Illinois Workers' Compensation Commission
Questions & Answers from Fee Schedule Seminars
1/25/2010

The IWCC has directly responded to many emails regarding questions that have arisen during the course of the seminars and webinar, as well as general questions that are routinely submitted (responses to these questions are too numerous and individualized to be included in this document). Many of these questions already appear on the Commission's web page, "Frequently Asked Medical Questions" at http://www.iwcc.il.gov/faqmed.htm/. Whenever you have a question, please check that page first.

The fee schedule regulations cannot address all of the thousands of issues that can arise. Our hope is that system participants will continue to use common coding and reimbursement practices to fill in the blanks. Whenever our regulations don't address an issue, we encourage parties to follow common billing and coding conventions. If a dispute still exists, the only way to get an authoritative answer is for the employer or employee to take the issue before an arbitrator.

Commission administrators and the Workers' Compensation Medical Fee Advisory Board (WCMFAB) do address the issues they can, in an effort to assure that reasonable and necessary medical treatment is paid promptly and correctly.

We appreciate all the questions raised and the exchanges between payers and providers that occurred during the seminars. We all learned things. The discussions prompted us to issue guidelines on the three issues below, and to make a correction to the Instructions and Guidelines. Thanks to everyone for the input.

1. Allied Health Care Providers and Modifiers

Allied Health care providers, such as physician assistants and nurses, use the modifier -AS to designate their assistance in a surgery. Since they do not use the -80, -81, or -82 modifiers listed in the Instructions and Guidelines for assistance at surgery, disputes have arisen over how these professionals should be paid.

Section 9 of the Instructions and Guidelines states:

*"*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."

If an allied health care professional provides the same service that a physician would at surgery, then he or she is entitled to the same reimbursement as a physician. The fact that the professional is not a doctor is not a basis to reduce payment. Since they are reporting with a modifier –AS, a translation will have to be made as to whether that –AS represents an -80, -81, or -82 modifier.

We do understand that there might be a conflicting provision in the NCCI edits, but it is superseded by a specific rule adopted by the Commission.

Conclusion: Allied health care providers should be paid the lesser of the actual charge or 15% of the surgeon's fee for modifier 81 (minimum assistant surgeon) and 20% for modifier 80 (assistant surgeon) or 82 (assistant surgeon (when qualified resident surgeon not available), as directed in Section 8(G) of the Instructions and Guidelines.

2. Anesthesia and CRNAs/MD Supervisors

The IWCC has taken the position that what represents one full payment for a service should be made for professional anesthesia services. This issue is more easily managed when both a CRNA and MD supervisor are part of the same practice and share the same tax ID. Apparently, we have situations where the supervising MD is billing for services with his/her own tax ID, and the hospital is billing for the staff CRNA services with the hospital's tax ID. Professional services are paid at 76% of charges for hospital professional, and per the professional services fee schedule for the MD. Who gets paid and how do they get paid when the supervising physician and hospital staff CRNA are submitting charges for the same service *from two different tax ID numbers*?

Conclusion: There is not a binding regulation on this point, but the Commission recommends that the MD supervisor receive 100% of the amount allowed under the fee schedule, and then he or she should pay the CRNA, based on the arrangements between the MD and the hospital.

3. Codes not Found in Hospital Outpatient Surgical Facility (HOSF) and ASTC Schedules

The IWCC used the CMS list of HOSF procedure codes (not reimbursement levels) to develop the HOSF and ASTC fee schedules. This list is more extensive than that approved by CMS for ASTCs. CMS excludes codes from this list for two main reasons:

1. The procedure is relatively minor and the facility component is included in the physician's charge for the procedure;
2. CMS believes the procedure should be done inpatient.

For procedures that CMS classifies as inpatient, the IWCC recommends that if the procedure is performed in a hospital, payers and providers should use the POC76 default for the procedure. During the seminars, IWCC administrators said that there should be no payment for the procedure if performed in an ASTC setting.

