ILLINOIS WORKERS' COMPENSATION COMMISSION
MEDICAL FEE SCHEDULE
INSTRUCTIONS AND GUIDELINES
FOR TREATMENT 2/1/09 - 7/5/10 & 10/29/10 - 8/31/11

Revised 5/14/10: Outdated text referring to old DRG codes on page 7 deleted
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Introduction and Purpose

Pursuant to Section 8.2 of the Illinois Workers' Compensation Act (820 ILCS 305/8.2; Public Act 94-277), the Illinois Workers' Compensation Commission (Commission) has promulgated a comprehensive fee schedule to establish maximum medical payments for both professional and facility fees generated on workers' compensation claims.

The maximum medical payments (also referred to as "fee schedule amounts") were formulated by determining the 90% of the 80th percentile from health care provider fees from August 1, 2002 through August 1, 2004. Fee schedule amounts were established for 29 geo-zips (the three-digit zip code where the treatment was provided) in Illinois. An initial 4.96% increase was applied to the fee schedule amounts (the Consumer Price Index-U (CPI-U) for the period August 1, 2004 through

September 30, 2005). The Commission will automatically increase or decrease the maximum allowable payment based upon the CPI-U on an annual basis.

In addition to maximum medical payments based upon historical fee data, the Commission has set maximum medical payment amounts in a manner consistent with Section 8.2 of the Act:

1) For entire service categories (e.g., 76% of the charged amount for dental services) or
2) For fees within a service category where data was insufficient to establish a fee schedule amount (e.g., POC76 for a new code).

For the purposes of this fee schedule, "POC76" means reimbursement should occur at 76% of the charged amount.

The fee schedule amounts apply *only* to procedures, treatments, and services provided on or after February 1, 2006.

The fee schedule does not preclude any privately and independently negotiated rates or agreements between a provider and a carrier, or a provider and an employer, that are negotiated for the purposes of providing services covered under the Illinois Workers' Compensation Act.

This document is intended to assist with fee schedule application, and to insure correct billing and reimbursement on workers' compensation medical claims. This document is NOT intended, and should not be construed, as a utilization review guide or practice manual.

Reference Materials

This schedule is in accordance with the following documents, including codes, guidelines, and modifiers:

1. *Current Procedural Terminology*, copyright, American Medical Association, 515 N. State St., Chicago, IL, 60610, Chicago, 2006.
2. *HCPCS Level II*, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland, 21244, Baltimore, 2006.
3. *National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0*, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland, 21244, Baltimore, 2006.
4. *Relative Value Guide*, copyright, American Society of Anesthesiologists, 520 North Northwest Highway, Park Ridge, Illinois, 60068-2573, Park Ridge, 2006.
5. Diagnosis-Related Group (DRG) classification system, Centers for Medicare and Medicaid Services (CMS), *Federal Register*, vol. 70, no. 155, August 2005.
6. Medicare Severity Diagnosis Related Group (MS-DRG) classification system, Centers for Medicare and Medicaid Services (CMS), 42 CFR 411, 2007.

Section 1. Ambulatory Surgical Treatment Center Services

The Ambulatory Surgical Treatment Center (ASTC) fee schedule provides the maximum medical fee schedule amount for surgical services administered in an ASTC setting for codes 10021 - 69990. The ASTC is a partial global reimbursement schedule[1] in that all charges rendered during the operative session are subject to a single fee schedule amount; however, the following exceptions do exist – these are the carve-out categories/revenue codes which should be paid at 65% of charged amount:

- Prosthetics/orthotics
- Pacemaker
- Lens implants
- Implants
- Investigational devices
- Drugs requiring detailed coding

Charges billed under the above listed items will be at a provider's normal rates under its standard chargemaster.

For revenue code detail regarding these items, please refer to the "carve-out" information in Sections 6 and 7.

The ASTC fee schedule shall be subject to Sections 8(B) and 8(F) of this fee schedule; however, only the provisions that apply to multiple procedures and bilateral surgeries in 8(B) and applicable modifiers in 8(F) shall be used.

Special note on ASTC radiology, pathology and laboratory charges:

The fee schedule amounts listed do not include charges for radiology, pathology and laboratory; therefore, these charges must be submitted under separate claim forms. These charges will be subject to the professional services fee schedule.

This schedule applies to licensed ambulatory surgical treatment centers as defined by the Illinois Department of Public Health:

"Any institution or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures, as evidenced by use of the facilities by physicians or podiatrists in the performance of surgical procedures that constitutes more than 50 percent of the activities at that location.

Any place, located within an institution or building, such as a surgical suite or an operating room with related facilities in a physician's office or group practice clinic, devoted primarily to the performance of surgical procedures. This provision shall apply regardless of whether or not the institution or building in which the place is located is devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures. This provision shall include any place that meets the definition of an ambulatory surgical center under the rules of the federal Centers for Medicare & Medicaid Services (CMS) (42 CFR 416). However, when such a place is located within and operated in conjunction with

[1] Aside from the carve-outs discussed below, the ASTC does not cover radiology, pathology and laboratory charges that would be covered under the HOSF fee schedule. Due to the fact that ASTCs do not normally charge for these categories, charges associated with revenue codes 300 to 359 were removed from the raw database prior to calculating the fee schedule amounts.

the offices of a single physician or podiatrist, or a group of physicians or podiatrists, it shall not be considered an ambulatory surgical treatment center, unless: it meets the definition of and has expressed an intent to apply for certification as an ambulatory surgical center under the rules of the federal CMS (42 CFR 416); or it is used by physicians or podiatrists who are not part of the practice; or it is utilized by the physicians or podiatrists for surgical procedures which constitute more than 50 percent of the activities at that location."

For the purposes of this schedule, the term "ambulatory surgical treatment center," does not include:

Hospitals: Any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85].

Long-term care facilities: Any person or institution required to be licensed pursuant to the Nursing Home Care Act [210 ILCS 45].

State facilities: Hospitals or ambulatory surgical treatment centers maintained by the State or any Department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control.

Federal facilities: Hospitals or ambulatory surgical treatment centers maintained by the federal government or agencies thereof.

Dental surgery facilities: Any place, agency, clinic, or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures. (Section 3(A) of the Act). (Title 77: Public Health Chapter I: Department of Public Health Subchapter b: Hospital and Ambulatory Care Facilities Part 205 Ambulatory Surgical Treatment Center Licensing Requirements Section 205.110 Definitions).

Section 2. Anesthesia Services

An anesthesia fee schedule has been established using historical charge data from August 1, 2002 through August 1, 2004. The historical charge data was analyzed and formulated to establish a "conversion factor." The American Medical Association (AMA) and the American Society of Anesthesiologists (ASA) are both responsible for developing anesthesia codes and guidelines. The conversion factor is to be used in manner consistent with guidelines from these two organizations. Specifically, a conversion factor is a dollar amount that is to be used within the context of the 2006 Relative Value Guide.

A. General Guidelines

Anesthesia time begins when an anesthesiologist OR certified registered nurse anesthetist (CRNA) *physically starts* to prepare the patient for the induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist is no longer in *constant* attendance (when the patient is safely put under postoperative supervision).

B. Base value, physical status modifier, time units, and qualifying circumstances

The maximum fee schedule reimbursement amount for anesthesia services is determined by the following formula:

Base Value + Time Units + Modifying Units = Total Units

Total Units X Conversion Factor = Total Fee

1. All anesthesia services reported using CPT codes 00100-01999 have an assigned **Base Value** unit(s) (e.g., 00632…7 units). The base value represents the value of all usual anesthesia services administered during the service EXCEPT time and modifying factors.

