ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF EMERGENCY AMENDMENTS

1) Heading of the Part: Miscellaneous

2) Code Citation: 50 Ill. Adm. Code 7110.90

3)

Section Numbers:	Emergency Action:
7110.90	Amendment

4) Statutory Authority:
820 ILCS 305/8.2 and 5 ILCS 100/5-45

5) Effective Date of amendment:

6) If this emergency amendment is to expire before the end of the 150-day period, please specify the date on which it is to expire: None

7) Date Filed with the Index Department:

8) A copy of the emergency amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Reason for Emergency:

In 2005, the Illinois General Assembly passed PA 94-277 which included the requirement that the Illinois Workers' Compensation Commission ("Commission") promulgate a medical fee schedule for medical services provided to worker's compensation claimants. The intent of the medical fee schedule was to help stem the precipitous rise of medical costs associated with workers' compensation claims. The General Assembly considered the implementation of the medical fee schedule to be of sufficient immediate importance that it mandated the medical fee schedule be put into effect within 6 months of the effective date of the Act. Therefore the rules promulgating the medical fee schedule were implemented on an emergency basis.

The Commission has become aware of two situations that seriously interfere with proper administration of the medical fee schedule and seriously undermine the purpose of the legislative enactment; a precipitous and unjustifiable rise in the charges medical providers impose for implanted devices (which under the fee schedule are currently reimbursed at 65% of current charges), and the refusal of some insurance administrators to pay accredited (in contrast to licensed) ambulatory surgical care facilities for services provided to workers' compensation claimants.

The Illinois Workers' Compensation Commission has determined that these current anomalies constitute a threat to the public welfare. The apparent price gouging regarding

implanted devices substantially interferes with controlling the costs associated with the administration of workers' compensation claims and could likely result in a further erosion of the business climate in Illinois, and result in either the loss of additional jobs or the retardation of potential job growth in Illinois. Similarly, the unjustifiable denial of

payments to accredited ambulatory surgical care facilities has a significant negative impact on rising medical costs associated with workers' compensation claims because it incentivizes providers to render care in full service hospitals significantly increasing medical care costs, and often delaying treatment. In addition, the refusal to pay for service provided by accredited ambulatory surgical care facilities will result, directly in reduced public access to quality and cost-effective medical treatment in Illinois.

The Medical Fee Advisory Board, which is comprised of business, labor, and medical representatives, unanimously approved the proposed rule changes at its last meeting on May 13, 2010. The full Commission unanimously approved these rules and the determination that their implementation constituted an emergency on June 25, 2010

10) A Complete Description of the Subjects and Issues Involved:

AMBULATORY SURGICAL CARE:

Currently, Commission rules provide that Ambulatory Surgical Care Centers ("ASTCs") licensed by the Illinois Department of Public Health ("IDPH") are eligible for reimbursement for treatment provided to Workers' Compensation claimants. However, there are only 140 licensed ASTCs in Illinois and IDPH has not issued any additional licenses for new ASTCs for the last several years. All new such facilities have not been able to attain licensure, but many have become accredited by reputable accrediting agencies. These facilities are referred to as Ambulatory Surgical Care Facilities ("ASTFs"). Under the accrediting system, ASCFs have to show substantially the same level of medical treatment and care as those currently licensed by IDPH. The Commission has concluded that there is no material difference in the quality of care between licensed centers and accredited facilities, and the current rules give unwarranted preference to the licensed facilities over the accredited facilities.

Prior to the current rules implementing the medical fee schedule, workers' compensation insurer carriers paid ASTFs on the same basis as licensed ASTCs. In promulgating the rules implementing the medical fee schedule, the Commission neither intended to exclude medical treatment provided by accredited facilities nor to exclude them from eligibility for reimbursement. Nevertheless, because of the language in the current rules, reimbursement to accredited facilities has not been consistent. Some insurers and claims administrators have simply paid the accredited facilities, others have not paid them at all, and others have paid on an inconsistent basis.

This inconsistency results in obvious inequities. In addition, Ambulatory Surgical Care is a rapidly growing sector of the Illinois medical care industry. They provide quality health care at a relatively low cost. The current flawed reimbursement regimen incentivizes workers' compensation claimants to forego treatment at accredited facilities and seek treatment from more expensive providers such as full-service hospitals. This situation seriously undermines the intent of PA 94-277 is containing health care costs associated with the Workers' Compensation system.

IMPLANTS:

From the outset, the Commission was cognizant of the possible abuse in the pricing of medical implants submitted for reimbursement under the Workers' Compensation Act. Therefore, under the current medical fee schedule, the Commission set the reimbursement rate for implants at 65% of the actual charge. The default rate for medical services not specifically covered under the fee schedule is 76% of actual charge. Despite the lower reimbursement rates, the Commission has become aware of apparent abuse of pricing for implants, effectively undermining the cost-controlling efforts of the General Assembly and Commission.

Even with the 65% reimbursement rates, some providers have inflated their reported charges for implants so high that the final reimbursement is as much as 33% over the average cost from other providers. The Commission, upon recommendation of the Medical Fee Advisory Board, has concluded that providing reimbursement based on the actual manufacturer's invoice price is the most equitable and consistent method for setting reimbursement levels. States that have implemented cost-plus reimbursement rates for implants in workers' compensation cases ranged from 10% to 60% above costs, with the median reimbursement to be about 20% over costs.

The Commission, upon recommendation of the Medical fee Advisory Board, concluded that a 25% cost-plus reimbursement rate is reasonable. It provides a significant profit margin while providing cost-containment and certainty for payers. In addition, in order to arrive at an accurate provider's cost, the Commission decided that the invoice price would be net of any rebates but also that actual and customary shipping costs for the implants additionally would be reimbursed.

