
AV (Anesthesia Value)	Value assigned by dept and used in the calculation of anesthesia payment.
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 (Assist 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* base amount payable for ages 0-20 years when followed by "C".
Max Qty (Maximum Quantity)	The maximum number of units payable for the code.
State Max (State Maximum)	The maximum allowable reimbursement (reflects combined professional and technical components where applicable) *or* The base amount payable for ages 21 years and older when followed by "(A)".
Add-On	**Surg**: 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. **Child**: The amount added to the state maximum for services rendered to ages 0-20 years. Preventive medicine and Evaluation and Management code add-ons are payable only to Primary Care Providers. **Adult**: The amount added to the state maximum for services rendered to ages 21 years and older. Preventive medicine and Evaluation and Management code add-ons are payable only to Primary Care Providers.