   The usual anesthesia services included in the base value includes the usual pre- and postoperative visits, administration of fluids and/or blood products incident to the anesthesia care, and interruption of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). The placement of arterial central venous and pulmonary atrially catheters or the use of transesophageal echo cardiography (TEE) are not included in the base unit value.

2. All anesthesia services are reported by use of the anesthesia 5-digit procedure codes, plus the addition of a **Physical Status Modifier**. These modifying units may be added to the base values. The use of other optional modifiers may be appropriate. The unit values for the physical status modifiers are as follows:

	Unit Values
•P1 – Healthy patient……………………………………..	0
•P2 – Mild systemic disease………...................................	0
•P3 – Severe systemic disease…………………...................	1
•P4 – Severe systemic disease—constant threat to life……	2
•P5 – Moribund patient ………………………………….	3
•P6 – Brain-dead patient/organ donor…………………….	0

3. **Time Units** are calculated by allowing 1.0 unit for each segment of time as is customary in the local area (e.g., 1.0 unit for each 15 minutes of anesthesia time).

4. In addition to unit amounts established by considering the base value units and time units, additional unit values may be established by reporting extraordinary circumstances (e.g., total body hypothermia). These are referred to as **Qualifying Circumstances.** Qualifying Circumstances are always reported in addition to the base value units, using the following codes:

CPT Code and Description	Unit Values
• 99100 Extreme age ……………………………………...…..	1
• 99116 Utilization of total body hypothermia ……………..……	5
• 99135 Utilization of controlled hypotension	5
• 99140 Emergency conditions (specify) ……….…….…………	2

   Example for calculating a fee schedule reimbursement amount in geozip 606

Procedure CPT 01744:	Anesthesia for open or surgical arthroscopic procedures--elbow
Time of Anesthesia Services:	1 hour 15 minutes
Physical Status:	P1
Qualifying Circumstances:	None

Translation:	
Base Value for 01744	5 units
Time (75 minutes divided by 15) +	5 units
Physical Status (P1) +	0 units
Qualifying Circumstances-none (0 units)	+ 0 units
Total Units =	10 units

Fee Schedule Calculation	
Total Units	10 Units
Fee Schedule Conversion Factor (for geo-zip 606)	X $92.99
Maximum Fee Schedule Amount =	$929.90

C. Special Coding Situations

Special coding situations such as those involving multiple procedures, additional procedures, unusual monitoring, prolonged physician services, postoperative pain management, monitored (stand-by anesthesia), invasive anesthesia and chronic pain management services require application of the fee schedule in a manner consistent with guidelines of the ASA.

Section 3. Dental Services

All dental fees shall be paid at 76% of charged amount unless the service is billed under codes listed in this fee schedule (e.g., CPT or HCPCS).

Section 4. Emergency Room Services

All emergency room facility fees shall be paid at 76% of charged amounts unless otherwise addressed in this section.

This fee schedule will apply to all facility fees from any department or facility of a hospital, whether situated on or off the main hospital campus, that: (1) is licensed by the State as an emergency room or emergency department, and: (2) is held out to the public as providing care for emergency medical conditions without requiring an appointment; or during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.

All emergency room facility bills are subject to the radiology, pathology & laboratory and physical medicine and rehabilitation fee schedule provisions listed in Section 7.

Please note that surgical procedures (and all related charges) performed during an emergency room encounter are exempt from Section 7(D) Hospital Outpatient Surgical Facility fee schedule provisions. Please consult the "*Special note on emergency room cases*" provision found in Section 7(D) for further clarification.

Emergency room physicians, billing for professional services and using their own Tax ID number, are subject to the professional services fee schedule; however, if the professional services are billed by the hospital facility using the facility's Tax ID number, then these charges are to be paid at 76% of the charged amount.

Section 5. HCPCS (Healthcare Common Procedure Coding System) Level II

The fee schedule will incorporate the HCPCS (Healthcare Common Procedure Coding System) Level II codes and modifiers not included in CPT.

Section 6. Hospital Inpatient Services: Standard and Trauma

The coding mechanism upon which the inpatient fee schedules are based is that of DRG (diagnosis-related group). A DRG is a code that groups patients into homogeneous classifications that demonstrate similar length-of-stay patterns and use of hospital resources.

Two hospital inpatient fee schedules have been established using historical charge data (minus charge data from eight revenue codes). The first fee schedule is the standard DRG fee schedule that will apply to the vast majority of hospital inpatient bills. The second fee schedule is the trauma DRG fee schedule that will apply to a small number of inpatient bills that involve trauma admissions at designated trauma centers.

General Guidelines for Standard Inpatient and Trauma Inpatient Care

A. Definition of Inpatient

Inpatient care shall be defined as when a patient is admitted to a hospital where services include, but are not limited to, bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services. Observation stays are reimbursed under the outpatient schedule.

B. Clearly Identifiable DRG

As reimbursement is based upon DRG, hospital providers must clearly identify the DRG in a manner consistent with this fee schedule. The DRG assignment will be made in a manner consistent with grouping practices used by the hospital when billing both government and private carriers (e.g., CMS Grouper Version 24.0). Hospitals shall list the DRG code on the UB-04.

C. DRG as a Global Reimbursement and Revenue Code Exceptions to Global Reimbursement

The DRG fee schedule amount reflects the maximum medical fee schedule amount for an entire inpatient hospital stay.

There are, however, eight exceptions:

- 0274 (prosthetics/orthotics)
- 0275 (pacemaker)
- 0276 (lens implants)
- 0278 (implants)
- 0540 and 545 (ambulance)
- 0624 (investigational devices)
- 0636 (drugs requiring detailed coding)

These charges are classified as "pass-through charges" and are paid at a rate of 65% of the charged amount. These revenue codes will not be covered under the DRG fee schedule amount. Once pass-through charges are identified and removed, all remaining charges are subject to the DRG fee schedule amount.

Charges billed under the above listed revenue codes shall be at a provider's normal rates under its standard chargemaster.

If the fee schedule amount defaults to 76% of charged amount, these rules will still apply. Remove all charges from the applicable revenue code line items and pay at 65% of charged amount: the remaining total charges will then be paid at 76%.

D. Cost Outliers

The Illinois Workers' Compensation Act recognizes that there are cases where the costs for treating an injured worker are unusually high in relation to other patients treated within the same assigned DRG. This fee schedule will use the following formula to determine if cost outlier payments should be made. If, after subtracting the pass-through revenue code charges, the balance of the bill is at least two times the fee schedule amount, the charged amount meets the definition of a cost outlier. The maximum fee schedule amount will be as follows: the pass-through revenue code charges are reimbursed at 65% of actual charge and the balance of the bill will be reimbursed at the fee schedule amount plus 76% of the portion of the charges that exceed the fee schedule amount. The pass-through revenue code charges shall be billed at the provider's normal rates under its standard chargemaster.

E. Professional Services Performed in Conjunction with Other Services Associated with the Hospitalization

Charges for professional services performed in conjunction with charges for other services associated with the hospitalization and billed by a hospital on a UB-04/CMS 1450 or a 1500 claim form (billing form established by Centers for Medicare and Medicaid Services for use by physicians) using the hospital's own tax identification number shall be reimbursed at 76% of actual charge in addition to the amount listed in this schedule for the assigned surgical code. Health care professionals who perform services and bill for services using their own tax identification number on a separate claim form shall be subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8).

