

- 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) All procedures, treatments and services subject to this schedule are reimbursed at 76% of actual charge, except as provided in subsection (h)(1)(C).
 - C) 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.
 - D) ASTC facility charges, and professional services performed in an ASTC billed by an ASTC using the ASTC's tax identification number, shall be subject to the ASTC 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 ASTC 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 ASTC 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) $\text{Base Value} + \text{Time Units} + \text{Modifying Units} = \text{Total Units}$
- $\text{Total Units} \times \text{Conversion Factor} = \text{Total Fee}$
- 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 Facility**
 - 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) 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 amount of payment for an inpatient hospital stay, except as provided in subsections (h)(6)(E) and (h)(6)(F).
 - B) 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.
 - C) 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-92/CMS 1450 FL 19 (uniform billing form used by hospitals; FL 19 is the form locator number that indicates where the codes are to be listed on the UB-92/CMS 1450 form) are subject to the hospital inpatient trauma schedule.
 - D) Hospital providers must identify the DRG code on each bill (UB-92/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.
 - E) 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.

- F) In the case of cost outliers (extraordinary treatment in which the bill for an inpatient stay is equal to or above two times the fee schedule amount for the assigned DRG after pass-through revenue code charges referred to in subsection (h)(6)(E) 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.

7) Hospital Outpatient

- A) All procedures, treatments and services subject to this schedule are reimbursed at 76% of actual charge, except as provided in subsection (h)(7)(B).
- B) When hospital outpatient services involve ambulatory surgical procedures, 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.
- C) Hospital outpatient facility charges, and professional services performed in a hospital outpatient facility billed by the facility using the facility's tax identification number, shall be subject to the hospital outpatient 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 a hospital outpatient 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 hospital outpatient schedule.

- 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.

- 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 1 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)

(Source: Added at 30 Ill. Reg.11743, effective June 22, 2006)