

**ILLINOIS WORKERS' COMPENSATION COMMISSION
MEDICAL FEE SCHEDULE
INSTRUCTIONS AND GUIDELINES
FOR TREATMENT ON OR AFTER 9/1/11**

Revised 2/21/13: On page 7, added 0274 (prosthetics/orthotics) to list of nonimplantables.

Table of Contents

Introduction and Purpose

Reference Materials

Section 1. Ambulatory Surgical Treatment Center and Accredited Ambulatory

Treatment Facility Services

- A. Overview**
- B. Applicability and accreditation**
- C. Codes not included on the fee schedule**
- D. Radiology, pathology, and laboratory charges**

Section 2. Anesthesia Services

- A. General guidelines**
- B. Base value, physical status modifier, time units, and qualifying circumstances**
- C. Special coding situations for anesthesia**

Section 3. Dental Services

Section 4. Emergency Room Facility Services

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

Section 6. Hospital Inpatient Services: Standard and Trauma

- A. Overview**
- B. General guidelines for standard inpatient and trauma inpatient care**

Section 7. Hospital Outpatient Services

- A. Radiology**
- B. Pathology and Laboratory**
- C. Physical Medicine and Rehabilitation**
- D. Hospital Outpatient Surgical Facility (“HOSF”)**
- E. Codes Not Found on the HOSF fee schedule**
- F. Emergency Room Cases**
- G. Cost Outliers**

Section 8. Professional Services

- A. Evaluation and Management**
- B. Surgery**
 - “Payment Guide to Global Days, Multiple Procedures, Bilateral Surgeries, Assistant Surgeons, Co-Surgeons, and Team Surgery”**
- C. Radiology Services**
- D. Pathology and Laboratory**
- E. Medicine Services**
- F. Modifiers**
- G. Miscellaneous Services Codes (99024-99091)**
- H. Section 12 Medical Examinations**

Section 9. Allied Health Care Professionals

Section 10. Correct Coding

Section 11. Independent Diagnostic Testing Facilities

Section 12. Out-of-State Treatment

Section 13. Rehabilitation Hospital Services

Section 14. Prescriptions

Section 15. Billing Examples

Introduction and Purpose

Pursuant to Section 8.2 of the Workers' Compensation Act,¹ the Illinois Workers' Compensation Commission ("Commission") establishes and maintains a comprehensive fee schedule setting forth the 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. The Commission increases or decreases the maximum allowable payment based upon the CPI-U on an annual basis. For treatments and services provided on or after 1/1/12, the geozips were collapsed into regions to create new fee schedule amounts.

In addition to maximum medical payments based upon historical fee data, the Commission also determines fee schedule amounts based on other provisions in Section 8.2. For fees within a service category where data was insufficient to establish a fee schedule amount, a default reimbursement code "POC53.2" appears. "POC53.2" means reimbursement should occur at 53.2% of the charged amount.²

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 Workers' Compensation Act.

These Instructions and Guidelines are intended to assist with fee schedule application, and to ensure correct billing and reimbursement on workers' compensation medical claims in accordance with Section 8.2 of the Workers' Compensation Act and Section 7110.90 of the Commission's rules. This document is not intended and should not be construed as a utilization review guide, practice manual, or legal advice. If you are seeking legal advice or a legal interpretation, you may choose to consult an attorney.

Reference Materials

The Instructions and Guidelines reference the most recent editions of following documents, including codes, guidelines, and modifiers:³

1. *Current Procedural Terminology*, copyright, American Medical Association.
2. *HCPCS Level II*, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.
3. *National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers*, U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.
4. *Relative Value Guide*, copyright, American Society of Anesthesiologists.
5. Medicare Severity Diagnosis Related Group (MS-DRG) classification system, Centers for Medicare and Medicaid Services (CMS).

¹ 820 ILCS 305/8.2. Section 8.2 was first added to the Act by Public Act 94-277.

² Prior to September 1, 2011, the default rate was 76% of charges. The 53.2% reflects the 30% fee schedule reduction instituted by P.A. 97-18.

³ See 820 ILCS 305/8.2(a-1)(6).

Section 1. Ambulatory Surgical Treatment Center and Accredited Ambulatory Treatment Facility Services

A. Overview

The Ambulatory Surgical fee schedule provides the maximum medical fee schedule amount for surgical services administered in a recognized ambulatory surgical setting for codes 10021 - 69990.⁴ The Ambulatory Surgical fee schedule is a partial global reimbursement schedule⁵ in that all charges rendered during the operative session are subject to a single fee schedule amount. There are exceptions for the following carve-out categories/revenue codes, which should be paid as explained in Section 6(C):

- Prosthetics/orthotics
- Pacemaker
- Lens implants
- Implants
- Investigational devices
- Drugs requiring detailed coding⁶

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 Section 6(C) of these Instructions and Guidelines..

