Section 7110.90 Illinois Workers' Compensation Commission Medical Fee Schedule

a) In accordance with Sections 8(a), 8.2 and 16 of the Workers' Compensation Act [820 ILCS 305/8(a), 8.2 and 16] (the Act), the Illinois Workers' Compensation Commission Medical Fee Schedule, including payment rates, instructions, guidelines, and payment guides and policies regarding application of the schedule, is adopted as a fee schedule to be used in setting the maximum allowable payment for a medical procedure, treatment or service covered under the Act. The fee schedule is published on the Internet at no charge to the user via a link from the Commission's website at www.iwcc.il.gov. The fee schedule may be examined at any of the offices of the Illinois Workers' Compensation Commission.

b) The payment rates for procedures, services or treatments in the fee schedule were established in accordance with Section 8.2 of the Act by determining 90% of the 80th percentile of charges utilizing health care provider and hospital charges from August 1, 2002 through August 1, 2004. The charges were adjusted by the Consumer Price Index-U for the period August 1, 2004 through September 30, 2005. The payment rates in the fee schedule are designated by geozip (geographic area in which all zip codes have the same first 3 digits).

c) The fee schedule applies to any medical procedure, treatment or service covered by the Act and rendered on or after February 1, 2006, regardless of the date of injury.

d) 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.

e) Whenever the fee schedule does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be at 76% of actual charge, except where this Section provides that revenue codes (codes that identify a specific accommodation or ancillary charge on a UB-04/CMS 1450 uniform billing form used by hospitals) are to be deducted from the charge and reimbursed at 65% of charge billed at 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.

f) Reimbursement under the fee schedule for a procedure, treatment or service, as designated by the geozip where the treatment occurred, shall be based on the place of service.

g) Out-of-State Treatment

1) If the procedure, treatment or service is rendered outside the State 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. Charges for a procedure, treatment or service outside the State shall be subject to the instructions, guidelines, and payment guides and policies in this fee schedule.

2) Where the charges are for facility fees (ambulatory surgical treatment center, hospital inpatient (standard and trauma), and hospital outpatient services), the following revenue codes are pass-through charges to be deducted from the charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster.

h) The fee schedule includes the following service categories:

1) Ambulatory Surgical Treatment Center (ASTC)

A) This schedule applies to licensed ambulatory surgical treatment centers as defined by the Illinois Department of Public Health (77 Ill. Adm. Code 205.110).

B) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515 North State Street, Chicago, Illinois 60610, 2006, no later dates or editions.

C) This schedule provides the maximum fee schedule amount for surgical services administered in an ASTC setting for codes 10021 through 69990. The schedule is a partial global reimbursement schedule in that all charges rendered during the operative session are subject to a single fee schedule amount, except as provided in subsections (h)(1)(D) and (h)(1)(F).

D) The following revenue codes are pass-through charges to be deducted from the charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624

(investigational devices); and 0636 (drugs requiring detailed coding). Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster.

E) All professional services performed in an ASTC setting are subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8).

F) This schedule does not apply to the professional or technical components of radiology and pathology and laboratory services performed in an ASTC setting. Charges for these services must be submitted on a separate claim form and shall be subject to the professional services schedule in subsection (h)(8).

G) Surgery services under this schedule shall be reimbursed in accordance with the Multiple Procedure and Bilateral Surgery provisions of the Payment Guide in Section 8B of the instructions and guidelines in the fee schedule and the applicable modifiers in Section 8F of the instructions and guidelines in the fee schedule.

2) Anesthesia

A) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515 North State Street, Chicago, Illinois 60610, 2006, no later dates or editions, and the Relative Value Guide, American Society of Anesthesiologists, 520 North Northwest Highway, Park Ridge, Illinois 60068-2573, 2006, no later dates or editions.

B) This schedule was established utilizing health care provider charges from August 1, 2002 through August 1, 2004 from which a conversion factor was established. The maximum fee schedule reimbursement amount is determined by multiplying the conversion factor set forth in the schedule by the sum of all units according to guidelines set forth in the Relative Value Guide as follows:

i) Base Value + Time Units + Modifying Units = Total Units

Total Units x Conversion Factor = Total Fee

ii) Physical status modifying units may be added to the basic value and time units and, in addition, units may be added

for qualifying circumstances (extraordinary circumstances) in accordance with the Relative Value Guide.

C) 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 the Relative Value Guide.

D) 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).

3) Dental
All procedures, treatments and services are reimbursed at 76% of actual charge unless services are billed under the HCPCS Level II schedule in subsection (h)(5) or professional fee schedule in subsection (h)(8).

4) Emergency Room

A) This schedule applies to any department or facility of a hospital licensed by the Illinois Department of Public Health pursuant to the Hospital Licensing Act [210 ILCS 85] that:

i) operates as an emergency room or emergency department, whether situated on or off the main hospital campus; and

ii) is held out to the public as providing care for emergency medical conditions without requiring an appointment, or has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis during the previous calendar year.

B) All procedures, treatments and services subject to this schedule are reimbursed at 76% of actual charge.