Special Guidelines for Trauma Inpatient Care

Section 8.2 of the Illinois Workers' Compensation Act specifically refers to "trauma," and the IWCC addresses this section with the Trauma Inpatient Fee Schedule. All inpatient hospital bills from state-

designated Level I and Level II trauma centers (as designated by the Illinois Department of Public Health) and which contain an admission type of "5" on the UB-04 FL14[2] are subject to the Trauma Inpatient Fee Schedule (not the standard fee schedule).

All trauma admissions are subject to the same rules discussed in this section.

Section 7. Hospital Outpatient Services

The Illinois Department of Public Health defines a hospital as any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85].

No fees submitted from a hospital for outpatient services will be subject to the professional services or HCPCS fee schedules.

This schedule includes radiology, pathology and laboratory, physical medicine and rehabilitation as well as scheduled surgical services performed in a hospital outpatient setting that were not performed during an emergency room encounter or inpatient hospital admission. The radiology, pathology and laboratory and physical medicine and rehabilitation schedules shall be applied to the number of units billed on the UB-04.

A. Radiology

The hospital outpatient radiology fee schedule provides the maximum medical fee schedule amount for radiological services performed (in a hospital outpatient setting) for codes 70010 – 79999. This maximum medical fee schedule amount is for the technical component of radiological services provided in this setting, and billed in conjunction with revenue codes 320 to 359, 400 through 409 and 610 through 619. This schedule does not apply when the bill type requires the application of the hospital inpatient DRG fee schedule, or hospital outpatient surgical facility fee schedule. This fee schedule will apply to all other hospital outpatient settings including emergency room visits.

Note: Professional radiological services billed by a hospital, and using the hospital's Tax ID number are to be paid at 76% of the charged amount. Professional radiological services billed by radiologists or radiology groups using their own Tax ID number (even though the technical component is performed in a hospital setting), are subject to the professional services fee schedule.

B. Pathology and Laboratory

The hospital outpatient pathology and laboratory fee schedule provides the maximum medical fee schedule amount for pathology and laboratory services performed (in a hospital outpatient setting) for codes 80048-89356. This maximum medical fee schedule amount is for the technical component of pathology and laboratory services provided in this setting, and billed in conjunction with revenue codes 300-319. This schedule does not apply when the bill type requires the application of the hospital inpatient DRG fee schedule, or hospital outpatient surgical facility fee schedule. This fee schedule will apply to all other hospital outpatient settings including emergency room visits.

[2] UB-04 refers to uniform billing form used by hospitals. "FL" is the acronym for "form locator" and the number that immediately follows it indicates where on the UB-04 billing form the CPT/HCPCS and revenue codes are listed.

Note: Professional services in this area billed by a hospital and using the hospital's Tax ID number are to be paid at 76% of the charged amount. Professional pathology services rendered by pathologists or pathology groups using their own Tax ID number (even though the technical component is performed in a hospital setting) are subject to the professional services fee schedule.

C. Physical Medicine and Rehabilitation

The hospital outpatient physical medicine and rehabilitation fee schedule provides the maximum medical fee schedule amount for physical therapy services performed (in a hospital outpatient setting) for codes 97001-97799. This maximum medical fee schedule amount is for all physical and occupational therapy services in the aforementioned code range and in conjunction with revenue codes 420-439. This schedule does not apply when the bill type requires the application of the hospital inpatient DRG fee schedule, or hospital outpatient surgical facility fee schedule. This fee schedule will apply to all other hospital outpatient settings including emergency room visits.

D. Hospital Outpatient Surgical Facility

The Hospital Outpatient Surgical Facility (HOSF) fee schedule provides the maximum medical fee schedule amount for surgical services administered (in a hospital outpatient setting) for codes 10021 - 69990. The Illinois Department of Public Health defines a hospital as any institution, place, building or agency required to be licensed pursuant to the Hospital Licensing Act [210 ILCS 85]. The HOSF fee schedule is a global reimbursement schedule in that all charges/line items rendered during the operative session are subject to a single fee schedule amount; however, the following exceptions do exist – these are the carve-out categories/revenue codes, which should be paid at 65% of charged amount. Except for the carve-out/revenue codes listed below, this fee schedule shall not be applied on a line item basis.

- 0274 (prosthetics/orthotics)
- 0275 (pacemaker)
- 0276 (lens implants)
- 0278 (implants)
- 0540 and 545 (ambulance)
- 0624 (investigational devices)
- 0636 (drugs requiring detailed coding)

Charges billed under the above listed revenue codes shall be at a provider's normal rates under its standard chargemaster.

The HOSF fee schedule shall be subject to Sections 8(B) and 8(F) of this fee schedule; however, only the provisions that apply to multiple procedures and bilateral surgeries in 8(B) and applicable modifiers in 8(F) shall be used.

Special note on emergency room cases:

Surgical sessions initiated as part of an emergency room visit (bills containing revenue codes 450 to 459) are not subject to the HOSF fee schedule. Emergency room bills not subject to the HOSF fee schedule are still subject to the hospital outpatient services radiology, pathology and laboratory, and physical medicine/rehabilitation fee schedules. All other emergency room charges shall be paid at 76% of the charged amount.

When an outpatient surgical procedure is not recognized/found in the HOSF fee schedule, all charges are to be paid at 76% of the charged amount subject to the 65% carve-out categories discussed above.

When professional services (e.g., CRNA services) are billed by a hospital in conjunction with the other charges associated with the scheduled surgery, using the facility's Tax ID number, whether billed on a UB-04 or on a separate 1500 claim form, these charges will be removed and paid at 76% of the charged amount. No fees submitted from a hospital for outpatient services will be subject to the professional services or HCPCS fee schedules.

E. Cost Outliers

The Illinois Workers' Compensation Act recognizes that there are cases where the costs for treating an injured worker are unusually high in relation to other patients treated with the same procedure code(s). This fee schedule will use the following formula to determine if cost outlier payments should be made for outpatient surgical facility charges. If, after subtracting the pass-through revenue code charges, the balance of the bill is at least two times the fee schedule amount, the charged amount meets the definition of a cost outlier. The maximum fee schedule amount will be as follows: the pass-through revenue code charges are reimbursed at 65% of actual charge and the balance of the bill will be reimbursed at the fee schedule amount plus 76% of the portion of the charges that exceed the fee schedule amount. The pass-through revenue code charges shall be billed at the provider's normal rates under its standard chargemaster.

Section 8. Professional Services

The fee schedule for professional services is based on the American Medical Association Current Procedural Terminology (CPT) code set.

A. Evaluation and Management

The fee schedule defers to the guides and descriptions in the CPT in establishing the correct classification of evaluation and management services (codes 99201-99499).

Modifiers

Modifiers for evaluation and management include, but are not limited to: 21, 22, 24, 25, 32, 52, 53, 57, and 59. See the modifier chart below or refer to the CPT for further information.

B. Surgery

Please refer to the table, "Payment Guide to Global Days, Multiple Procedures, Bilateral Surgeries, Assistant Surgeons, Co-Surgeons, and Team Surgery," when determining global days and when determining which codes support applying modifiers for multiple procedures, bilateral surgeries, assistant surgeons, co-surgeons, and team surgery.

C. Radiology Services

The fee schedule provides three categories of maximum medical reimbursement for radiology codes 70010-79999:

1) Total component (sometimes referred to as "global");
2) Professional component; and
3) Technical component.

When a charge is submitted by one physician who provides *both* the technical and professional components of a radiology procedure, designated by no attached modifier, the maximum medical reimbursement will be the amount listed in the "TOTAL" column.

When a charge is submitted for a physician's interpretation and report on radiology procedure, or other professional services related to that procedure, as designated by the -26 modifier, the maximum medical reimbursement will be that listed in the "PC AMOUNT" column of the fee schedule.