Conclusion: After more consideration and consultation, the Commission now recommends that codes excluded from the CMS template due to an "inpatient designation" should default to POC76 in <u>both</u> HOSF and ASTC settings. Codes excluded from the template as being bundled into the procedure would continue at a "no reimbursement level."

Correction #1: The IWCC has posted a corrected Example #6 in the Instructions and Guidelines: "HOSFFS Multiple Bilateral Procedures – Entire Bill Minus Carve-outs – Geozip 600". Based on feedback from the Webinar, we realized the example incorrectly applies a -50 modifier to a code, per the Payment Guide to Global Days.

Q: On the last example *(Example #6 in the Instructions and Guidelines)*, the 2nd code is not subject to bilateral payment adjustment per the payment guide, so why would it be multiplied by 150%?

A: **IWCC investigated this example and determined that the sample bill contained coding applications contrary to the rules/logic as we have listed in the Instructions and Guidelines/Payment Guides. In this case, the hospital used a bilateral procedure modifier, but our payment guide does not recognize the use of the -50 modifier for codes 27692 and 27393. Based on this discovery, we posted a revised Example #6. Thanks for the correction.**

Some of the other questions asked during the seminar are listed on the following pages, roughly sorted by subject area.

Fee Schedule Seminar Questions and Answers

General Issues

1. Q: Can the PowerPoint presentation be e-mailed to participants for future reference or is it available for download?
2. Q: When will the slides from this presentation be available on the website?

A: **The presentation is available at http://www.iwcc.il.gov/fsseminar.pdf .**

3. Q: Is the fee schedule to be followed is wherever the treatment is rendered?

A: **Yes, payment is based on the place of treatment.**

4. Q: Is the effective date of the 2010 reimbursement reductions January 1 or July 1, 2010?
5. Q: Will hospital rates be updated effective 1/1/2010 or just medical?

A: **The CPI change applies to ALL fee schedule amounts and took effect 1/1/2010. Fees went DOWN 1.48% on 1/1/10. Every year, all treatment on or after 1/1 should be paid at the new rate.**

6. Q: On the fee schedule website, do we use the last bullet ("2009 (New MS-DRG") only for hospital reimbursements after 6/30/09, or for ALL reimbursements after 6/30/09.

A: **Using this bullet will retrieve ALL fee schedule amounts on or after 6/30/09.**

Balance Billing Issues

7. Q: Providers are billing the claimants' employer for balance that is not paid. Is that a correct practice?

A: **The employer is responsible for the payment of benefits, and an insurer may make the payments on the employer's behalf. If your intent is to advise the employer of a conflict regarding payment, it is permissible. The fee schedule amount represents full payment, so it is not permissible to bill the employer for unpaid amounts of correctly-paid bills.**

8. Q: If an insurance company denies payment, and a wc case is pending, should we bill their group insurance?
9. Q: Can we choose to bill the patient's health insurance if the claim is in litigation?

A: **We are not aware of a strict prohibition, but we suspect it would be denied by health insurance and/or paid at a lower rate. Many providers at the seminars said it is in their financial interest to await the outcome of litigation. This is a choice to be made by the provider. The IWCC cannot give advice on this.**

10. Q: What if there is a patient who was denied WC and isn't responding to our requests for information regarding the WC case, and we have a denial letter from the WC. Can we bill the patient?

A: **Yes.**

11. Q: If the claim has been determined to be non-compensable, can we bill the patient for full billed charges?

A: **Yes.**

12. Q: What if you have a patient who was denied a WC case. Patient has attorney and reopened the case. IWCC status is in arbitration and the next date is on file. Patient attorney stated bill private insurance. What are the policy rules which we can bill the patient? Can we bill insurance, and what other restrictions can be involved in a case like this regarding the bill?

