Illinois Department of Healthcare and Family Services

Practitioner Fee Schedule Key

Revised 7/11/2018

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

- Advanced Practice Nurses
- Dentists Providing Medical Services
- Encounter Rate Clinics
- Hospitals Billing Fee-For-Service for Outpatient Services
- Imaging Centers
- Independent Diagnostic Testing Facilities (IDTFs)
- Independent Laboratories
- Local Health Departments
- Optometrists Providing Medical Services
- Physicians
- 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 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
Note is B or C, any of the above providers	***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 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 Practitioner Handbook. **<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	**<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

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 and 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 with Title XIX (19) eligibility, but not for adults or children age 0 through 18 with Title XXI (21) or state-funded eligibility.
F*	Vaccine is not available through the VFC program. Additional *Unit Price* 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
I*	• Enter name of vaccine in Note Field (Loop 2400 of 837P) • Vaccine restricted to females age 9 through 25 years • Vaccine is supplied through the VFC program for children age 9 through18 years with Title XIX (19) eligibility • Obstetric/Gynecology providers are reimbursed for the vaccine product for ages 9 through 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 the Practitioner Handbook.
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) • The EPSDT indicator is required to identify as a preventive service • Vaccine restricted to age 9 through 26 years • Vaccine is supplied through the VFC program for children age 9 through 18 years with Title XIX (19) eligibility • Obstetric/Gynecology providers are reimbursed for the vaccine product for ages 9 through 26 as shown in the State Max column
N	Prior approval required for practitioner-purchased and administered drug. Prior approval guidelines.
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	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.

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
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.
Y*	For private stock vaccines administered to children age 0 through 18 with Title XXI (21) or state-funded eligibility refer to the applicable billing guidelines and examples provided in the Practitioner Handbook or the Encounter Clinic Handbook, and on the Non-Institutional Providers Resources webpage
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 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 the Practitioner Handbook. **Medical/surgical procedures**: *The number listed in the days/units field must be "1".Append* 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 the Practitioner Handbook.
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 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. • Child add-ons for preventive E/M codes are payable only to the participant's Primary Care Provider and practitioners meeting the enrollment requirements for the Maternal and Child Health Program. **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. • Adult add-ons for preventive E/M codes are payable only to the participant's Primary Care Provider.
Rate reduced by 2.7%	Maximum amount payable after 2.7% rate reduction per the SMART Act (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, I, M, Y:

- All available vaccines for children age 0 through 18 with Title XIX (19) eligibility 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 for the purposes of administering and billing the HPV vaccine.
- For VFC-obtained vaccines administered to Title XIX (19) eligible children, 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.
- Effective October 1, 2016 through June 30, 2019 private stock vaccines that had previously been available through VFC prior to October 1, 2016 for Title XXI (21) and State-Funded eligible children will be reimbursed at the lesser of the provider charge amount or the $6.40 *Unit Price* rate *plus* the *State Max* rate as noted on the Practitioner Fee Schedule. This policy does not apply to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Encounter Rate Clinics (ERCs). Refer to the January 17, 2017 provider notice for more information.
- The E/M service payment includes reimbursement for the injection service except when noted. Billing guidelines are available in the Practitioner Handbook.
- For vaccines not available through the VFC program and administered to any child, the Department will reimburse the medically necessary vaccine product as shown in the *State Max* column. The additional $6.40 administrative cost reimbursement does not apply.
- FQHCs, RHCs and ERCs may bill private stock vaccines either fee-for-service or as part of a medical encounter when administered to children age 0 through 18 with Title XXI (21) or state-funded eligibility. Private stock vaccines for this population must be billed with the GB modifier appended to each vaccine-specific procedure code and include the provider's usual and customary charge. The Department will reimburse the medically necessary vaccine product as shown in the *State Max* column.
- Vaccine billing instructions and examples may be found in the Practitioner Handbook or the Encounter Clinic Services Handbook (as applicable by provider type) as well as on the Non-Institutional Providers Resources webpage.