When a charge is submitted for only the technical component (costs associated with equipment, supplies, technical personnel etc.), as designated by a –TC modifier, the maximum medical reimbursement will be that listed in the "TC AMOUNT" column. Note: The TC modifier is not found in the CPT book, but it is a modifier for "technical component" found in HCPCS Level II. The fee schedule recognizes and instructs the use of the –TC modifier when billing for the technical component of a radiology procedure.

Default Instructions

When the fee schedule defaults to POC76 in the "TOTAL" column, the amount paid will be 76% of the total charge. The professional and technical components will be paid at 76% of the charged amount. (e.g., for modifier 26 - professional component, pay 76% of charged amount; for modifier TC - technical component, pay 76% of charged amount).

Modifiers

Aside from modifiers 26 and TC for the professional and technical components, other modifiers for radiology include, but are not limited to: 22, 52, 59, 76, and 77. See the modifier chart below or refer to the CPT for further information.

D. Pathology and Laboratory

The fee schedule provides three categories of maximum medical reimbursement for pathology and laboratory CPT codes 80048-89356:

1) A total fee for a service that is a combination of the technical and professional components;
2) A professional component for when a pathologist provides an opinion on, or reviews test results; and
3) A technical component.

When a charge is submitted by one physician who provides *both* the technical and professional components of a pathology or laboratory, designated by no attached modifier, the maximum medical reimbursement will be the amount listed in the "TOTAL" column.

When a charge is submitted for a physician's interpretation of a test or procedure, or other professional services related to that test or procedure, as designated by the -26 modifier, the maximum medical reimbursement will be that listed in the "PC AMOUNT" column of the fee schedule.

When a charge is submitted for only the technical component, as designated by a –TC modifier, the maximum medical reimbursement will be that listed in the "TC AMOUNT" column. Note: The TC modifier is not found in the CPT book, but it is a modifier for "technical component" found in HCPCS Level II. The fee schedule recognizes and instructs the use of the –TC modifier when billing for the technical component of a pathology or laboratory procedure.

Default Instructions

When the fee schedule defaults to POC76 in the "TOTAL" column, the amount paid will be 76% of the total charge. The professional and technical components will be paid at 76% of the charged amount. (e.g., for modifier 26 - professional component, pay 76% of charged amount; for modifier TC - technical component, pay 76% of charged amount).

Modifiers

Aside from modifiers 26 and TC for the professional and technical components, other modifiers for pathology include, but are not limited to: 22, 52, 59, 90, 91. See the modifier chart below or refer to the CPT book for further information.

E. Medicine Services

The fee schedule provides three categories of maximum medical reimbursement for medicine codes 90281-99602:

1) Total component (sometimes referred to as "global");
2) Professional component; and
3) Technical component.

When a charge is submitted by one physician who provides *both* the technical and professional components of a medicine code, designated by no attached modifier, the maximum medical reimbursement will be the amount listed in the "TOTAL" column.

When a charge is submitted for a physician's professional component of a medicine code, as designated by the -26 modifier, the maximum medical reimbursement will be that listed in the "PC AMOUNT" column of the fee schedule.

When a charge is submitted for only the technical component, as designated by a –TC modifier, the maximum medical reimbursement will be that listed in the "TC AMOUNT" column. Note: The TC modifier is not found in the CPT book, but it is a modifier for "technical component" found in HCPCS Level II. The fee schedule recognizes and instructs the use of the –TC modifier when billing for the technical component of a medicine procedure.

Default Instructions

When the fee schedule defaults to POC76 in the "TOTAL" column, the amount paid will be 76% of the total charge. The professional and technical components will be paid at 76% of the charged amount. (e.g., for modifier 26 - professional component, pay 76% of charged amount; for modifier TC - technical component, pay 76% of charged amount).

Modifiers

Aside from modifiers 26 and TC for the professional and technical components, other modifiers for medicine include, but are not limited to: 22, 32, 51, 52, 53, 55, 56, 57, 58, 59, 76, 77, 78, 79, 90, 99.52, 59, 90, 91. See the modifier chart below or refer to the CPT for further information.

F. Modifiers

Modifier	AMA Description/Illinois Instructions	Payment Policy/ Documentation Requirements
	Due to copyright restrictions, the actual modifier descriptions are not listed. Please refer to *Current Procedural Terminology (CPT®),* American Medical Association, 2006.	
21	Please refer to CPT.	125 percent of fee schedule amount. Appropriate documentation includes cover letter detailing how evaluation exceeded highest-level code.
22	Please refer to CPT. Specific instructions for the Illinois fee schedule: Clinical examples include, but are NOT limited to following: 1. Mangled Extremity – Complex injury to limb (arm/leg) with potential for limb loss. Neurovascular, soft tissue, bone disruption consistent with intent of guideline. i.e., open fractures beyond grade II beyond tendon injuries, punch press. 2. Revision Surgery – Documentation of presence of scarring, complex tissue defects. Non-union of fracture, and fusion. Scarring of joint and adhesions. Required lysis of scar to mobilize nerves and joints. Correction of instability / deformity resulting from prior surgery. 3. Morbid Obesity – BMI => 40 (wt / ht x 704.5 = BMI) Affects wound healing, fusion, rehabilitation, outcome measures	125 percent of fee schedule amount. Appropriate documentation includes cover letter and/or photos for documentation.
23	Please refer to CPT.	125% of fee schedule amount when documented that procedure required general anesthesia.
24	Please refer to CPT.	Lesser of charge or fee schedule amount for E/M service.

25	Please refer to CPT.	Separate payment is made at the lesser of the charged amount or fee schedule amount according to CPT description. Modifier 25 allows separate payment for services without requiring documentation with the claim form.
26	Please refer to CPT.	Fee schedule recognizes modifier and adjusts payment accordingly – no further adjustments are needed.
32	Please refer to CPT.	Lesser of charge or fee schedule amount.
47	Please refer to CPT.	Lesser of charge or fee schedule amount.
50	Please refer to CPT. Appropriate Usage for Modifier 50: When the procedure is done bilaterally **AND** the Payment Guide indicator (BILT SURG) for the procedure is "1," report the procedure code once; append with modifier 50 and report with one unit of service. This modifier is only appropriate when the service performed on two bilateral body parts. Inappropriate Usage for Modifier 50: Reporting this modifier when the service is performed on different areas of the same side of the body. The BILT SURG indicator is 0, 2, 3, or 9. When removing a lesion on the right arm and one of the left arm. On a procedure code that is described as bilateral in its CPT description.	150% of the fee schedule amount.
51	Please refer to CPT. Appropriate Usage of Modifier 51: When the same physician performs more than one surgical service at the same session. When procedure codes have an indicator of "2" or "3" (MULT SURG) in the Payment Guide chart. Append modifier 51 to the additional services performed. Be sure that it is appended to the procedure code with the lower allowed amount.	Lesser of the actual charge or 100% of the fee schedule amount for the procedure with the highest payment. Payment of the second through fifth surgical procedures is based on the lesser of 50% of the actual charge or 50% of the fee schedule amount. Surgical procedures beyond the fifth are

	Inappropriate Usage of Modifier 51: Do not use with designated add-on codes. Reporting modifier 51 on ALL lines of service. Multiple surgery pricing logic applies to bilateral services (modifier 50) that are performed on the same day with other procedures. Multiple surgeries are ranked based on allowed amount, not the billed amount.	priced on a "by-report" basis. This payment policy should also apply to multiple endoscopic procedures.
52	Please refer to CPT.	Lesser of charge or 76% of fee schedule amount.
53	Please refer to CPT.	Lesser of charge or 76% of fee schedule amount.
54	Please refer to CPT. Modifier 54 is used to indicate that the surgeon is billing for only the surgical care and another physician is providing all or part of the postoperative care. Appropriate Usage of Modifier 54: When all or part of the postoperative care is relinquished to a physician who is not a member of the same group. Appended to the procedure code that describes the surgical procedure performed that has a 10 or 90-day postoperative period. Inappropriate Usage of Modifier 54: Appending modifier 54 to a surgical procedure without a global period. Appending this modifier to an E/M procedure code.	Lesser of charge or fee schedule amount and documentation of service.
56	Please refer to CPT.	Lesser of charge or fee schedule amount for pre-operative services based on E/M codes.
57	Please refer to CPT.	Separate payment for the lesser of the actual charge or the fee schedule amount is to be made for the visit at which the decision to perform the surgery was made.
58	Please refer to CPT.	Payment is made at the lesser of the charged amount or fee schedule amount for the staged or related procedure.

