Illinois Department of Healthcare and Family Services

Practitioner Fee Schedule Key

Revised 04/22/2016

The Practitioner Fee Schedule applies to charges submitted by the following providers:

- Advanced Practice Nurses
- Dentists Providing Medical Services
- Encounter Rate Clinics
- Fee-For-Service Hospitals
- Imaging Centers
- Independent Diagnostic Testing Facilities (IDTFs)
- Independent Laboratories
- Local Health Departments
- Optometrists Providing Medical Services
- Physicians
- Portable X-ray Companies

<table>
<tr><th colspan="2">INSTRUCTIONS FOR BILLING MULTIPLES</th></tr>
<tr><td>Note is A:</td><td><u>For providers listed above with the exception of Portable X-ray companies and Independent Laboratories:</u>
Quantity up to and including 5:
Claim may 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 on the paper HFS 2360 with all test results attached.
Enter in the days/units field the number of tests performed on a single date of service.
<u>For Portable X-ray companies and Independent Laboratories</u>:
Quantity up to and including 5:
Claim may be submitted electronically.
Enter in the days/units field the number of tests performed on a single date of service.
Quantity exceeding 5:
Claim must be submitted on the paper HFS 2211 with all test results attached.
Enter the specific procedure code on one service section for the first test.
Enter the unlisted procedure code for any quantity beyond one in the next service section and include the total number and name of additional tests in the description field for the unlisted code.</td></tr>
<tr><td>Note is B or C, any of the above providers:</td><td>*The number listed in the days/units field must be “1” and procedures are:
<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</td></tr>
</table>

	service section. • List the total number and name of additional tests in the description field. • Attach documentation for all tests.
Note is H:	**<u>Providers billing multiples on the HFS 2360:</u>** • Claim may 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. **<u>Provider Type 061 Independent laboratory billing multiples on the HFS 2211</u>:** • Claim may be submitted electronically. • Enter the specific procedure code on one service section for the first test. • Enter the unlisted procedure code for any quantities greater than one in the next service section. • Include the total number of additional tests, up to the max quantity, and name of additional tests in the description/note 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>PLEASE NOTE</u>: The number listed in the days/units field must be "1"*** **<u>Practitioner purchased and administered drugs</u>**: • Claim may be submitted electronically or on paper. • Enter the name of the drug, strength of the drug, and the amount given in the description or note field/NTE segment according to NDC billing guidelines available in Chapter A-200 Practitioner Handbook Appendix A-6. **<u>Medical/surgical procedures</u>**: • Claim must be submitted on the paper HFS 2360 with the specific procedure code and quantity of one in the days/units field of one service section with documentation attached. • When billing quantities greater than one, enter the unlisted procedure code in the next service section and the number of times performed in the description/note field. **<u>Provider Type 061 Independent laboratory billing multiples on the HFS 2211</u>:** • Claims must be submitted on paper. • Enter the specific procedure code on one service section for the first test. • Enter the unlisted procedure code for quantities greater than one on the second service section and include the total number and name of the additional tests in the description/note field. • Attach documentation for all tests.
HP = N; Max qty is "1" or blank, and note fields are blank, and procedures are:	**<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 field.

Fee Schedule Key

Revised 4/22/2016

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.
F*	Vaccine is not available through the VFC.
G*	Vaccine is supplied for children, but not adults, through the VFC.
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.
I*	• Enter name of vaccine in Note Field (Loop 2400 of 837P). • Vaccine restricted to females age 9-25 years. • Vaccine is supplied through the VFC program for ages 9-18 years. • Obstetric/Gynecology providers are reimbursed for the vaccine product for ages 9-25 as shown in the State Max column.
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 Chapter A-200 Practitioner Handbook Section A-225.18.
K	Prior approval required for surgeon and assistant surgeon. Anesthesia services for these codes must be billed using the five-digit anesthesia procedure code.
M*	• Enter name of vaccine in Note Field (Loop 2400 of 837P). • Vaccine restricted to age 9-26 years. • Vaccine is supplied through the VFC program for ages 9-18 years. • Obstetric/Gynecology providers are reimbursed for the vaccine product for ages 9-25 as shown in the State Max column.
N	Prior approval required for practitioner-purchased and administered drug. Prior approval guidelines.
P	Add-on is paid only to the PCP.
Q	State maximum amount 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%.
S	Additional amount paid to any provider for the component performed: • Global add-on = $51.66. • Professional component add-on = $10.33. • Technical component add-on = $41.33.
T	A $12.00 dispensing fee is allowed for 340B enrolled providers when billed