A: **Yes, you can bill private insurance. You cannot bill the patient under the WC claim.**

13. Q: Can a patient be sent a "notification letter" rather than a bill to notify them of a current balance without it violating the balance billing issue?

A: **Yes, see balance billing provision, Section 8.2(e) of the Act.**

14. Q: Patient comes to office, we file health insurance and they pay. Then we get records and it's turned into a WC case. Who and when does health insurance get refunded after case has been settled by patient?

A: **The fee schedule does not precisely address how a non-comp payer is reimbursed for a claim that is later classified as WC.**

15. Q: If case is open, can we bill the private insurance or would it be considered billing patient since it is their insurance?

A: **Most commercial contracts with providers require a provider to inform an insurance company if treatment is related to automobile or an on-the-job injury. Not informing can be in violation of your contract.**

16. Q: What should we do when a patient has a surgery and does not mention WC, and then a year later we find out he has an IWCC case and owes balances in regards to the WC case. Do we stop pursuing payments on those charges once we are notified? What about charges already paid via co-pay?

A: **We don't know. The way to get an authoritative answer on complicated scenarios is to take the issue before an arbitrator. Generally, once the worker tells you there is a case pending with the IWCC, the prohibition against balance billing kicks in.**

BILLING/PAYMENT ISSUES

17. Q: Should you bill at fee schedule amount or round up for services?

A: **You should bill your normal charges. The fee schedule determines maximum medical payments. You should not increase your charges because of the fee schedule.**

18. Q: Could we deny the professional charge on the UB and request it be billed on HCFA and apply fee schedule?

A: **The fee schedule does not require hospitals to report professional charges on a separate HCFA, although the ASTC fee schedule does request that laboratory and radiology charges be submitted on a separate claim form.**

19. Q: What if a WC injury is in litigation but they have Medicaid and the time limit for them is 1 year and it is denied as WC after a year, is there a way to get Medicaid to pay?

A: **Medicaid can be billed first: payment from Medicaid is the provider's payment. If the provider waits for the bigger payment and it exceeds the billing limit for Medicaid, all is lost. On the other hand, Medicaid will seek repayment from the liability company (the total payment being paid by the liability company) to insure the patient, or the injured worker doesn't receive any additional payment due to the medical bills. These issues are business decisions of the provider. The IWCC cannot advise.**

20. Q: If a provider is paid by self-insured health benefits for a denied claim, then the claim is later awarded by the arbitrator, can that provider force the employer to pay under work comp and reimburse the health benefits?
A: **This appears to be an unusual circumstance in a litigated scenario, for which the IWCC does not have a specific response in terms of the basic application of the fee schedule.**

21. Q: Can a surgeon bill for surgical services under one tax ID#/group, then bill post-op care under a different tax ID number/group in order to try to get payment for follow-up care normally included in the global reimbursement?
A: **No, this would appear to be fraudulent behavior.**

22. Q: Should we expect 76% for RX/drug charges that are not on the fee schedule?
A **Prescription drugs shall be paid at the usual and customary rate. Our regulations do not specify how to arrive at U&C. If there is a dispute, the parties could take the issue before an arbitrator. Drugs provided by a facility can be paid as part of the fee schedule amount, the POC76 default, or the 65% carve out amount – it all depends on how they are listed and on what type of bill is being submitted.**

23. Q: Why would the facility get paid at 76% of billed charges for a professional charge?
A: **By law, payment defaults to 76% when the IWCC was unable to calculate a fee. When the fee schedule was constructed, an appropriate database of professional service charges in a hospital setting was not available.**

24. Q: Will you please address that some providers believe they can bill the employee for ANY individual charge that is disallowed by the work comp carrier. For instance, if a charge is not covered under work comp law, such as CPT 97010, they bill the patient.
A: **When 97010 is part of another modality, this would be an inappropriate billing, and it would therefore be improper to bill the patient.**