59	Please refer to CPT. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Appropriate Usage of Modifier 59: The physician may need to indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate session, or separate injury (or area of injury). In the situation described above, the 59 modifier may be used with the secondary, additional or lesser procedure. Inappropriate Usage of Modifier 59: The 59 modifier may <u>not</u> be <u>submitted with</u>: E/M Codes When you do not have supporting documentation of separate and distinct status. When billing for the exact same procedure code performed twice on the same day. The 59 modifier should <u>only</u> be <u>used if no other valid modifier is available</u> to identify the services.	Lesser of charge or fee schedule amount and documentation of service.
62	Please refer to CPT. Co-Surgeons – Modifier 62 Global surgery roles apply to each of the physicians participating in a co-surgery. Reimbursement is at 75% of the global surgery fee schedule amount for co-surgeons. If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure, and both surgeons need to use the same codes. The following Payment Guide indicators identify services for which two surgeons, each in a different specialty, may be paid: 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons may be paid if supporting documentation is supplied to establish medical necessity. 2 = Co-surgeons permitted. No documentation is required if two-specialty requirement is met.	Total payment will equal 150% of the lesser of the charged amount or fee schedule amount for the surgical procedure(s) performed, to be divided equally between the co-surgeons.

66	Please refer to CPT. Team Surgeons – Modifier 66 Global surgery rules apply to each of the physicians participating in a team surgery. Reimbursement is determined "By Report." If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." The following Payment Guide indicators identify services for which team surgeons may be paid: 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons may be paid if supporting documentation is supplied to establish medical necessity of a team. Pay by report. 2 = Team surgeons may be paid. Paid by report.	Each individual surgeon is paid lesser of charge or fee schedule amount. Documentation for medical necessity is required.
73	Please refer to CPT.	Lesser of charge or 76% of fee schedule amount.
74	Please refer to CPT.	Lesser of charge or 76% of fee schedule amount.
76	Please refer to CPT.	Physician is paid lesser of charge or fee schedule amount.
77	Please refer to CPT.	Physician is paid lesser of charge or fee schedule amount.
78	Please refer to CPT.	Surgeon is paid lesser of charge or fee schedule amount.
79	Please refer to CPT.	Surgeon is paid lesser of charge or fee schedule amount.
80 81 82	Please refer to CPT. An "assistant at surgery" is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The "assistant at surgery" provides more than just ancillary services.	For 80: Lesser of actual charge or 20% of fee schedule amount. For 81: Lesser of actual charge or 15% of fee schedule amount. For 82: Lesser of actual charge or 20% of fee schedule amount.
90	Please refer to CPT.	Lesser of charged amount or fee schedule amount - and provision of documentation.
91	Please refer to CPT.	Lesser of charge or fee schedule amount.

G. Removed Codes

Because the historical charge data associated with Miscellaneous Services codes (99024-99091) are extremely variable, the Commission has removed these CPT codes from the schedule. These codes should be paid at the usual and customary rate. Any code used to report a Section 12 exam (occasionally referred to as an independent medical exam) is not subject to the fee schedule, and is to be paid at an amount agreed to between the provider and requester of services.

Section 9. Allied Health Care Professionals

Allied health care professionals such as certified registered nurse anesthetists (CRNAs), physician assistants (PAs) and nurse practitioners (NPs) will be reimbursed at the same rate as all other health care professionals when performing, coding and billing for the same services.

Section 10. Correct Coding

The fee schedule requires that services be reported with the HCPCS/CPT codes that most comprehensively describe the services performed. The Commission incorporates the National Correct Coding Initiative (NCCI) as the review standard as it relates to bundling edits, and prohibits any proprietary bundling edits more restrictive than the NCCI. The NCCI is contained in the National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Centers for Medicare and Medicaid services, Version 12.0, 2006.

Section 11. Independent Diagnostic Testing Facilities

All fees from independently operated diagnostic testing facilities will be subject to the professional services and HCPCS fee schedules.

Section 12. Out-of-State Treatment

For out-of-state medical services on Illinois workers' compensation claims, reimbursement will be the greater of 76% of the charged amount or the amount set forth in a workers' compensation medical fee schedule adopted by the state in which the procedure, treatment or service is rendered, if such a schedule has been adopted.

Facility fees will be paid at 65% of charged amount for prosthetics/orthotics, pacemaker, lens implants, implants, ambulance, investigational devices and drugs requiring detailed coding. See Sections 1, 6 and 7 above for additional information on facility fees.

All charges for out-of-state treatments are subject to the other instructions and guidelines in this fee schedule.

Section 13. Rehabilitation Hospital Services

The Illinois Workers' Compensation Commission has established a per diem amount (the fixed daily amount paid to a hospital for all services provided during the course of the day) for the following three hospitals:

Marianjoy Rehabilitation Hospital
26W171 Roosevelt Road
Wheaton, IL 60187

Schwab Rehabilitation Center - Anixter Center
1401 South California Avenue
Chicago, IL 60608

Rehabilitation Institute of Chicago
345 E. Superior Street
Chicago, IL 60611

The per diem amount is determined by matching up the primary diagnosis code with a corresponding fee schedule amount. For illustration, the 2009 per diem amounts for each medical condition appear below.

Medical Condition	Geozip 601	Geozip 606
Amputation	POC76	POC76
Brain Injury	$1,812.42	$2,465.13
Burns	$2,286.64	$2,286.64
Congenital Deformities	$2,144.57	$2,269.31
Hip Fracture	$1,511.60	$2,039.42
Major Multiple Trauma	$1,810.40	$1,889.07
Neurological Disorders	$1,723.71	$2,272.56
Osteoarthritis	$1,444.21	$1,782.00
Rheumatoid Arthritis	$1,800.59	$1,800.59
Spinal Cord Injury	$1,837.52	$2,212.64
Stroke	$1,664.89	$2,193.54
Systemic Vasculidities	POC76	POC76
Joint Replacements	$1,752.58	$2,102.39
All Other	POC76	POC76

A list of ICD-9-CM diagnosis codes associated with each medical condition is available at http://www.iwcc.il.gov/ICD9.xls/.

There are no carve-out or outlier provisions associated with this part of the fee schedule.

Note: The hospital inpatient fee schedules were created with data supplied by the Illinois Department of Public Health (IDPH). The data specific to the rehabilitation hospitals that was formerly blended into the DRG fee schedule was used to develop the rehabilitation hospital fee schedule. Additionally, the data from the rehabilitation hospitals will be excluded from the calculation of the new MS-DRG fee schedules so that duplicative use of the data will not occur.