	with the "UD" modifier. For additional information and eligibility requirements, providers may reference the Informational Notice dated April 15. ***Dispensing fees were reduced by $1.00 for dates of service May 1, 2015 – June 30, 2015**
U	A $35.00 dispensing is fee 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 allowed to 340B providers for the following procedure codes: • J3490 when billing Depo-SubQ Provera 104mg Injection • J8499 when billing Emergency Contraceptives (ECPs), effective June 1, 2016 ***Dispensing fees were reduced by $1.00 for dates of service May 1, 2015 – June 30, 2015.**
V	Smoking cessation counseling services for pregnant and post-partum women in addition to children 2-21 years under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
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.
X	Claim must be submitted on paper with a copy of the invoice showing the practitioner's acquisition cost for the item attached.
Prog Cov (Program Coverage)	**04**-Medicaid covered services. **09**-Qualified Medicare Beneficiary (QMB) coverage only.
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: **Anesthesia codes:** system priced according to Chapter A-200, Section A-221 and Appendix A-7. **Practitioner purchased and administered drugs**: *The number listed in the days/units field must be "1".* Claims may be submitted electronically or on paper. 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 available in Chapter A-200 Practitioner Handbook Appendix A-6. **Medical/surgical procedures**: *The number listed in the days/units field must be "1".* Claims must be submitted on paper. The specific name of the procedure and the total number of times performed must be submitted in the description/note field, and the procedure note must be attached. **Provider Type 061 Independent laboratory billing on the HFS 2211:** Claims must be submitted on paper. The specific name of the procedure and total number of times performed must be submitted in the description/note field, and the test report(s) must be attached.
NDC Ind (NDC indicator)	If "Y", the 11-digit NDC must be billed according to NDC billing guidelines available in Chapter A-200 Practitioner Handbook Appendix A-6.
Surg Ind (Surgery Indicator)	**N** or blank = Not considered surgical. **I** = Incidental. Procedure may not pay separately when billed with visit or other surgical codes. **M** = Major. Reimbursement for procedure includes 30-day postoperative care.
AV (Anesthesia Value)	Value assigned by the Department and used in the calculation of anesthesia rates.

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* 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 by any practitioner to participants age 0-20 years, with the exception of preventive E/M codes. • Add-ons for *preventive* Evaluation and Management codes are payable only to Primary Care Providers. **Adult** • The amount added to the state maximum for services rendered by any practitioner to participants age 21 years and older, with the exception of preventive E/M codes. • Add-ons for *preventive* Evaluation and Management codes are payable only to Primary Care Providers.
Rate reduced by 2.7%	Maximum amount payable after 2.7% rate reduction per SMART (PA097-0689). Exempt: Physicians, Dentists, Advanced Practice Nurses, Community Mental Health Providers, FQHCs, RHCs, ERCs, LEAs, DORS Schools, School-based Clinics, Local Health Departments, and Early Intervention.

Vaccine Information for Notes E, F, G, I, M:

- All available vaccines for children through age 18 should be obtained through the Vaccines for Children (VFC) program. Specialty/sub-specialty OB-GYN practitioners are not required to participate in the VFC program.
- The department will reimburse the administrative cost shown in the Unit Price column. Administrative cost refers to the practice expense of obtaining the vaccine through the VFC program.
- For vaccines not available through the VFC program, the department will reimburse the medically necessary vaccine product as shown in the State Max column.
- The E/M service payment includes reimbursement for the injection service except when noted. Billing guidelines are available in the Chapter A-200 Practitioner Handbook, Section A-226.