This fee schedule is subject to Sections 8(B) and 8(F) of these Instructions and Guidelines. However, only the provisions that apply to multiple procedures and bilateral surgeries in 8(B) and applicable modifiers in Section 8(F) of the Instructions and Guidelines shall be used.⁷

B. Applicability and accreditation

The Ambulatory Surgical fee schedule applies to licensed ambulatory surgical treatment centers as defined by the Illinois Department of Public Health in Section 205.110 of its Administrative Rules.⁸ The schedule also applies to ambulatory surgical treatment facilities accredited by one of the following organizations: American Association for the Accreditation of Ambulatory Surgical Facilities, Joint Commission on Healthcare Organizations, or Accreditation Association for Ambulatory Health Care.⁹

C. Codes not included on this fee schedule

The Commission used commonly referenced ambulatory surgical procedure codes (not reimbursement levels) to develop this fee schedule. This list 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. The procedure is commonly performed as inpatient.

⁴ 50 Ill. Adm. Code 7110.90(h)(1)(C).

⁵ 50 Ill. Adm. Code 7110.90(h)(1)(C). Aside from the carve-outs, the Ambulatory Surgical Treatment Center and Accredited Ambulatory Treatment Facility Services fee schedule does not cover radiology, pathology, and laboratory charges that would be covered under the Hospital Outpatient Surgical Facility ("HOSF") fee schedule. Due to the fact that surgical treatment centers and facilities do not uniformly 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.

⁶ 50 Ill. Adm. Code 7110.90(h)(1)(D)(i) and (ii).

⁷ 50 Ill. Adm. Code 7110.90(h)(1)(G).

⁸ For a complete definition of an Ambulatory Surgical Treatment Center, see 77 Ill. Adm. Code 205.110.

⁹ 50 Ill. Adm. Code 7110.90(h)(1)(A).

For procedures that are commonly performed as inpatient, the Commission recommends that payers and providers use the POC53.2 default reimbursement for these facility bills.

D. Radiology, pathology, and laboratory charges

The Ambulatory Surgical fee schedule amounts listed do not include charges for radiology, pathology, and laboratory. These charges must be submitted under separate claim forms.¹⁰ These charges are subject to the professional services fee schedule.

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.”¹¹ 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 a manner consistent with guidelines from these two organizations. Specifically, a conversion factor is a dollar amount that is to be used with the ASA 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).¹²

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:

$$\text{Base Value} + \text{Time Units} + \text{Modifying Units} = \text{Total Units}$$

$$\text{Total Units} \times \text{Conversion Factor} = \text{Total Fee}$$

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 arterial 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:

¹⁰ 50 Ill. Adm. Code 7110.90(h)(1)(F).

¹¹ 50 Ill. Adm. Code 7110.90(h)(2)(B).

¹² 50 Ill. Adm. Code 7110.90(h)(2)(D).

	<u>Unit Values</u>
•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:

<u>CPT Code and Description</u>	<u>Unit Values</u>
• 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 Region 1 in 2012:

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 Region 1) X \$78.16
 Maximum Fee Schedule Amount = \$781.16

C. Special coding situations for anesthesia

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.¹³

¹³ 50 Ill. Adm. Code 7110.90(h)(2)(C).

Section 3. Dental Services

Public Act 97-18 provided that the Commission shall establish a fee schedule for dental services.¹⁴ Prior to the creation of this dental fee schedule, all dental fees are to be reimbursed under the default POC53.2 code¹⁵, which means that reimbursement is 53.2% of charged amount unless the service is billed under codes listed in this fee schedule (e.g., CPT or HCPCS).¹⁶

The Commission has now posted a dental fee schedule. It applies to treatment rendered on and after June 20, 2012.

Section 4. Emergency Room Facility Services

This fee schedule applies 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.¹⁷

Emergency room facility fees are to be paid at 53.2% of charged amounts.¹⁸ Radiology, pathology, laboratory, physical medicine, and rehabilitation services are paid according to the Hospital Outpatient Fee Schedule.¹⁹

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 (“HOSF”) fee schedule provisions.²⁰ You may also refer to Section 7(F) of these Instructions and Guidelines, which discusses emergency room cases.

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 53.2% of the charged amount.²¹

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

The fee schedule incorporates the HCPCS Level II codes and modifiers not included in CPT.²²

Section 6. Hospital Inpatient Services: Standard and Trauma

A. Overview

The coding mechanism upon which the hospital inpatient fee schedules are based is that of MS-DRG (medical severity diagnosis-related group).²³ A MS-DRG is a code that groups patients into homogeneous classifications that demonstrate similar length-of-stay patterns and use of hospital resources.

¹⁴ See P.A. 97-18.

¹⁵ Please note that prior to September 1, 2011, the POC code was reimbursed at 76% of the charge

¹⁶ 50 Ill. Adm. Code 7110.90(h)(3).