Example: (Days X Per Diem = Maximum Medical Payment)

1. Identify which one of the three rehab. hospitals is providing services. In this example, the provider is Marianjoy Rehabilitation Hospital (geozip 601).
2. Identify the number of days that services were provided as found on UB-04 Form Locator 6. In this example, the dates of service are from 10/5/09 through 10/17/09 (13 days).

3. Identify the primary diagnosis code from the UB-04 Form Locator 66. Example: 851.04 (Cortex {cerebral} contusion without mention of open intracranial wound with prolonged {more than 24 hours} loss of consciousness and return to pre-existing conscious level).

Medical Condition	**ICD-9-CM code**	**601**	**606**
Brain Injury	851.03	$1,812.42	$2,465.13
Brain Injury	**851.04**	**$1,812.42**	**$2,465.13**
Brain Injury	851.05	$1,812.42	$2,465.13

4. The final calculation is 13 days X $1,812.42 = $23,561.46.

5. If the charged amount is less than $23,561.46, then the lesser amount is to be paid. If the charged amount is greater than $23,561.46, then $23,561.46 would be paid.

Section 14. Billing Examples

Because coding can be complex, the IWCC cannot provide an example for each and every potential coding combination. The IWCC recommends that industry participants utilize the fee schedule consistent with generally accepted coding practices and reimbursement policies, in conjunction with the relevant fee schedule provisions found in the Instructions and Guidelines. The following examples apply the fee schedule to various billing circumstances.

Note: These examples were written based on the fee schedules introduced by IWCC in September 2008. These fee schedule amounts were increased by 5.37% for 2009, and will be adjusted every year thereafter. These examples are intended to be illustrative and assist with fee schedule application. Please consult the correct year to determine current/actual fee schedule amounts.

Example #1: Hospital Outpatient Surgical Facility Fee Schedule (HOSFFS) Single Procedure With No Carve-outs– Geozip 616

The below UB-04 bill is an example of an outpatient surgical facility bill submitted by a hospital in geozip 616. The key HCPCS code related to revenue code 360, which describes the surgical procedure performed, is 64721, and the total charges for the operative session are $6,259.05.

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		092208	003	$61.80
258	IV Solution		092208	001	$78.25
270	Med/Surg Supplies and De		092208	006	$142.00
272	Sterile Supply		092208	006	$525.00
300	Laboratory	81025	092208	001	$116.00
300	Laboratory	36415	092208	001	$14.00
360	**Operating Room Services**	**64721RT**	**092208**	**001**	**$2,627.00**
370	Anesthesia		092208	002	$2,446.00
710	Recovery Room		092208	002	$247.00
	Total Charges				**$6,259.05**

The relevant amount as contained in the HOSF fee schedule:

		Geozip 616
64721	Carpal Tunnel Surgery	**5818.89**

Since the HOSF fee schedule provides the maximum fee schedule amount for all services provided in a single operative session, the reimbursement amount for this billing in geozip 616 would be $5,818.89

as compared to the total charges of $6,259.05. A close examination of the above listed revenue codes does not reveal any exceptions or carve-outs that need to be considered.

Billed:	**$6,259.05**
Paid	**$5,818.89**

Example #2: HOSFFS Single Procedure with Several Revenue Code Carve-outs – Geozip 616

This UB-04 bill is an example of an outpatient surgical facility bill submitted by a hospital in geozip 616. The key HCPCS code related to revenue code 360 is 29807, and the total charges for the operative session are $18,506.10.

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		091008	012	$352.10
258	IV Solution		091008	014	$1,368.50
270	Med/Surg Supplies and De		091008	023	$1,238.00
272	Sterile Supply		091008	005	$354.00
278	**Other Implants**		**091008**	**005**	**$2,664.00**
360	**Operating Room Services**	**29807RT**	**091008**	**001**	**$6,207.00**
370	Anesthesia		091008	006	$4,748.00
636	**Drugs Req Detailed Codin**	**J2405**	**091008**	**004**	**$68.35**
636	**Drugs Req Detailed Codin**	**J3010**	**091008**	**001**	**$17.50**
637	Self Administratable Drugs		091008	001	$3.65
710	Recovery Room		091008	006	$1,485.00
	Total Charges				**$18,506.10**

The relevant amount as contained in the HOSF fee schedule:

		Geozip 616
29807	Repair of SLAP Lesion	**14833.43**

Since the HOSF fee schedule provides an amount for all services provided in a single operative session, the maximum fee schedule amount for this billing, in geozip 616, would be $14,833.43. A close examination of the above listed revenue codes reveals two carve-outs, revenue codes 278 and 636. These carve-outs total $2,749.85, and are paid at 65% of the charged amount or $1,787.40 (this adjusted carve-out amount will be reintroduced to the maximum fee schedule amount once the remaining charges are analyzed).

The remaining charges, after carve-outs, are $15,756.25, and the fee schedule amount listed above is $14,833.43. Since the remaining charges are greater than the fee schedule amount, the fee schedule amount prevails. To calculate the final payment, the adjusted carve-out amount of $1,787.40 is added to the fee schedule amount of $14,833.43 for a final fee schedule payment amount of $16,620.83.

Billed	**$18,506.10**
Minus carve-out	**- $2,749.85**
Amount to be applied to fee schedule	**$15,756.25**
Fee schedule amount	**$14,833.43**
Plus carve-out @ 65%	**+ $1,787.40**
Paid	**$16,620.83**

Example #3: HOSFFS Multiple Surgical Procedure with Revenue Code Carve-outs and Professional Fee Pass-Throughs – Geozip 606

This UB-04 bill is an example of an outpatient surgical facility bill submitted by a hospital in geozip 606 with multiple surgical procedures performed in the same operative setting and professional services being billed in conjunction with facility charges. The key HCPCS codes related to revenue code 360 are 11044, 14040 (listed twice) and 15240 and the total charges for the operative session are $14,757.81.

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy				$842.77
270	Med Sur-Supplies				$2,208.00
312	Pathol/Histol	88304	092108	6	$248.00
312	Pathol/Histol	88311	092108	42	$82.00
360	**OR Services**	**11044**	**092108**	**1**	**$1,948.00**
360	**OR Services**	**14040**	**092108**	**1**	**$1,948.00**
360	**OR Services**	**14040**	**092108**	**1**	**$1,948.00**
360	**OR Services**	**15240**	**092108**	**1**	**$1,948.00**
370	Anesthesia		092108	1	$259.00
636	**Drug/Detail Code**	**J7030**	**092108**	**1**	**$100.00**
636	**Drug/Detail Code**	**J7120**	**092108**	**1**	**$100.00**
636	**Drug/Detail Code**	**J0690**	**092108**	**2**	**$87.04**
636	**Drug/Detail Code**	**J1885**	**092108**	**2**	**$75.00**
636	**Drug/Detail Code**	**J2250**	**092108**	**2**	**$75.00**
636	**Drug/Detail Code**	**J3010**	**092108**	**3**	**$75.00**
710	Recovery Room		092108	3	$229.00
730	EKG/ECG	93005	092108	1	$145.00
964	**Pro Fees Anesthesia CRNA**		**092108**	**115**	**$2,415.00**
985	**Prof Fees EKG**	**93010**	**092108**	**1**	**$25.00**
	Total Charges				**$14,757.81**

The relevant amounts as contained in the HOSF fee schedule:

		Geozip 606
11044	Debridement, Skin, Partial Thickness	**2381.79**
14040	Adj. Tissue Transfer	**4856.39**
15240	Full Thickness Graft	**4856.39**

The rule for multiple surgical procedures is that the highest paying procedure is calculated as 100% of the fee schedule amount. The remaining procedures (up to 5 procedures) are paid at 50% of the fee schedule amount. These fee schedule amounts are totaled together and compared to the total charges on the bill. In this case, procedure code 14040 is paid at $4,856.39 as the highest paying procedure. All other procedures (including those listed more than once – if appropriate) are paid at 50% of the fee schedule amount. In the above example, the total maximum fee schedule allowance is $10,903.69 ($4,856.39 [for HCPCS 15240 @100%] + $2,428.20 [for HCPCS 14040 @50%] + $2,428.20 [for HCPCS 14040 @50%] + $1,190.90 [for HCPCS 11044 @50%]).