25. Q: If a payor pays more than the fee schedule, do we have to refund the money?
A: **Yes. The fee schedule amounts represent the maximum medical payment under the fee schedule, unless the parties have a contract.**

26. Q: (Do we have to include the) Exact diagnosis code that is in the patient's case file? For example, they have a hip fracture and we, as a home health agency, use an aftercare for hip fracture diagnosis. If we require exact codes, how do we obtain?
A: **The aftercare diagnosis is appropriate for a home health agency and should not prohibit payment because it differs from the diagnosis listed by the attending surgeon/physician. If you think it is in your best interest to obtain the exact diagnosis listed by the attending physician, it would seem reasonable to ask the patient or referring physician for this piece of information.**

27. Q: Is there an effective date for the NCCI clarification regarding CPT 97010?
A: **The NCCI edits took effect with the fee schedule on 2/1/06. Recently, the NCCI publisher clarified that hot and cold packs are always considered bundled into other physical medicine codes. Because there was legitimate confusion, the IWCC would not recommend reclamation of past payments, but would encourage that this finding be applied as you move forward. But this is only a recommendation; our regulations don't address such scenarios.**

28. Q: Is there any information on the recent changes with the implants where the payer can subpoena the invoice and an arbitrator can set a "reasonable fee"?

A: **The regulation regarding implants has not changed. The rules say that carve-outs shall be "billed at the provider's normal rates under its standard chargemaster." We wait for precedents to be set in case law in the interpretation of that rule.**

29. Q: Do hospitals have to provide our chargemaster to the payor? We have received this request from Bill Review Companies.

A: **It is appropriate to ask for a chargemaster to verify certain items, such as charges for implants.**

30. Q: How are professional services defined on hospital bill – Professional revs, CPTs?

A: **The most common method of identifying professional fees is by identifying those revenue codes that signify professional fees (e.g. 960-989).**

31. Q: Hospitals have started listing virtually every drug charge under rev code 636 just to get reimbursement over DRG rates. Is that OK?

A: **Hospitals should bill using the same revenue codes it uses for all payers. If, in fact, inappropriate revenue codes are being used, it could be challenged.**

32. Q: Is there an official document stating unbundling does not apply to inpatient claims? When we have inpatient claims that reach an outlier, sometimes payers will deny lines as unbundled. This lowers the reimbursement allowed. Unbundling is an outpatient denial, not an inpatient.

A: **The IWCC did not adopt an official document to dictate what services should be bundled into a particular revenue code. Unless the hospital is ignoring common billing practices, services should not be bundled so as to deny an outlier payment.**

33. Q: What options do hospitals have if the claim goes to arbitration, and a decision is not made for awhile? Arbitration then denies the workers comp case, but now it is too late to bill the patient's health insurance. We have tried appealing, but the health insurance and the employer have denied payment.

A: **A hospital should check its managed care agreement. Many have provisions for acting in "good faith." If it was a legitimate claim, you should not be penalized for waiting for the WC claim to finalize. If health insurance will not accept as "timely," you can bill the patient. Also, you could file a claim with the patient's health insurance during arbitration, knowing it will be denied, if only to have it entered into their system.**

34. Q: Despite your good intentions, paying a percent of charges for implants is an invitation to greedy. Even if a facility bills everyone the same "normal" high amount for an implant (often hundreds of times above their cost), the fact is that they will accept payment from group health payors at much lower rates (nearer to their cost) than they will accept from a work comp carrier – all because they know that IL work comp law mandates the higher payment rate. I strongly encourage you to beg the Commission to remedy this. I can provide numerous examples of charges far, far, above the facility's cost. Even at 65% reimbursement, they make thousands of dollars profit on an implant to which they have added no value. It is terribly disappointing that IL has not changed this formula for 2010

A: **The Medical Fee Advisory Board's report to the General Assembly recommends re-examining the implant rule. Policy change is difficult and can take some time.**