¹⁷ 50 Ill. Adm. Code 7110.90(h)(4)(A)(i) and (ii).

¹⁸ 50 Ill. Adm. Code 7110.90(h)(4)(B).

¹⁹ 50 Ill. Adm. Code 7110.90(h)(4)(C).

²⁰ 50 Ill. Adm. Code 7110.90(h)(4)(D).

²¹ 50 Ill. Adm. Code 7110.90(h)(4)(D).

²² 50 Ill. Adm. Code 7110.90(h)(5).

²³ 50 Ill. Adm. Code 7110.90(h)(6)(B).

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 MS-DRG fee schedule that will apply to the vast majority of hospital inpatient bills. The second fee schedule is the trauma MS-DRG fee schedule that will apply to a small number of inpatient bills that involve trauma admissions at designated trauma centers.

B. General guidelines for standard inpatient and trauma inpatient care

1. Definition of Inpatient

Inpatient care is 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.²⁴ Observation stays are reimbursed under the outpatient schedule.

2. Clearly Identifiable MS-DRG

As reimbursement is based upon MS-DRG, hospital providers must clearly identify the MS-DRG in a manner consistent with the Standard and Trauma fee schedule. The MS-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., the current CMS Grouper Version). Hospitals shall list the MS-DRG code on the UB-04.

3. MS-DRG as a Global Reimbursement and Revenue Code Exceptions to Global Reimbursement

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

There are, however, eight exceptions. The following codes are classified as “pass-through” or “carve-out” charges.²⁵ These revenue codes will not be covered under the MS-DRG fee schedule amount.

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

Once pass-through charges are identified and removed, all remaining charges are subject to the MS-DRG fee schedule amount.

Non-implantable devices or supplies (0274 (prosthetics/orthotics), 0540 and 545 (ambulance), and 0636 (drugs requiring detailed coding)) shall be reimbursed at 65% of actual charge (the provider's normal rates under its standard chargemaster). A standard chargemaster is the provider's list of charges for procedures, services and supplies used to bill payers in a consistent manner.

Implants within the carve-out revenue codes/categories or implants otherwise identified by any individual or grouped revenue codes/categories are to be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges, whether or not the implant charge is submitted by a provider in conjunction with a bill for all other

²⁴ 50 Ill. Adm. Code 7110.90(h)(6)(C).

²⁵ 50 Ill. Adm. Code 7110.90(h)(6)(F).

services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or submitted by the manufacturer of the implant.

If the fee schedule amount defaults to 53.2% of charged amount, these rules will still apply. Remove all charges from the applicable revenue code line items and pay as explained above: the remaining total charges will then be paid at 53.2%.

4. Cost Outliers

Section 8.2(c) of the Workers' Compensation Act requires the Commission to set forth a process by rule to determine whether an additional adjustment should be made to the fee schedule amount for procedures, treatments, and services that involve extra-ordinary treatment.

The Commission promulgated an outlier rule for inpatient care in Section 7110.90(h)(6)(G) of the Commission's rules.²⁶ On and after September 1, 2011, cost outliers are defined as extraordinary treatment in which the bill for an inpatient stay is at least 2.857 times the fee schedule amount for the assigned DRG after pass-through revenue code charges have been deducted. The maximum reimbursement amount for cost outliers will be the assigned DRG fee schedule amount plus 53.2% of the charges that exceed that DRG amount. The pass-through revenue code charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster. Implants shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges.²⁷

5. 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 53.2% of actual charge in addition to the amount listed in this schedule for the assigned surgical code.²⁸ 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 fee schedule or the Professional Services fee schedule.

6. Special Guidelines for Trauma Inpatient Care

Section 8.2(a) of the Workers' Compensation Act specifically requires the Commission to promulgate a fee schedule for "trauma." For 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 FL14²⁹ are subject to the Trauma Inpatient Fee Schedule (not the standard fee schedule).³⁰

All trauma admissions are subject to the provisions of the Standard Inpatient fee schedule.

²⁶ 50 Ill. Adm. Code 7110.90(h)(6)(G)(ii). The other outlier rule promulgated by the Commission relates to Hospital Outpatient Surgical Charges. See 50 Ill. Adm. Code 7110.90(h)(7)(F)(iv).

²⁷ Please note that prior to September 1, 2011, cost outliers are defined as extraordinary treatment in which the bill for an inpatient stay is at least two times the fee schedule amount for the assigned DRG after pass-through revenue code charges have been deducted. For these cost outliers occurring before September 1, 2011, the maximum reimbursement amount will be the assigned DRG fee schedule amount plus 76% of the charges that exceed that DRG amount. The pass-through revenue code charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster. See 50 Ill. Adm. Code 7110.90(h)(6)(G)(i).