Before the fee schedule allowance is applied, we must make sure that all carve-outs and/or other charges that need to be evaluated independently are removed. In this case, we have $512.04 in charges from revenue code 636. These charges need to be removed from the total charges, adjusted to 65% of the charged amount, and reintroduced to the final payment calculation. The carve-out amount that will be reintroduced is $332.83. This case also contains charges for professional services, which are not

part of the facility fee schedule calculation. These services listed with revenue codes 964 and 985 totaling $2,440.00 must be removed from the total charges, adjusted to 76% of the charged amount, and reintroduced to the final payment calculation. The carve-out amount that will be introduced is $1,854.40.

In summary, we have a base maximum fee schedule amount of $10,903.69 + carve-out reimbursement of $332.83 (paid at 65% of the charged amount) + the professional services at $1854.40 (paid at 76% of the charged amount) for a final payable amount of $13,090.92.

Billed	**$14,757.81**
Minus Professional Services	**$2,440.00**
Minus carve-out	**- $512.04**
Amount to be applied to fee schedule	**$11,805.77**
Fee schedule amount	**$10,903.69**
Professional Services @ 76%	**$1,854.40**
Plus carve-out @ 65%	**+ $332.83**
Paid	**$13,090.92**

Example #4: HOSFFS Operating Room Services Originating from an Emergency Room – HCPCS/CPT Codes Are Subject to HOSFFS for Radiology and Path/Lab – All Remaining Charges Paid at 76% - Geozip 601

This UB-04 bill illustrates several fee schedule applications:

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges/FS Amount
250	Pharmacy		091008	7	$950.00
250	Pharmacy		091008	10	$305.56
270	Med Sur-Supplies		091008	27	$1,170.00
300	**Laboratory**	**80048**	**091008**	**1**	**$105.00/FS $120.98**
300	**Laboratory**	**82962**	**091008**	**2**	**$84.00/FS $68.00**
300	**Laboratory**	**85025**	**091008**	**1**	**$82.00/FS $69.73**
300	**Laboratory**	**82962**	**091008**	**1**	**$42.00/FS 34.00**
312	**Pathol/Histol**	**88304**	**091008**	**1**	**$248.00/FS $204.97**
320	**DX X-Ray**	**73090LT**	**091008**	**1**	**$292.00/FS $255.95**
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	20103LT	091008	1	$1,459.00
370	Anesthesia		091008	1	$259.00
450	**Emerg Room**	**9928525**	**091008**	**1**	**$676.00**
450	**Emerg Room**	**90765**	**091008**	**1**	**$268.00**
450	**Emerg Room**	**90775**	**091008**	**1**	**$165.00**
710	Recovery Room		091008	5	$501.00
762	Observation Rm		091008	15	$705.00
762	Observation Rm		091008	6	$94.00
	Total Charges				$11,751.39

1. Since this billing has an emergency room component, as evidenced by the line items associated with revenue code 450, the HOSF fee schedule will not apply.

2. The laboratory, pathology and radiology charges on the bill ARE still subject to the radiology, pathology and laboratory provisions of the hospital outpatient fee schedule. For illustration purposes, the fee schedule amount is designated by the "FS", and is listed next to the actual charges.

3. All portions of the bill not subject to those fee schedule sections just mentioned in number 2, would be paid at 76% of the charged amount under the fee schedule.

Billed	**$11,751.39**
Lab/Path/Rad charges	**- $853.00**
Remaining ER amount	**$10,898.39**
Fee schedule amount ($10,898.30 X 76%)	**$8,282.78**
Lab/Path/Rad fees (per scheduled listings)	**+ $737.65**
Paid	**$9,020.43**

Example #5: HOSFFS One or More Procedures Not Found in Fee Schedule – Entire Bill Minus Carve-outs Defaults to 76% of the Charged Amount

This UB-04 bill contains procedures not found in the fee schedule:

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		090608	14	$585.00
250	Pharmacy		090608	3	$176.45
258	IV Solution		090608	6	$560.50
270	Med/Surg Supplies and De		090608	17	$1,014.00
272	Sterile Supply		090608	12	$1,137.00
360	Operating Room Services	29826RT	090608	1	$5,329.00
360	Operating Room Services	2981959RT	090608	1	$0.00
360	**Operating Room Services**	**2347259RT**	**090608**	**1**	**$0.00**
370	Anesthesia		090608	5	$4,173.00
636	Drugs Req Detailed Codin	J2405	090608	4	$68.35
636	Drugs Req Detailed Codin	J3010	090608	15	$102.05
637	Self Administrable Drugs		090608	6	$404.40
637	Self Administrable Drugs		090608	2	$1.00
710	Recovery Room		090608	3	$1,270.00
762	Observation Room		090608	25	$858.00
	Total Charges				$15,679.05

The above billing lists a surgical procedure (2347259RT) for which a fee schedule amount does not exist. Since the calculation of a fee schedule amount would include a combination of an amount for every procedure performed, it is impossible to calculate when a fee for one or more procedures is not provided in the fee schedule. In these situations the entire bill, minus carve-outs or other exceptions, defaults to POC76.

Some hospital billing software lists a procedure that was performed in the operative session, but does not list a line item dollar amount for every procedure (e.g., some hospitals only list a dollar amount

with the first procedure listed). It must be emphasized that the IWCC HOSF fee schedule is concerned with the total charges on a bill – and not line item dollar amounts, therefore, the fee schedule calculation should take into account all listed procedures regardless of line item listed amounts.

Billed	**$15,679.05**
Minus carve-out (636 Rev Code)	**- $170.40**
Amount applied to fee schedule	**$15,508.65**
Paid at 76%	**$11,786.57**
Plus carve-out paid @ 65%	**+ $110.76**
Paid	**$11,897.33**

Example #6: HOSFFS Multiple Bilateral Procedures – Entire Bill Minus Carve-outs – Geozip 600

This UB-04 bill contains three bilateral procedures performed in the same operative session:

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		60508	6	$172.10
258	IV Solution		60508	1	$90.75
270	Med/Surg Supplies and De		60508	3	$593.00
272	Sterile Supply		60508	3	$584.00
360	**Operating Room Services**	**2739350**	**60508**	**1**	**$30,727.00**
360	**Operating Room Services**	**2769150**	**60508**	**1**	**$0.00**
360	**Operating Room Services**	**2769250**	**60508**	**1**	**$0.00**
370	Anesthesia		60508	3	$3,237.00
636	**Drugs Req Detailed Codin**	**J2405**	**60508**	**4**	**$21.05**
636	**Drugs Req Detailed Codin**	**J3010**	**60508**	**1**	**$18.90**
637	Self Administrable Drugs		60508	1	$3.70
710	Recovery Room		60508	7	$1,820.00
	Total Charges				$37,267.50

The relevant amounts as contained in the HOSF fee schedule:

		Geozip 600
27393	Lengthening of hamstring tendon; single tendon	7039.55
27691	Transfer or transplant of single tendon, deep	11510.35
27692	Transfer or transplant of single tendon, each additional	11510.35

Code 27691.50 is the highest weighted procedure and is paid at 150% of the fee schedule amount or $17,265.53 ($11,510.35 x 150%).