35. Q: For ASTCs, if a surgery procedure is not valued (POC76) does the fee schedule apply like hospitals, where the entire bill is paid at 76% except carveouts?
A: **Yes.**

36. Q: If professional services are billed by an ASTC, should they be denied and billed under the providers Tax ID or pay per the medical fee schedule?
A: **The fee schedule was developed from data that did not include professional fees – and as such the amount listed in the fee schedule does not include reimbursement for professional fees. The fee schedule does not specifically require that professional fees be submitted on a separate claim form as this is not the normal practice. Professional fees should be paid per the professional services fee schedule. The fee schedule does provide the following point of direction, however, as follows: "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."**

37. Q: On the ASTC claims, should be billed on a UB04 or HCFA 1500?
A: **ASC claims can be billed on a UB04 or HCFA 1500 form.**

38. Q: Why would payers ask for a TC modifier on claims for radiology services when we only bill hospital services?
A: **The IWCC has taken the position that a TC modifier is not required when billed by a hospital on a UB-04 (assuming that it is a technical charge).**

39. Q: Concerning MS-DRG schedule, the email notification stated that the Workers Compensation Medical Fee Advisory Board and the Commission asked providers and payors to follow a July 31, 2009 effective date. Are the DRG's effective on that date, or 6/30/2009 as posted on the website? Can the state say definitely one way or the other?
A: **The 6/30/09 date in the rules is the official date. The advisory board suggested (not required) parties cooperate and follow a 7/31/09 implementation date. If parties don't agree to cooperate, the 6/30/09 date controls.**

40. Q: Is there a schedule for hospital outpatient Radiology, Pathology, etc?
A: **Yes - Hospital Outpatient (10021 - 97755; For other procedures, refer to the Instructions and Guidelines).**

41. Q: Is the MS-DRG crosswalk available online?
A: **Yes, it is at http://www.iwcc.il.gov/faqmed.htm#msdrg .**

42. Q: Whenever Gallagher Bassett denies a bill for not having modifier 26 or TC on the bill, can we tell them "no, it is not required?"
A: **Yes, assuming that you are a hospital provider and you are using revenue codes that clearly distinguish between professional and technical components.**

43. Q: Does the Department of Labor require TC modifier on UB?
A: **The IWCC does not require the TC modifier. We don't know if it is required by the Department of Labor.**

44. Q: The fact that there is a separate reimbursement for professional components versus technical components gave many payors reason to request a modifier. If hospitals only bill for facility services, why even mention the professional component?
A: **The fee schedule does not detail exact billing requirements. The IWCC had neither the time nor expertise to implement such a system. It is our understanding that hospitals bill for both professional and technical services, but that most other payers do not require the TC modifier. We are asking payers to accept mainstream billing practices by hospitals (which do not include usage of the TC modifier) and to use revenue codes to determine professional and technical components.**

45. Q: Can you clarify: 65% carve-outs apply to any services, such as IP, ER, Surgical and all other OP?
A: **The 65% carve-out applies to all inpatient, ER, hospital outpatient, and ASTC services.**

46. Q: On slide 59, can you expand on "Follow sections 8B for multiple and bilateral procedures." We want to verify that an additional payment is due for these services.
A: **Slide 59 covered basic components of the ASTC fee schedule. When multiple or bilateral procedures are performed, reimbursement amounts are subject to the listed provisions in the Instructions and Guidelines (e.g., these provisions will tell you if you can or cannot bill for a multiple procedure).**

47. Q: If a hospital does not bill a radiology code with any modifier, can it still be paid at the technical component rate, or does the full component rate have to be paid?
A: **Technical component rate.**

48. Q: What is the difference between global fee schedule in the outpatient hospital FS and partial global reimbursement in the ASTC FS?
A: **The ASTC fee schedule 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.**

49. Q: Does the global fee schedule apply if multiple procedures were performed in a single operative session?
A: **Refer to the examples in the Instructions and Guidelines.**