²⁸ 50 Ill. Adm. Code 7110.90(h)(6)(H).

²⁹ 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.

³⁰ 50 Ill. Adm. Code 7110.90(h)(6)(D).

Section 7. Hospital Outpatient Services

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-04.³¹

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 – 79999.³²

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 MS-DRG fee schedule, or hospital outpatient surgical facility fee schedule. This fee schedule applies 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 53.2% 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 80048-89356.³³ 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 MS-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 services in this area billed by a hospital and using the hospital's Tax ID number are to be paid at 53.2% 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 97001-97799.³⁴ 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

³¹ 50 Ill. Adm. Code 7110.90(h)(7)(B)

³² 50 Ill. Adm. Code 7110.90(h)(7)(C)(i).

³³ 50 Ill. Adm. Code 7110.90(h)(7)(D)(i).

³⁴ 50 Ill. Adm. Code 7110.90(h)(7)(E)(i).

the hospital inpatient MS-DRG fee schedule, or hospital outpatient surgical facility fee schedule. This fee schedule applies to all other hospital outpatient settings including emergency room visits.

D. Hospital Outpatient Surgical Facility (“HOSF”)

The HOSF fee schedule provides the maximum medical fee schedule amount for surgical services administered in a hospital outpatient setting for codes 10021 - 69990.³⁵

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 as explained in Section 6(B)(3) of these Instructions and Guidelines. 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 is subject to Sections 8(B) and 8(F) of the Instructions and Guidelines. However, only the provisions that apply to multiple procedures and bilateral surgeries in 8(B) and applicable modifiers in 8(F) shall be used.

E. Codes not found in the HOSF schedule

The Commission used commonly referenced HOSF procedure codes (not reimbursement levels) to develop this HOSF fee schedule. This schedule 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. The procedure is commonly performed as inpatient.

For procedures that are commonly performed as inpatient, the Commission recommends that payers and providers use the POC53.2 default for these facility bills.

F. 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 this 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 53.2% of the charged amount.

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 53.2% of the

³⁵ 50 Ill. Adm. Code 7110.90(h)(7)(F)(i).

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

G. Cost Outliers

There is also a cost outlier provision for the HOSF fee schedule. On and after September 1, 2011, cost outliers are defined as extraordinary treatment in which the bill for an outpatient surgery is at least 2.857 times the fee schedule amount for the assigned code(s) after pass-through revenue code charges have been deducted), the maximum reimbursement amount will be the assigned code(s) fee schedule amount plus 53.2% of the charges that exceed that code(s) amount.³⁶ The pass-through revenue code charges are still reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster. Implants shall be reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges.³⁷

Section 8. Professional Services

The Professional Services fee schedule is based on the American Medical Association Current Procedural Terminology (CPT) code set.³⁸

A. Evaluation and Management

The fee schedule adopts the guides and descriptions in the CPT in establishing the correct classification of evaluation and management services (codes 99201-99499).³⁹

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 a radiology procedure, or other professional services related to that procedure, as designated by the -26 modifier, the

³⁶ 50 Ill. Adm. Code 7110.90(h)(7)(F)(iv).

³⁷ Please note that prior to September 1, 2011, cost outliers, are defined as extraordinary treatment in which the bill for an outpatient surgery is at least two times the fee schedule amount for the assigned code after pass-through revenue code charges have been deducted), the maximum reimbursement amount will be the assigned code(s) fee schedule amount plus 76% of the charges that exceed that code(s) amount. The pass-through revenue code charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster. See 50 Ill. Adm. Code 7110.90(h)(7)(F)(iv).

³⁸ 50 Ill. Adm. Code 7110.90(h)(8)(A).

³⁹ 50 Ill. Adm. Code 7110.90(h)(8)(A).

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 POC53.2 in the “TOTAL” column, the amount paid will be 53.2% of the total charge. The professional and technical components will be paid at 53.2% of the charged amount. (e.g., for modifier 26 - professional component, pay 53.2% of charged amount; for modifier TC - technical component, pay 53.2% 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 in Section 8(F) of these Instructions and Guidelines 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 POC53.2 in the “TOTAL” column, the amount paid will be 53.2% of the total charge. The professional and technical components will be paid at 53.2% of the charged amount. (e.g., for modifier 26 - professional component, pay 53.2% of charged amount; for modifier TC - technical component, pay 53.2% 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 POC53.2 in the “TOTAL” column, the amount paid will be 53.2% of the total charge. The professional and technical components will be paid at 53.2% of the charged amount, (e.g., for modifier 26 - professional component, pay 53.2% of charged amount; for modifier TC - technical component, pay 53.2% 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
21	Due to copyright restrictions, the actual modifier descriptions are not listed. Please refer to the applicable version of <i>Current Procedural Terminology (CPT®)</i>, American Medical Association. Please refer to CPT.	125% 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 the 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% 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 is 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 priced on a “by-report”