C) Radiology, pathology and laboratory and physical medicine and rehabilitation services performed in an emergency room shall be reimbursed in accordance with the radiology schedule in

subsection (h)(7)(C), the pathology and laboratory schedule in subsection (h)(7)(D) and the physical medicine and rehabilitation schedule in subsection (h)(7)(E).

D) Emergency room facility charges, and professional services delivered in an emergency room facility billed by the facility using the facility's tax identification number, shall be subject to the emergency room facility schedule and are not subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8). Health care professionals who perform services in an emergency room facility and bill for services using their own tax identification number on a separate claim form shall be subject to the HCPCS Level II schedule in subsection (h)(5) or the professional services schedule in subsection (h)(8) and are not covered under the emergency room facility schedule.

5) HCPCS (Healthcare Common Procedure Coding System) Level II
The use of this schedule is in accordance with the HCPCS Level II, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, 2006, no later dates or editions. Level II of the HCPCS is a standardized coding system used to identify products and services not included in the Current Procedural Terminology codes.

6) Hospital Inpatient: Standard and Trauma

A) The use of these schedules is in accordance with the Diagnosis-Related Group (DRG) classification system established by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR 405 (2005), no later dates or editions. A DRG is a diagnosis-related group code that groups patients into homogeneous classifications that demonstrate similar length-of-stay patterns and use of hospital resources. The DRG determines the maximum fee schedule amount for an inpatient hospital stay, except as provided in subsections (h)(6)(F) and (h)(6)(G).

B) No later than June 30, 2009, the use of these schedules will be in accordance with the Medicare Severity Diagnosis Related Group (MS-DRG) classification system established by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR 411 (2007), no later dates or

editions. An MS-DRG is a diagnosis related group code that groups patients based on the severity of a patient's condition and resource consumption. The MS-DRG determines the maximum fee schedule amount for an inpatient hospital stay, except as provided in subsections (h)(6)(F) and (h)(6)(G).

C) Inpatient care shall be defined as when a patient is admitted to a hospital where services include, but are not limited to, bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

D) Inpatient hospital bills are subject to the hospital inpatient standard schedule. Inpatient hospital bills from trauma centers designated as Level I and Level II trauma centers by the Illinois Department of Public Health pursuant to 77 Ill. Adm. Code 515.2030 and 515.2040 and that contain an admission type of "5" on a UB-04/CMS 1450 FL 14 (uniform billing form used by hospitals; FL 14 is the form locator number that indicates where the codes are to be listed on the UB-04/CMS 1450 form) are subject to the hospital inpatient trauma schedule.

E) Hospital providers must identify the DRG code on each bill (UB-04/CMS 1450 claim form). The DRG assignment should be made in a manner consistent with the grouping practices used by the hospital when billing both government and private carriers.

F) The following revenue codes/pass-through charges are deducted from the DRG charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). If the maximum amount of payment for an inpatient hospital stay is 76% of actual charge, the DRG charge is determined after the pass-through charges are removed. Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster.

G) In the case of cost outliers (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 referred to in subsection (h)(6)(F) have been deducted), 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.

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

7) Hospital Outpatient

A) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515 North State Street, Chicago, Illinois 60610, 2006, no later dates or editions.

B) This schedule includes radiology, pathology and laboratory, and physical medicine and rehabilitation as well as 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.

C) Radiology

i) This schedule provides the maximum fee schedule amount for radiology services performed in a hospital outpatient setting for codes 70010 through 79999. The schedule applies to the technical component of radiology services that are billed in conjunction with revenue codes 320 through 359, 400 through 409 and 610 through 619.

ii) This schedule does not apply when the bill type requires the application of the hospital inpatient schedule in subsection

(h)(6) or the hospital outpatient surgical facility schedule in subsection (h)(7)(F).

iii) Professional radiology services billed by a hospital using the hospital's tax identification number are reimbursed at 76% of actual charge. Radiologists or radiology groups who perform services using their own tax identification number shall be subject to the HCPCS Level II in subsection (h)(5) or the professional services schedule in subsection (h)(8) even though the technical component is performed in a hospital setting.

D) Pathology and Laboratory

i) This schedule provides the maximum fee schedule amount for pathology and laboratory services performed in a hospital outpatient setting for codes 80048 through 89356. This schedule applies to the technical component of pathology and laboratory services that are billed in conjunction with revenue codes 300 through 319.

ii) This schedule does not apply when the bill type requires the application of the hospital inpatient schedule in subsection (h)(6) or the hospital outpatient surgical facility schedule in subsection (h)(7)(F).

iii) Professional pathology and laboratory services billed by a hospital using the hospital's tax identification number are reimbursed at 76% of actual charge. Pathologists who perform services using their own tax identification number shall be subject to the HCPCS Level II in subsection (h)(5) or the professional services schedule in subsection (h)(8) even though the technical component is performed in a hospital setting.