50. Q: What fee schedule does outpatient surgery fall under when done in an urgent care setting – billed under REV 510? No ER charges billed.
A: **It would be hospital outpatient, but would default to POC76.**

51. Q: How can payors deny services citing unbundling when your fee schedule shows the services as being reimbursed separately? Example: They will not pay for recovery room for surgeries. It seems they pick and choose what they think should be paid.
A: **The IWCC does not have specific bundling edits at the revenue code level. If a hospital is using accepted software that lists accepted line items at the revenue code level, they should not be denied.**

52. Q: Would it be possible to add some ASTC and Emergency Room bill examples to the Instructions & Guidelines?
A: **The IWCC can add some examples – they will be listed in the FAMQ section.**

53. Q: Regarding your Example 1 on page 83 of your PowerPoint, why isn't the lab paid separately in addition to Single Procedure allowance?
A: **Because lab charges on hospital outpatient surgical facility bills are included in the fee schedule amount listed for that single procedure.**

54. How are facilities other than hospitals and ASTCs reimbursed?
A: **The fee schedule does not provide for reimbursement for non-licensed facilities.**

55. Q: Is there a limit on how many multiple procedures will be paid?
A: **No, under the IL fee schedule there is no limit to how many procedures, rendered on the same date of service in the same clinical setting, may be reimbursed, subject to fee schedule rules and guidelines. If the multiple procedure rule (MPR) applies, the first procedure (that which has the highest fee schedule amount) will be reimbursed at 100% of the fee schedule value. Secondary procedures 2-5 that are subject to the multiple procedure rule will each be paid at 50% of the fee schedule value. Procedures beyond the 5th should be priced on a "by-report" basis.**

56. Q: Where exactly is the list of Licensed ASTCs to be found?
A: **Go to http://www.idph.state.il.us/healthcarefacilities/astc.htm**

57. Q: Is there a contact we could speak with regarding the TC/26 Modifier requirement?
A: **Email** feeschdquestions.wcc@illinois.gov

MEDICAL RECORDS

58. Q: Does it state in the fee schedule that a provider must send the medical records along with the initial billing and not charge for requests of same on compensable claims?
A: **No. Our regulations don't address documentation other than to say bills should include "substantially all the required data elements necessary to adjudicate the bills." (Section 8.2(d)**

INTEREST

59. Q: What is the section that addresses interest being accessed to incorrect payments appeals?
60. Q: How to figure interest on incorrect payments?
A: **Section 8.2(d) of the WC Act provides that payment is due within 60 days of the date the payer receives substantially all the information needed to adjudicate a bill. Unpaid bills accrue interest of 1% per month. Calculate interest on the correct and remaining balance. Proceed as you would with any other unpaid bill by submitting a statement for accrued interest as part of the overall bill.**

61. Q: At what point can we start charging interest?
A: **The medical provider can charge interest on unpaid amounts after 60 days have passed from the date the payer received substantially all the information needed to adjudicate a bill.**

62. Q: Does the 1% interest apply to the city and state employees?
A: **Yes.**

63. Q: Can the medical provider file directly for a penalty at the IWCC?
A: **No, the provider has no standing in the IWCC court system. A provider could work through the employer or employee on the case to take an issue to the IWCC.**

64. Q: Where can a provider send a complaint, if a payor is not paying based on the IL Work Comp fee schedule?
A: **If the issue relates to a contract, contact Dept. of Insurance. The only way to obtain a binding legal decision on a dispute is for the employer or employee to take the issue before an arbitrator. Providers and insurance companies do not have standing to file a hearing, so they need to work through the employer/employee.**

CODING ISSUES

65. Q: To what extent does the Illinois fee schedule follow NCCI guidelines vs CPT coding guidelines?
A: **Need to know where there is a conflict or overlap to answer the question. The NCCI guidelines were adopted to address bundling edits.**