	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.	basis. This payment policy should also apply to multiple endoscopic procedures.
52	Please refer to CPT.	Lesser of charge or 53.2% of fee schedule amount.
53	Please refer to CPT.	Lesser of charge or 53.2% 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 53.2% of fee schedule amount.
74	Please refer to CPT.	Lesser of charge or 53.2% 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: The lesser of 20% of the fee schedule amount or 20% of the primary surgeon’s fee. For 81: The lesser of 15% of the fee schedule amount or 15% of the primary surgeon’s fee. For 82: The lesser of 20% of the fee schedule amount or 20% of the primary surgeon’s fee.
90	Please refer to CPT.	Lesser of charge or fee schedule amount - and provision of documentation.
91	Please refer to CPT.	Lesser of charge or fee schedule amount.

G. Miscellaneous Services Codes (99024-99091)

Miscellaneous Services codes (99024-99091) are not included in the fee schedule. These codes should be paid at the usual and customary rate.

H. Section 12 Medical Examinations

Any code used to report a Section 12 exam (also referred to as an independent medical exam) is not included in the fee schedule, and is to be paid at an amount agreed to between the provider and requester of the Section 12 exam.

Section 9. Allied Health Care Professionals

Allied health care professionals, such as certified registered nurse anesthetists (CRNAs), physician assistants (PAs) and nurse practitioners (NPs), are to be reimbursed at the same rate as all other health care professionals when performing, coding and billing for the same services.⁴⁰

Section 10. Correct Coding

The fee schedule requires that services be reported with the HCPCS/CPT codes that most comprehensively describe the services performed.⁴¹ 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. The applicable version of the NCCI edits shall be determined by the date of service.

Section 11. Independent Diagnostic Testing Facilities

All fees from independently operated diagnostic testing facilities are subject to the Professional Services and HCPCS fee schedules where applicable.⁴² An independent diagnostic testing facility is defined in the Commission's rules as an entity independent of a hospital or physician's office, whether a fixed location, a mobile entity, or an individual nonphysician practitioner, in which diagnostic tests are performed by licensed or certified nonphysician personnel under appropriate physician supervision.

Section 12. Out-of-State Treatment

Prior to June 28, 2011, if the procedure, treatment or service is rendered outside of Illinois, the amount of reimbursement shall be the greater of 76% of actual charge 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.⁴³ Charges for a procedure, treatment or service outside the State shall be subject to the instructions, guidelines, and payment guides and policies in the applicable fee schedule.

On and after June 28, 2011, providers of out-of-state procedures, treatments, services, products, or supplies shall be reimbursed at the lesser of that state's fee schedule amount or the fee schedule amount for the region in which the employee resides. If no fee schedule exists in that state, the provider shall be reimbursed at the lesser of the actual charge or the fee schedule amount for the region in which the employee resides. If the employee does not reside in this State, providers of out-of-state treatments, services, products, or supplies shall be reimbursed at the lesser of the actual charge or the fee schedule amount for the location of the hearing site.

Facility fees will be paid as explained in Section 6(B)(3) for prosthetics/orthotics, pacemaker, lens implants, implants, ambulance, investigational devices and drugs requiring detailed coding.⁴⁴

⁴⁰ 50 Ill. Adm. Code 7110.90(j).

⁴¹ 50 Ill. Adm. Code 7110.90(i).

⁴² 50 Ill. Adm. Code 7110.90(k).

⁴³ 50 Ill. Adm. Code 7110.90(g).

⁴⁴ For additional information on facility fees, please see Section 1, 6, and 7 of these Instructions and Guidelines.

All charges for out-of-state treatments are subject to the provisions of the applicable fee schedule.

Section 13. Rehabilitation Hospital Inpatient Services

The Rehabilitation Hospital Inpatient fee schedule applies to service provided at inpatient rehabilitation hospitals that are freestanding.⁴⁵ The reimbursement for these services is a per diem amount.⁴⁶ This per diem is based on an assigned primary diagnosis code and shall reimburse the rehabilitation hospital for all services provided in the course of a day. There are currently three freestanding rehabilitation hospitals in Illinois:

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.⁴⁷ 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. They are considered bundled into the global amount.

The hospital inpatient fee schedules were created with data supplied by the Illinois Department of Public Health. 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 rehabilitation hospitals is providing services. In this example, the provider is Marianjoy Rehabilitation Hospital.
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 1/1/12 through 1/13/12 (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).

Brain Injury	\$1,546.05
--------------	------------

4. The final calculation is 13 days X \$1,546.05 = \$20,098.65
5. If the charged amount is less than \$20,098.65, then the lesser amount is to be paid. If the charged amount is greater than \$20,098.65, then \$20,098.65 would be paid.

⁴⁵ 50 Ill. Adm. Code 7110.90(h)(9)(A).

