Illinois Department of Healthcare and Family Services

Practitioner Fee Schedule Key

Revised 03/16/15

For charges submitted by Physicians, Advanced Practice Nurses, Imaging Centers, IDTFs, 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:	**Providers billing multiples on the HFS2360:** Enter in the days/units field the number of tests performed on a single date of service. For a quantity up to 5, the claim may be submitted electronically. For a quantity exceeding 5, the claim must be submitted on paper with all test results attached. **Provider Type 061 Independent laboratory billing multiples on the HFS2211:** Submit the specific procedure code on one service section, submit the unlisted procedure code for any quantity beyond one in the next service section, and list total number and name of additional tests in *description field.* When the quantity exceeds 5, attach documentation for all tests.
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 the specific procedure code on one service section, submit the unlisted procedure code for any quantity beyond one in the next service section, and list total number and name of additional tests in *description field*. Attach documentation for all tests. **Provider Type 061 Independent laboratory billing multiples on the HFS2211:** submit the specific procedure code on one service section, submit the unlisted procedure code for any quantity beyond one in the next service section, and list total number and name of additional tests in *description field.* Attach documentation for all tests.
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 the specific procedure code on one service section, submit the unlisted procedure code for any quantity beyond one in the next service section, and list total number and name of additional tests in *description field*. **Provider Type 061 Independent laboratory billing multiples on the HFS2211:** submit the specific procedure code on one service section, submit the unlisted procedure code for any quantity beyond one in the next service section, and list total number and name of additional tests in *description field.* Attach documentation for all tests.
Note is H: **(Note is H)**	**Providers billing multiples on the HFS2360:** Enter in the days/units field the number of tests performed on a single date of service. **Provider Type 061 Independent laboratory billing multiples on the HFS2211:** submit the specific procedure code on one service section, submit the unlisted procedure code for any quantity beyond one in the next service section, and 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.
	***The number listed in the days/units field must be "1".**

HP=Y:	-**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 in Chapter A-200 Practitioner Handbook (pdf) Appendix A-6. -**Medical/surgical procedures**: 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 procedure note must be attached. **Provider Type 061 Independent laboratory billing multiples on the HFS2211:** 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.
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**, submit the specific procedure code on one service section, submit the unlisted procedure code for any quantity beyond one in the next service section, and 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 0-18 years, as shown in the Unit Price column. Billing guidelines are available in Chapter A-200 Practitioner Handbook (pdf) Section A-226.
F	Vaccine is not available through the VFC. The department reimburses for the vaccine when it is medically necessary. Billing guidelines are available in Chapter A-200 Practitioner Handbook (pdf) Section A-226.
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. Billing guidelines are available in Chapter A-200 Practitioner Handbook Section A-226, located on the web site at http://www.hfs.illinois.gov/assets/a200.pdf.
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). Restricted to Females; age restricted to 10-25 years. Vaccine is supplied through the VFC program for ages 10-18 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 19-25years and for ages 10-25 years for non-VFC providers, as shown in the State Max column. Billing guidelines are available in Chapter A-200 Practitioner Handbook (pdf) Section A-226.
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. Billing guidelines are available in Chapter A-200 Practitioner Handbook (pdf) 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.

COLUMN HEADING	COLUMN DESCRIPTION
M	*Enter name of vaccine* in Note Field (Loop 2400 of 837P). 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. Billing guidelines are available in Chapter A-200 Practitioner Handbook (pdf) Section A-226 .
N	Prior approval required for practitioner-purchased and administered drug. For additional information, see Pharmacy prior approval guidelines
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%.
S	© indicates child professional and technical components, (A) indicates adult professional and technical components.
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 (pdf) dated April 15, 2013.
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. For additional information and requirements, providers may reference the Informational Notice (pdf) dated October 10, 2014. *****The $35.00 dispensing fee is allowed to 340B providers for procedure code J3490 when billing Depo-SubQ Provera 104mg Injection.
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). Providers may reference the Informational Notice (pdf) dated August 26, for additional information and requirements.
Prog Cov (Program Coverage)	**02**-limited coverage- no coverage for Transitional Assistance (GA) clients ages 18 yrs and older **04**-Medicaid covered services **09**-Qualified Medicare Beneficiary (QMB) coverage only (See Chapter 100 (pdf)Section 120.12.
Eff Date (Effective Date)	Effective date of codes added on or after 01/01/07 *or* date of change in payment policy.

COLUMN HEADING	COLUMN DESCRIPTION
HP (Hand Priced Indicator)	If "Y", special pricing methodology is applied: -**Anesthesia codes** are 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 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 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 HFS2211:** 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 = 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 dept 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. **C= 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. **A = 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.
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 Depts, and Early Intervention.