66. Q: What do you mean by Usual and Customary?
A: **Usual and Customary is an undefined amount paid by payers in the absence of a scheduled and published fee amount. U&C amounts vary from carrier to carrier – they are also proprietary, and, as such, it is difficult to ascertain additional information regarding a specified amount.**

67. Q: For Usual and Customary prescriptions, how do you handle when prescripts are charged at 3 times the price, and only paid if case is won?
A: **This question requires further definition/facts before an answer can be provided.**

68. Q: Is Usual and Customary 76% of charge?
A: **Usual and Customary is undefined. Some payers use 76% of charges as U&C in Illinois as it was established as the standard default.**

69. Q: We see creative coding from providers who like to use codes listed at POC76 (for instance, "99" codes.) The charges for these codes are generally very high when compared with similar procedures. This means that the provider is entitled to 76% of however much they choose to bill. Is the State of IL considering changing the POC76 rule? It appears to be an invitation to increased charges.
A: **If a provider is using a "99" code when in fact there is proper code to describe the procedure it would be appropriate to use the more precise code and apply the fee schedule accordingly.**

70. Q: Is 97010 (Hot/cold packs) reimbursable if no physical medicine procedure is provide?
A: **In certain limited circumstances, CPT code 97010 may be separately reimbursable, provided that it is not billed in conjunction with any physical therapy or chiropractic modality or evaluation. It may be necessary, however, to provide supporting clinical documentation to support that bundling should not apply**.

71. Q: Where do you find the $ amount to be applied to each of the modifiers?
A: **The Instructions and Guidelines provide a % and how it relates to a fee schedule amount – you need to combine the two to establish the correct payment amount.**

72. Q: Can a MD bill the carrier for a "facility fee" if his medical practice is not a licensed ASTC?
A: **A non-licensed ASC can bill a carrier for a "facility fee", but the fee schedule does not require payment.**

ASSISTANCE AT SURGERY/ALLIED HEALTH CARE PROFESSIONALS

73. Q: If we pay facility for CRNA charges is this the full payment for anesthesia?
A: **The fee schedule was designed to pay the professional providing the anesthesia per the fee schedule provisions. If the CRNA and supervising MD share the same tax ID number, payment could be made to that tax ID in several acceptable manners (e.g., 50% to MD, 50% to CRNA – if two separate bills were submitted). The WCMFAB has recommended paying the MD supervisor the full amount, where bills are submitted by the supervising MD with one tax ID number, and the professional CRNA charges are submitted by a hospital with another tax ID number. Any CRNA amount can then be distributed by the MD per the agreement between the hospital and supervising MD – since a payer will not be privy to this arrangement.**

74. Q: The modifier instructions address assistant surgeon modifiers 81, 82, etc. What percentage should modifier -AS be reimbursed?
A: **When allied healthcare providers provide the same service as a physician, they are paid the same as though a physician performed that service – you would have to determine what the AS modifier represents.**

75. Q: Physician Assistants that are used as assistant surgeons in surgery should be paid at the same rate as an assistant surgeon. Does this mean that they should be billed at the same rate as the primary surgeon and then reduced by 76% and then by 20%?
A: **PAs could submit the bill at 20% of the primary surgeon's fee. If the fee schedule shows POC76 for a procedure, payment should be Surgeon's fee X 76% X 20%.**

76. Q: Can you please address how payment is handled for an assistant surgeon for POC 76 codes? Is the allowance based on a percentage of the surgeon's fee schedule allowance?
A: **It seems logical that you would determine 20% of the primary surgeon's fee and then multiply that by 76% of charges.**

77. Q: A PA is an assistant for surgery so we would expect payment the same as if a surgeon assisted?
A: **Correct.**

78. Q: A PA usually uses modifier –AS when assisting, so what are you are saying is that the –AS modifier is also reimbursed at 20% of the surgeon's charge?
A: **Yes.**