⁴⁶ 50 Ill. Adm. Code 7110.90(h)(9)(B).

⁴⁷ Please note that for the Rehabilitation Institute of Chicago, there are specific reimbursements for the ICD-9 codes for Brain Injury, Major Multiple Trauma, and Spinal Cord Injury effective March 27, 2012.

Section 14. Prescriptions

Prescriptions filled and dispensed outside of a licensed pharmacy are to be reimbursed at the Average Wholesale Price plus a dispensing fee of \$4.18. Average Wholesale Price or its equivalent as registered by the National Drug Code shall be set forth for that drug on that date as published in Medispan.⁴⁸ Effective November 20, 2012, if the prescription is repackaged, then the Average Wholesale Price used to determine the maximum reimbursement shall be the Average Wholesale Price for the underlying drug product, as identified by its National Drug Code from the original labeler.⁴⁹

Section 15. Billing Examples

Because coding can be complex, the Commission cannot provide an example for each and every potential coding combination. The Commission 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.

Please note that 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– Region 1

The below UB-04 bill is an example of an outpatient surgical facility bill submitted by a hospital in Region 1. 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		011212	003	\$61.80
258	IV Solution		011212	001	\$78.25
270	Med/Surg Supplies and De		011212	006	\$142.00
272	Sterile Supply		011212	006	\$525.00
300	Laboratory	81025	011212	001	\$116.00
300	Laboratory	36415	011212	001	\$14.00
360	Operating Room Services	64721RT	011212	001	\$2,627.00
370	Anesthesia		011212	002	\$2,446.00
710	Recovery Room		011212	002	\$247.00
	Total Charges				\$6,259.05

The relevant amount as contained in the HOSF fee schedule:

		Region 1
64721	Carpal Tunnel Surgery	\$3,962.79

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 Region 1 would be \$3,962.79 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: **\$3,962.79**

⁴⁸ 50 Ill. Adm. Code 7110.90(10)(A), (B), and (C).

⁴⁹ 50 Ill. Adm. Code 7110.90(D).

Example #2: HOSFFS Single Procedure with Revenue Code Carve-outs – Region 3

This UB-04 bill is an example of an outpatient surgical facility bill submitted by a Region 3 hospital. The key HCPCS code related to revenue code 360 is 29807, and the total charges for the operative session are \$15,842.10.

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		021012	012	\$352.10
258	IV Solution		021012	014	\$1,368.50
270	Med/Surg Supplies and De		021012	023	\$1,238.00
272	Sterile Supply		021012	005	\$354.00
360	Operating Room Services	29807RT	021012	001	\$6,207.00
370	Anesthesia		021012	006	\$4,748.00
636	Drugs Req Detailed Coding	J2405	021012	004	\$68.35
636	Drugs Req Detailed Coding	J3010	021012	001	\$17.50
637	Self Administratable Drugs		021012	001	\$3.65
710	Recovery Room		021012	006	\$1,485.00
	Total Charges				\$15,842.10

The relevant amount as contained in the HOSF fee schedule:

		Region 3
29807	Repair of SLAP Lesion	\$7,684.82

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 Region 3, would be \$7,684.82.

A close examination of the above listed revenue codes reveals two carve-outs, revenue code 636. These carve-outs are paid at 65% of the charged amount (while implants are to be paid at 25% over the net invoice price less rebates, plus actual and reasonable shipping charges the remaining carveouts are still paid at 65% of charges under the new legislation). This adjusted carve-out amount will be reintroduced to the maximum fee schedule amount once the remaining charges are analyzed).

Billed	\$15,842.10
Minus carve-outs	- \$85.85
Amount to be applied to fee schedule	\$15,756.25
Fee schedule amount	\$7,684.82
Plus carve-outs @ 65%	+ \$55.80
Paid	\$7,740.62

Example #3: HOSFFS Multiple Surgical Procedure with Revenue Code Carve-outs and Professional Fee Pass-Throughs – Region 1

This UB-04 bill is an example of an outpatient surgical facility bill submitted by a hospital in Region 1 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	020712	6	\$248.00
312	Pathol/Histol	88311	020712	42	\$82.00

360	OR Services	11044	020712	1	\$1,948.00
360	OR Services	14040	020712	1	\$1,948.00
360	OR Services	14040	020712	1	\$1,948.00
360	OR Services	15240	020712	1	\$1,948.00
370	Anesthesia		020712	1	\$259.00
636	Drug/Detail Code	J7030	020712	1	\$100.00
636	Drug/Detail Code	J7120	020712	1	\$100.00
636	Drug/Detail Code	J0690	020712	2	\$87.04
636	Drug/Detail Code	J1885	020712	2	\$75.00
636	Drug/Detail Code	J2250	020712	2	\$75.00
636	Drug/Detail Code	J3010	020712	3	\$75.00
710	Recovery Room		020712	3	\$229.00
730	EKG/ECG	93005	020712	1	\$145.00
964	Pro Fees Anesthesia CRNA		020712	115	\$2,415.00
985	Prof Fees EKG	93010	020712	1	\$25.00
	Total Charges				\$14,757.81