Code 27692.50 represents each additional tendon (bilaterally) and would result in a fee schedule amount of $17,265.53 ($11,510.35 x 150%). Since 27692 is an add-on code, multiple surgical pricing logic is not applied to this step.

The lowest weighted procedure is 27393.50 with a fee schedule amount of $7,039.55, which must be multiplied by 150% for bilateral, then multiplied by 50% for multiple or $5,279.66 ($7,039.55 x 150% x 50%).

****Note: calculation revised 11/1/09****

Billed	**$37,267.50**
Minus carve-out (Rev. Code 636)	**- $39.95**
Amount Applied to Fee Schedule	**$37,227.55**
Fee Schedule Amount for 27691.50 ($11,510.35 x 150%)	**$17,265.53**
Fee Schedule Amount for 27692.50 ($11,510.35 x 150%)	**$17,265.53**
Fee Schedule Amount for 27393.50 ($7,039.55 x 150% x 50%)	**$5,279.66**
Total fee schedule amount allowed	**$39,836.69**
Fee Schedule Amount (Amount Applied to FS <FS)	**$37,227.55**
Plus carve-out paid @ 65% (65% x $39.95)	**+ $25.97**
	$37,253.52

Bilateral procedures are reported with a unit of one, as they should be. Despite the order in which a facility bills for the procedures performed, the highest paying/highest weighted procedure must go first. Subsequent procedures would be subject to multiple surgical cutbacks. Finally, the fact that a hospital facility does not list a dollar amount for a procedure (see example above) will not exclude fee schedule amounts for these procedures. While these zero dollar amounts may look unusual, they are reported this way with certain hospital billing software's and the dollar amounts for all procedures are reported with the first procedure listed on the bill. Given that the hospital outpatient surgical facility fee schedule is global in nature, this should not cause any problems in applying the fee schedule.

Example #7: Professional Services Fee Schedule (ProServ) Multiple Surgical Procedures – Geozip 600

From 1500 form:

Dates of Service		Procedure Code	Modifier	Charges
From	To			
9012008	9012008	26320	51	$3,000.00
9012008	9012008	25000	51	$1,200.00
9012008	9012008	25447	51	$3,000.00
9012008	9012008	25310	LT	$3,000.00
Total				$10,200.00

From fee schedule:

Code	Geozip 600
26320	$2,914.58
25000	$1,499.77
25447	$4,499.33
25310	$3,073.55

The fee schedule ranks 25447 as the highest paying procedure, followed by codes 25310, 26320 and 25000, respectively. Since 25447 is billed at $3,000 below the fee schedule amount, the maximum payment (excluding any contractual arrangement) would be $3,000.

While the provider listed 25310 as the primary procedure, the weighting of procedures must be determined by the fee schedule. Procedure code 25310 becomes a lesser-ranked procedure and would be paid at the lesser of 50% of charges or 50% of the fee schedule amount, which in this case would be 50% of charges, or $1,500.00.

The next ranked multiple procedure, 26320, would also be paid at the lesser of 50% of the charged amount or 50% of the fee schedule amount. Since the fee schedule amount is lesser, payment would be made at $2,914.58 x 50%, or $1,457.29.

The last code, 25000, would also be paid at the lesser of 50% of the charged amount or 50% of the fee schedule amount. Since the fee schedule amount is greater than the charged amount, payment would default to 50% of charges, or $600.00 ($1,200.00 x 50%).

Billed:	**$10,200.00**
Fee Schedule Amount for 25447.51 ($3,000.00 x 100%)	**$3,000.00**
Fee Schedule Amount for 25310.LT ($3,000.00 x 50%)	**$1,500.00**
Fee Schedule Amount for 26320.51 ($2,914.58 x 50%)	**$1,457.29**
Fee Schedule Amount for 25000.51 ($1,200.00 x 50%)	**+ $600.00**
Paid	**$6,557.29**

Examples of Modifier -59. Examples of certain circumstances that indicate that a procedure or service was distinct or separate from other services performed on the same day. The following examples can be found at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf/*.

Example #8: Column 1 Code/Column 2 Code 11055/11720

CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
CPT Code 11720 – Debridement of nail(s) by any method(s); one to five
Policy: Mutually exclusive procedures
Modifier -59 is:

1) Only appropriate if procedures are performed for lesions anatomically separate from one another or if procedures are performed at separate patient encounters.
2) Don't report CPT codes 11055-11057 for removal of hyperkeratotic skin adjacent to nails needing debridement.

Example #9: Column 1 Code/Column 2 Code 11719/11720

CPT Code 11719 – Trimming of non-dystrophic nails, any number
CPT Code 11720 – Debridement of nail(s) by any method(s); one to five
Policy: Mutually exclusive procedures
Modifier -59 is:

1) Only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters

Example #10: Column 1 Code/Column 2 Code 17000/11100

CPT Code 17000 – Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
Policy: HCPCS/CPT coding manual instruction/guideline
Modifier -59 is:

1) Only appropriate if procedures are performed on separate lesions or at separate patient encounters.

Example #11: Column 1 Code/Column 2 Code 38221/38220

CPT code 38221 - Bone marrow; biopsy, needle or trocar
CPT code 38220 - Bone marrow; aspiration only
Policy: Standards of medical/surgical practice
Use of -59 modifier should be uncommon but appropriate for these circumstances:

1) Different sites - contralateral iliac crests; iliac crest and sternum
2) Different incisions - same iliac crest
3) Different encounters

Example #12: Column 1 Code/Column 2 Code 45385/45380

CPT Code 45385 - Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
CPT Code 45380 - Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
Policy: More extensive procedure
Modifier -59 is:

1) Only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

Example #13: Column 1 Code/Column 2 Code 47370/76942

CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
CPT Code 76942 – Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation
Policy: HCPCS/CPT coding manual instruction/guideline
Modifier -59 is:

1) Only appropriate if the ultrasonic guidance service 76942 is performed for a procedure done unrelated to the surgical laparoscopic ablation procedure.

Example #14: Column 1 Code/Column 2 Code 93015/93040

CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report
Policy: More extensive procedure
Modifier -59 is:

1) Only appropriate if the rhythm ECG service 93040 is performed unrelated to the cardiovascular stress test procedure at a different patient encounter.

Example #15: Column 1 Code/Column 2 Code 93529/76000

CPT Code 93529 – Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)
Policy: Standards of medical/surgical practice
Modifier -59 is:

1) Only appropriate if the fluoroscopy service 76000 is performed for a procedure done unrelated to the cardiac catheterization procedure.

Example #16: Column 1 Code/Column 2 Code 95903/95900

CPT Code 95903 – Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
CPT Code 95900 - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
Policy: More extensive procedure
Modifier -59 is:

1) Only appropriate if the two procedures are actually performed on different nerves or in separate patient encounters.

Example #17: Column 1 Code/Column 2 Code 97140/97530

CPT Code 97140 – Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
Policy: Mutually exclusive procedures
Modifier -59 is:

1) Only appropriate if the two procedures are performed in distinctly different 15-minute intervals.
2) The two codes cannot be reported together if performed during the same 15 minute time interval.

Example #18: Column 1 Code/Column 2 Code 98942/97112

CPT Code 98942 – Chiropractic manipulative treatment (CMT); spinal, five regions
CPT Code 97112 – Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
Policy: Standards of medical/surgical practice
Modifier -59 is:

1) Only appropriate if the physical therapy service 97112 is performed in a different region than the CMT and the provider is eligible to report physical therapy codes.