Illinois Department of Healthcare and Family Services

Practitioner Fee Schedule Key

Effective 07/01/2024 Updated 11/18/2024

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

- Advanced Practice Nurses
- Dentists Providing Medical Services
- Encounter Rate Clinics
- Imaging Centers
- Independent Diagnostic Testing Facilities (IDTFs)
- Independent Laboratories
- Local Health Departments
- Medi-check Clinics
- Optometrists Providing Medical Services
- Physicians and Physician Assistants
- Portable X-ray Companies

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** **<u>For Portable X-ray Companies and Independent Laboratories</u>**: ➢ Quantity up to and including 5: • Claim must 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 electronically** • 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/note field for the unlisted code***. • 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</u>: 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 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	**<u>All providers, except Independent Laboratories (Provider Type 061), billing multiples:</u>** • 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 **<u>Independent Laboratories (Provider Type 061) billing multiples</u>:** • Claim must 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>NOTE</u>: The number listed in the days/units field must be "1"*** **<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 available in the Practitioner Handbook **<u>Medical/surgical procedures</u>**: • Claim must be submitted electronically with the specific procedure code and quantity of '1' in the days/units field of one service section with documentation uploaded through the Attachment Upload Portal prior to submitting the claim electronically** • When billing quantities greater than '1' and there is no available add-on code for additional quantities, 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 Laboratories billing multiples</u>:** • Claims must be submitted electronically** • Enter the specific procedure code on one service section for the first test • Enter the unlisted procedure code for quantities greater than '1' on the second service section and include the total number and name of the 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**
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 *Unit Price* reimbursement is not applicable.
G	Coverage for gender affirmation services only. Claim must be billed electronically with a copy of the Department's prior authorization approval letter for gender affirmation surgery attached. Please refer to the January 3, 2020 provider notice.
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.
K	Prior approval required for surgeon(s). Prior approval not required for assistant surgeon. Anesthesia services for these codes must be billed using the five-digit anesthesia procedure code.
L	Billable only as a detail code by Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Encounter Rate Clinics (ERCs).
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.
O	(Effective 12/01/2021) Code is payable only for 340B drug dispensing fee(s) reimbursable in accordance with the November 18, 2021 provider notice.
P	Add-on is payable only to the PCP or affiliate within the same group.
Q	State maximum amount includes the Maternal Child Health Add-on amount for all providers.

R	• Covered only for ages 0 through 20 years • Reimbursement for professional and technical components splits at a rate other than 50%
S	If service is related to gender affirmation services, the claim must be billed electronically with a copy of the Department's prior authorization approval letter for gender affirmation surgery attached. Please refer to the Provider Notice issued 01/09/2020. Otherwise, the service will reject for lack of medical necessity if billed only with a gender affirmation diagnosis.
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 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 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. **Note:** The 340B dispensing fee applies only to Encounter Rate Clinics (ERCs), Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) when billing for Long-Acting Reversible Contraceptives (LARCs) fee-for-service separately from the medical encounter.
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.
X	Claim must be submitted electronically. A copy of the invoice showing the practitioner's acquisition cost for the item must be uploaded through the Attachment Upload Portal prior to submitting the claim electronically.**
Y	These services are reimbursable to licensed physicians and advanced practice nurses who meet the following criteria, in accordance with the February 3, 2023 provider notice: • Have a Child/Adolescent Psychiatric (CAP) residency or General Psychiatric Residency (GAP) specialty on their HFS provider file; and • Are enrolled in IMPACT with a psychiatric specialty Providers should confirm their CAP or GAP specialty using their Provider Information Sheet. ***NOTE:*** *These codes are not to be billed in conjunction with the Collaborative Care Model codes identified in the June 21, 2022 provider notice. As defined in the CPT codebook, the consultant practitioner should not have seen the patient in a face-to- face encounter within a 14-day period before or after the consult.*
Z	Rate for practitioners enrolled in the Breast Cancer Quality Screening & Treatment Initiative program. ***NOTE***: these rates are updated annually, every January 1st, to be the Chicago Metropolitan Area Medicare Level established rate in accordance with Administrative Rule 140.40(c).
AA	As stated in Chapter 200 of the Practitioner Handbook Topic 220.3: *If the participant is admitted to the hospital on the same service date as the observation, a charge may be submitted only for the initial inpatient visit. No payment will be made for the observation services.*

BB	Department policy on Observation care "discharge" will remain as a non-covered service. This was not a covered service using 99217 prior to that code becoming obsolete January 1, 2023, and will continue as non-covered when using these codes (99238 and 99239).
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.***
FF	Bonus payments will be reimbursed at a rate of $75 per postpartum visit, effective on/after 01/01/2023 if both of the following conditions are met, in accordance with the 02/21/23 provider notice: 1. The actual delivery date is included in the Loop 2300, DTP*454 'Initial Treatment Date' segment, of the 837P, or entered on a MEDI DDE claim. 2. The postpartum visit occurs within the first 26 days, or within 27-89 days, following the delivery date on file. Each time period will have a limit of one payable bonus payment. For instances when more than one claim is received during each of those time periods, the bonus payment will be reimbursed on the first claim received.
GG	Reimbursement is allowed for physicians enrolled with an anesthesiology specialty or certified registered nurse anesthetists, effective 7/1/2024. These dental sedation codes are billable ***ONLY*** for dental procedures
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 the Practitioner Handbook. **Practitioner purchased and administered drugs**: *The number listed in the days/units field must be "1".* 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 available in the Practitioner Handbook. **Medical/surgical procedures**: *The number listed in the days/units field must be "1".* 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**.

	Provider Type 061 Independent Laboratories: Claims must be submitted electronically**. The specific name of the procedure and total number of times performed must be submitted in the description/note field***. Test report(s) 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.
Surg Ind (Surgery Indicator)	**N** or blank = Not considered surgical. **I** = Incidental/minor procedure. Procedure may or may not pay separately when billed with a visit or other surgical codes. **M** = Major procedure. Reimbursement for procedure includes 30-day postoperative care.
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	**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 practitioners enrolled in the Maternal Child Health program. **Adult** The amount added to the state maximum for services rendered by practitioners enrolled in the Maternal Child Health program.
Rate reduced by 2.7%	Maximum amount payable after 2.7% rate reduction per the SMART Act (PA097- 0689). Exempt: Physicians, Physician Assistants, Dentists, Advanced Practice Nurses, Community Mental Health Providers, FQHCs, RHCs, ERCs, LEAs, DORS Schools, School-based Clinics, Local Health Departments, and Early Intervention.

*****Please note, surgical and medication abortion services **59840, 59841,** and **S0199** did not reflect the correct rates on the fee schedules dating ***October 1, 2022 – October 1. 2023*** to coincide with the Provider Notice Issued September 6, 2022 *regarding "Abortion services-Rate Increase and Billing Changes"*. Despite the error reflected on those fee schedules, correct rates existed within the claims processing system and were applied to claims.

**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.