The relevant amounts as contained in the HOSF fee schedule:

		Region 1
11044	Debridement, Skin, Partial Thickness	\$1,528.12
14040	Adj. Tissue Transfer	\$3,115.77
15240	Full Thickness Graft	\$3,115.77

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 \$3,115.77 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 **\$6,995.61** (\$3,115.77 [for HCPCS 15240 @100%] + \$1,557.89 [for HCPCS 14040 @50%] + \$1,557.89 [for HCPCS 14040@50%] + \$764.06 [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 53.2% 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 \$6,995.61 + carve-out reimbursement of \$332.83 (paid at 65% of the charged amount) + the professional services at \$1,298.08, (53.2% of the charged amount) for a final payable amount of \$8,626.52.

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	\$6,995.61
Professional Services @ 53.2%	\$1,298.08
Plus carve-out @ 65%	+ \$332.83
Paid	\$8,626.52

**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 53.2% - Region 14**

This UB-04 bill illustrates several fee schedule applications:

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges/FS Amount
250	Pharmacy		022612	7	\$950.00
250	Pharmacy		022612	10	\$305.56
270	Med Sur-Supplies		022612	27	\$1,170.00
300	Laboratory	80048	022612	1	\$105.00/FS \$85.31
300	Laboratory	82962	022612	2	\$84.00/FS \$35.32
300	Laboratory	85025	022612	1	\$82.00/FS \$54.90
300	Laboratory	82962	022612	1	\$42.00/FS \$17.66
312	Pathol/Histol	88304	022612	1	\$248.00/FS \$84.66
320	DX X-Ray	73090LT	022612	1	\$292.00/FS \$152.72
360	OR Services	24341LT	022612	1	\$1,459.00
360	OR Services	24341LT	022612	1	\$1,459.00
360	OR Services	20103LT	022612	1	\$1,459.00
370	Anesthesia		022612	1	\$259.00
450	Emerg Room	9928525	022612	1	\$676.00
450	Emerg Room	90765	022612	1	\$268.00
450	Emerg Room	90775	022612	1	\$165.00
710	Recovery Room		022612	5	\$501.00
762	Observation Rm		022612	15	\$705.00
762	Observation Rm		022612	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 “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 53.2% 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 (\$10,898.39 X 53.2%)	\$5,797.90
Lab/Path/Rad fees (per scheduled listings)	+ \$430.57
Paid	\$6,228.47

Example #5: HOSFFS One or More Procedures Lacking Fee Schedule Amount – Entire Bill Minus Carve-outs Defaults to 53.2% 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		011712	14	\$585.00
250	Pharmacy		011712	3	\$176.45
258	IV Solution		011712	6	\$560.50
270	Med/Surg Supplies and De		011712	17	\$1,014.00
272	Sterile Supply		011712	12	\$1,137.00
360	Operating Room Services	29826RT	011712	1	\$5,329.00
360	Operating Room Services	2981959RT	011712	1	\$0.00
360	Operating Room Services	2347259RT	011712	1	\$0.00
370	Anesthesia		011712	5	\$4,173.00
636	Drugs Req Detailed Codin	J2405	011712	4	\$68.35
636	Drugs Req Detailed Codin	J3010	011712	15	\$102.05
637	Self Administrable Drugs		011712	6	\$404.40
637	Self Administrable Drugs		011712	2	\$1.00
710	Recovery Room		011712	3	\$1,270.00
762	Observation Room		011712	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 POC53.2.

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 53.2%	\$8,250.60
Plus carve-out paid @ 65%	+ \$110.76
Paid	\$8,361.36

Example #6: HOSFFS Multiple Bilateral Procedures – Entire Bill Minus Carve-outs – Region 3

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		012212	6	\$172.10
258	IV Solution		012212	1	\$90.75
270	Med/Surg Supplies and De		012212	3	\$593.00
272	Sterile Supply		012212	3	\$584.00

360	Operating Room Services	2739350	012212	1	\$30,727.00
360	Operating Room Services	2769150	012212	1	\$0.00
360	Operating Room Services	2769250	012212	1	\$0.00
370	Anesthesia		012212	3	\$3,237.00
636	Drugs Req Detailed Codin	J2405	012212	4	\$21.05
636	Drugs Req Detailed Codin	J3010	012212	1	\$18.90
637	Self Administrable Drugs		012212	1	\$3.70
710	Recovery Room		012212	7	\$1,820.00
	Total Charges				\$37,267.50

The relevant amounts as contained in the HOSF fee schedule:

		Region 3
27393	Lengthening of hamstring tendon; single tendon	\$4,224.07
27691	Transfer or transplant of single tendon, deep	\$6,939.45
27692	Transfer or transplant of single tendon, each additional	\$6,939.45

Code 27691.50 is the highest weighted procedure and is paid at 150% of the fee schedule amount or \$10,409.18 (\$6,939.45 x 150%)

Code 27692.50 represents each additional tendon (bilaterally) and would result in a fee schedule amount of \$10,409.18 (\$6,939.45 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 \$4,224.07, which must be multiplied by 150% for bilateral, then multiplied by 50% for multiple or \$3,168.05 (\$4,224.07 x 150% x 50%).