11) Are there any proposed amendments to this Part Pending? No

12) Statement of Statewide Policy Objectives: Containment of medical costs and access to medical care.

13) Information and questions regarding this amendment shall be directed to:

ILLINOIS WORKERS' COMPENSATION COMMISSION

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Darrell Widen
Assistant General Counsel
Illinois Workers' Compensation Commission
8-281 JRTC
100 W. Randolph St.
Chicago IL 60601
Darrell.Widen@Illinois.gov
312-814-8770.

The full Text of the Emergency Amendment begins on the next page:

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TITLE 50: INSURANCE
CHAPTER II: ILLINOIS WORKERS' COMPENSATION COMMISSION

PART 7110
MISCELLANEOUS

Section

EMERGENCY

AUTHORITY: Implementing and authorized by the Workers' Compensation Act [820 ILCS 305].

SOURCE: Filed and effective March 1, 1977; amended at 5 Ill. Reg. 5533, effective May 12, 1981; amended at 6 Ill. Reg. 8040, effective July 1, 1982; codified at 7 Ill. Reg. 2352; emergency amendment at 14 Ill. Reg. 4929, effective March 9, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13161, effective August 1, 1990; emergency amendment at 30 Ill. Reg. 1912, effective February 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 11743, effective June 22, 2006; amended at 33 Ill. Reg. 2850, effective February 1, 2009; emergency amendment at 34 Ill. Reg. ___, effective ___, for a maximum of 150 days.

Section 7110.90 Illinois Workers' Compensation Commission Medical Fee Schedule
EMERGENCY

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 the following revenue codes/category descriptions (codes/categories that identify a specific accommodation or ancillary charge on a UB-04/CMS1450 or CMS1500 uniform billing form used ~~by hospitals~~for hospital or facility-based billing) are to be ~~deducted~~ carved out from the total charge and reimbursed separately (pass through charges). The carve-out revenue codes (categories) are: 0274 (prosthetics/orthotics); 0275 (pacemaker); 0276 (lens implant); 0278 (implants); 0540 and 0545 (ambulance); 0624 (investigational devices) and 0636 (drugs requiring detailed coding). 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. Non-implantable devices or supplies within the aforementioned carve-out revenue codes/categories shall be reimbursed at 65% of actual 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. All implant charges are to be paid 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 services associated with the implant, submitted by a provider on a separate claim form, submitted by a distributor, or is submitted by the manufacturer of the implant.

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, ambulatory surgical treatment facility, hospital inpatient (standard and trauma), and hospital outpatient services), ~~the following revenue codes are passthrough 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)~~ revenue code/category items as defined in subsection (e) are carved out and associated pass through charges to be deducted from the total charge and reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual and reasonable and customary shipping charges for implants. Charges for non-implantable items billed under the~~se~~ revenue codes identified in subsection (e) above shall be ~~billed~~ reimbursed at 65% of the provider's normal rates under its standard chargemaster as defined in subsection (e).

h) The fee schedule includes the following service categories:

1) Ambulatory Surgical Treatment Center (ASTC)

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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) or ambulatory surgical treatment facilities accredited by one of the following organizations; American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF), Joint Commission on Healthcare Organizations (JCAHO), or Accreditation Association for Ambulatory Health Care (AAAHC).

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 or accredited ambulatory surgical treatment facility 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) Revenue code items/categories as defined in subsection (e) are carved out and associated pass through charges to be deducted from the total charge and reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges for implants. 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 for non-implantable items billed under these revenue codes identified in subsection (e) above shall be billed reimbursed at 65% of the provider's normal rates under its standard chargemaster as defined in subsection (e).

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 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) Revenue code items/categories as defined in subsection (e) are carved out and associated pass through charges to be deducted from the total charge and reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges for implants. ~~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 passthrough charges are removed.~~ Charges for non-implantable items billed under the~~se~~ revenue codes identified in subsection (e) above shall be ~~billed~~ reimbursed at 65% of the provider's normal rates under its standard chargemaster as defined in subsection (e).

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. Revenue code items/categories as defined in subsection (e) are carved out and associated pass through charges to be deducted from the total charge and reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges for implants. Charges for non-implantable items billed under the revenue codes identified in subsection (e) above ~~The pass-through revenue code charges are reimbursed at 65% of actual charge and~~ shall be ~~billed~~ reimbursed at 65% of the provider's normal rates under its standard chargemaster as defined in subsection (e).

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) Revenue code items/categories as defined in subsection (e) are carved out and associated pass through charges to be deducted from the total charge and reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges for implants. ~~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 for non-implantable items billed under the~~se~~ revenue codes identified in subsection (e) above shall be ~~billed~~ reimbursed at 65% of the provider's normal rates under its standard chargemaster as defined in subsection (e).

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. Revenue code items/categories as defined in subsection (e) and referred to in subsection (h)(7)(F)(ii) are carved out and associated pass through charges to be deducted from the total charge and reimbursed at 25% above the net manufacturer's invoice price less rebates, plus actual reasonable and customary shipping charges for implants. ~~The pass-through revenue charges are~~ Charges for non-implantable items billed under the revenue codes identified in subsection (e) above shall be reimbursed at 65% of ~~actual charge and shall be billed at~~ the provider's normal rates under its standard chargemaster as defined in subsection (e).

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)

(Source: Amended at 33 Ill. Reg. 2850, effective February 1, 2009)

(Source: Emergency amendment at 34 Ill. Reg. _____, effective _____, for a maximum of 150 days)