E) Physical Medicine and Rehabilitation

i) This schedule provides the maximum fee schedule amount for physical therapy services performed in a hospital outpatient setting for codes 97001 through 97799. This schedule applies to all physical and occupational therapy services that are billed in conjunction with revenue codes 420 through 439.

ii) This schedule does not apply when the bill type requires the application of the hospital inpatient schedule in subsection (h)(6) or the hospital outpatient surgical facility schedule in subsection (h)(7)(F).

iii) All physical medicine and rehabilitation services provided in a hospital outpatient setting are subject to this schedule.

F) Hospital Outpatient Surgical Facility (HOSF)

i) This schedule provides a global maximum fee schedule amount for surgical services performed in a hospital outpatient setting for codes 10021 through 69990. All services performed in an operative session shall be reimbursed at a single fee schedule amount, except as provided in subsection (h)(7)(F)(ii). The single fee schedule amount shall represent the maximum amount payable for the total charges on a claim form that represents the total charges derived from all line items/revenue codes contained in the form. Except for the carve-out revenue codes listed in subsection (h)(7)(F)(ii), this fee schedule shall not be applied on a line item basis.

ii) The following revenue codes are pass-through charges to be deducted from the charge and reimbursed at 65% of actual charge: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices); and 0636 (drugs requiring detailed coding). Charges billed under these revenue codes shall be billed at the provider's normal rates under its standard chargemaster.

iii) Surgery services under this schedule shall be reimbursed in accordance with the Multiple Procedure and Bilateral Surgery provisions of the Payment Guide in Section 8B of the instructions and guidelines in the fee schedule and the applicable modifiers in Section 8F of the instructions and guidelines in the fee schedule.

iv) In the case of cost outliers (extraordinary treatment in which the bill for hospital outpatient facility surgical charges is at least two times the fee schedule amount for

the assigned code after pass-through revenue code charges referred to in subsection (h)(7)(F)(ii) have been deducted) the maximum reimbursement amount will be the assigned code fee schedule amount plus 76% of the charges that exceed the code amount. The pass-through revenue charges are reimbursed at 65% of actual charge and shall be billed at the provider's normal rates under its standard chargemaster.

v) Surgical services performed in the emergency room (revenue codes 450 through 459) are not subject to this schedule and shall be subject to the emergency room facility schedule in subsection (h)(4).

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

8) Professional Services

A) The use of this schedule is in accordance with the Current Procedural Terminology, American Medical Association, 515 North State Street, Chicago, Illinois 60610, 2006, no later dates or editions.

B) Services in this schedule include evaluation and management, surgery, physician, medicine, radiology, pathology and laboratory, chiropractic, physical therapy, and any other services covered under the Current Procedural Terminology.

C) Reimbursement for services under this schedule shall be in accordance with the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

D) Surgery services under this schedule shall be reimbursed in accordance with the Payment Guide to Global Days, Multiple Procedures, Bilateral Surgeries, Assistant Surgeons, Co-Surgeons, and Team Surgery in Section 8B of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

E) Medicine services under this schedule shall be reimbursed in accordance with the professional, technical and total component categories outlined in Section 8E of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

F) Pathology and laboratory services under this schedule shall be reimbursed in accordance with the professional, technical and total component categories outlined in Section 8D of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

G) Radiology services under this schedule shall be reimbursed in accordance with the professional, technical and total component categories outlined in Section 8C of the instructions and guidelines in the fee schedule and the modifiers table in Section 8F of the instructions and guidelines in the fee schedule.

9) Rehabilitation Hospitals

A) This schedule applies to inpatient rehabilitation hospitals that are freestanding.

B) This schedule reimburses a rehabilitation hospital one per diem rate per day, on the basis of the assigned primary diagnosis code. The single per diem rate shall reimburse the rehabilitation hospital for all services provided in the course of a day.

C) The use of this schedule is in accordance with The International Classification of Diseases, Ninth Revision, Clinical Modification, (ICD-9-CM), Volume 2, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, 2007, no later dates or editions.

i) The fee schedule requires that services be reported with the HCPCS Level II or Current Procedural Terminology codes that most comprehensively describe the services performed. Proprietary bundling edits more restrictive than the National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, 2006, no later dates or editions, are prohibited. Bundling edits is the process of reporting codes so that they most comprehensively describe the services performed.

j) An allied health care professional, such as a certified registered nurse anesthetist (CRNA), physician assistant (PA) or nurse practitioner (NP), is to be reimbursed at the same rate as other health care professionals when the allied health care professional is performing, coding and billing for the same services as other health care professionals.

k) Charges of an independently operated diagnostic testing facility shall be subject to the professional services and HCPCS Level II fee schedules where applicable. An independent diagnostic testing facility is 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.

l) No later than September 30, 2006 and each year thereafter, the Commission shall make an automatic adjustment to the maximum payment for a procedure, treatment or service in effect in January of that year. The Commission shall increase or decrease the maximum payment by the percentage change of increase or decrease in the Consumer Price Index-U for the 12-month period ending August 31 of that year. The change shall be effective January l of the following year. *The Consumer Price Index-U means the index published by the Bureau of Labor Statistics of the U.S. Department of Labor that measures the average change in prices of all goods and services purchased by all urban consumers, U.S. city average, all items, 1982-84=100*. (Section 8.2 of the Act)