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 (\$6,939.45 x 150%)	\$10,409.18
Fee Schedule Amount for 27692.50 (\$6,939.45 x 150%)	\$10,409.18
Fee Schedule Amount for 27393.50 (\$4,224.07 x 150% x 50%)	\$3,168.05
Total fee schedule amount allowed	\$23,986.41
Fee Schedule Amount	\$23,986.41
Plus carve-out paid @ 65%	+ \$25.97
	\$24,012.38

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 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 – Region 1

From 1500 form:

Dates of Service		Procedure Code	Modifier	Charges
From	To			
010612	010612	26320	51	\$3,000.00
010612	010612	25000	51	\$1,200.00
010612	010612	25447	51	\$3,000.00
010612	010612	25310	LT	\$3,000.00
Total				\$10,200.00

From fee schedule:

Code	Region 1
26320	\$2,130.38
25000	\$1,267.09
25447	\$3,406.84
25310	\$3,039.39

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 \$2,130.38 x 50%, or \$1,065.19.

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 charged amount is less than the fee schedule 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 (\$2,130.38 x 50%)	\$1,065.19
Fee Schedule Amount for 25000.51 (\$1,200.00 x 50%)	+ \$600.00
Paid	\$6,165.19

Example #8: Implants – Region 1

The below UB-04 bill is an example of a hospital inpatient bill submitted by a hospital in Region 1. The DRG assigned for this bill was MS-DRG 482 - hip and femur procedure except major joint without CC or MCC. The total charges for this inpatient stay are \$66,663.60.

From UB-04 form:

Rev. Cd.	Description	HCP/Rate	Serv. Date	Serv. Units	Total Charges
120	ROOM-BOARD/SEMI	516.60	020312	4	2066.40
230	NURSING INCREM		020312	4	1663.20
250	PHARMACY		020312	140	2759.68
258	IV SOLUTIONS		020312	4	299.14
260	IV THERAPY		020312	1	99.40
271	NON-STER SUPPLY		020312	4	1326.60
272	STERILE SUPPLY		020312	10	6695.40
278	SUPPLY/IMPLANTS		020312	35	26421.18
300	LABORATORY		020312	6	152.10
301	LAB/CHEMISTRY		020312	2	157.00
302	LAB/IMMUNOLOGY		020312	11	722.70
305	LAB/HEMATOLOGY		020312	8	635.90
307	LAB/UROLOGY		020312	1	34.10
320	DX X-RAY		020312	4	1784.60
360	OR SERVICES		020312	16	12189.50
370	ANESTHESIA		020312	17	4297.30
390	BLOOD/STOR-PROC		020312	6	1484.40
420	PHYSICAL THERAPY		020312	11	696.50
424	PHYS THERAPY/EVAL		020312	1	86.60
430	OCCUPATIONAL THERP		020312	6	509.70
434	OCCUP THERP/EVAL		020312	1	86.60
450	EMERGENCY ROOM		020312	7	1686.40
710	RECOVERY ROOM		020312	5	672.50
730	EKG-ECG		020312	1	136.70
					66663.60

The relevant amount as contained in the standard inpatient fee schedule:

		Region 1
DRG 482	hip and femur procedure ex major joint w/o CC or MCC	\$20,346.25

Implant under new reimbursement method effective 9/1/11 (for dates of service 9/1/11 and after):

All implants are to be paid at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges. (See invoice below)

Implant manufacturer's invoice	\$12,000.00
Rebate	NONE
Net invoice price minus rebate	\$12,000.00
Shipping	\$35.00

Paid: \$12,000.00 X 1.25 = \$15,000.00 + \$35 = \$15,035.00

Complete fee schedule calculation for entire bill:

Billed	\$66,663.60
Minus Implant	- \$26,421.18
Amount Applied to Fee Schedule	\$40,242.42
Fee Schedule Amount for Implant	\$15,035.00
Fee Schedule Amount for DRG 482	\$20,346.25
Total Fee Schedule Amount Paid	\$35,381.25

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 A: 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 B: 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 C: 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 D: 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 E: 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 F: 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 G: 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 H: 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 I: 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 J: 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 K: 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.