CONTRACT ISSUES

79. Q: If the provider has a PPO contract with a network, will the PPO network prevail?
A: **Yes.**

80. Q: We submitted a claim and received payment from Coventry that was priced by Aetna. Why are we getting paid by Aetna?
A: **This can only be answered by looking at network(s) contract(s).**

81. Q: Will you be discussing insurance carriers that take discounts in addition to the standard fee schedule? Three Rivers is one that processes our claims based on the fee schedule in addition to the set "contract discount amount". However, for our center, we EXCLUDE workers comp claims from the contract.
A: **If you have a complaint about a payer not following your contract, contact Dave Grant, Health Care Coordinator, IDOI, Managed Care Unit, at 217/782-6369 or dave.grant@illinois.gov.**

82. Q: We have payors taking double discounts. Aren't they supposed to pay according to the contract or fee schedule, which ever is the lesser?
A: **Under the fee schedule, the employer pays the lesser of the rate set forth in the schedule or the provider's actual charge. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in the contract shall prevail. Some contacts allow for a discount to be taken off of the fee schedule amount. Check your contracts to verify the proper application of the contact.**

83. Q: Some of the PPO companies have indicated their contract does indicate percentage off fee schedule.
A: **Look at the contract to verify this provision.**

84. Q: When the provider is looking for WC Carrier/ins info and cannot get a response from the employer or the patient/employee, are we allowed to bill the patient?
A: **Yes, providing you follow the parameters of Section 8.2(e).**

85. Q: How does a payor know if a hospital has a National PPO contract in place? In cases where a hospital advises of a contract, how then do we pay the bill?
A: **As a payor, it would seem to be your responsibility to understand contract agreements and payment rates.**

OUT-OF-STATE TREATMENT ISSUES

86. Q: On claims with a state of jurisdiction of IL and the patient now resides in Missouri (treatment was provided in patient's home), what is appropriate fee schedule used for reimbursement?
A: **76% of charges.**

The defining factor on out-of-state issues is where the worker filed the workers' compensation claim. If the worker filed the claim in Illinois, then Illinois law and the Illinois fee schedule apply.

For example, if a worker filed a claim in Illinois and received treatment in another state, IL law would apply. IL law provides that out-of-state treatment should be paid at the greater of 76% of the charged amount or that state's fee schedule (if that state has a schedule).

If the worker filed a claim in another state, the law in that state would govern how medical treatment shall be paid.

87. Q: Do you have a list of the states we have to accept for their fee schedules and a website to find their fee schedule to verify?
A: **There is a list of state WC Websites at http://www.iwcc.il.gov/faqmed.htm#Fslinks**

88. Q: If you are an out-of-state ASTC provider, how should you bill for your services now that the State of Illinois has adopted a partial-global reimbursement fee schedule?
A: **We would recommend that you bill as you would normally bill. Look at the provisions in the Instructions and Guidelines to see if your billing practice would cause a problem.**

89. Q: Regarding out-of-state treatment, what about states that do NOT have a fee schedule?
A: **Pay 76% of charge if a state does not have a fee schedule.**

90. Q: Did you say that out-of-state professional providers should be paid at IL fee schedule rate? Or at 76%?
A: **They should be paid at the greater of the other state's fee schedule or 76% of charges.**

91. Q: What about a worker that has a WC claim from Florida, but we are treating him here in Illinois, do we have to accept the Florida fee schedule?
A: **The IWCC has no jurisdiction over claims filed in other states. You can choose to accept the other state's fee schedule, or negotiate otherwise. We have been told that many providers accept another state's fee schedule amount, while others will negotiate what they believe to be reasonable reimbursement.**

92. Q: ASTCs have to line-item bill. When billing multiple procedures, the ASC fee quickly get higher than what the IL fee schedule allow. How are out-of-state providers supposed to bill for ASC fees?
A: **Out-of-state providers should bill as they normally do. If the fee schedule applies, then it should be applied – greater of fee schedule amount or 76% of charges.**