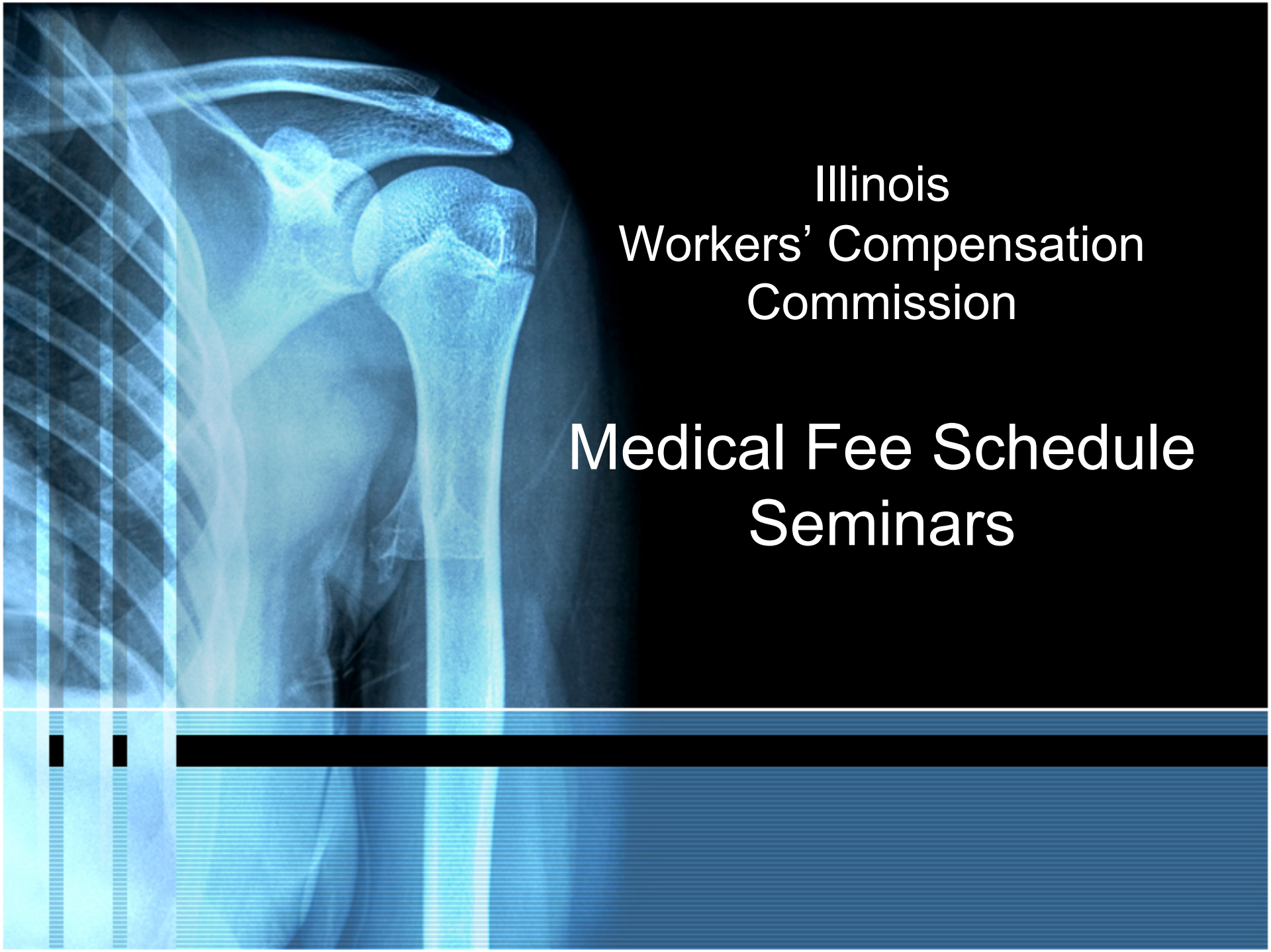
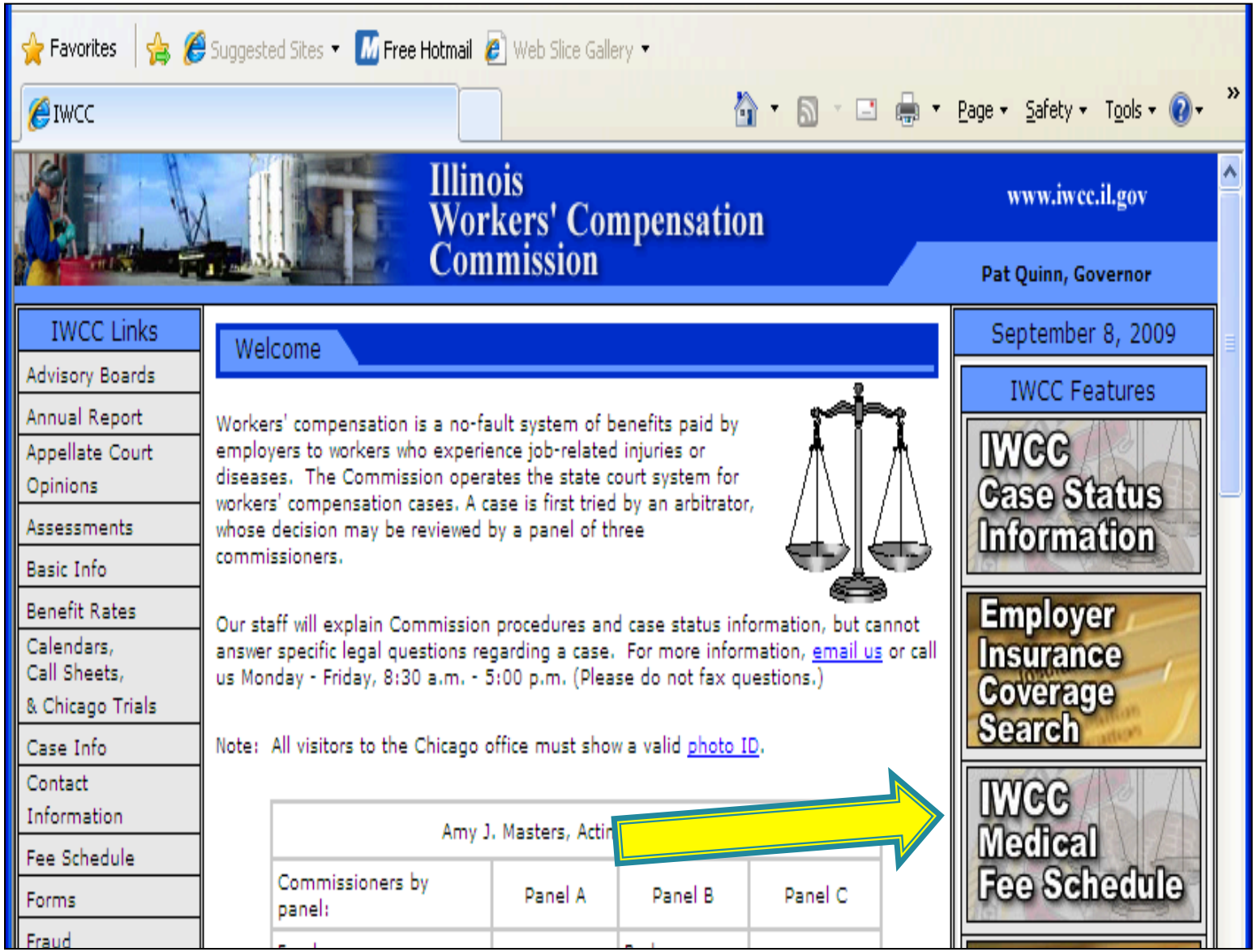

Illinois
Workers' Compensation
Commission
Medical Fee Schedule
Seminars

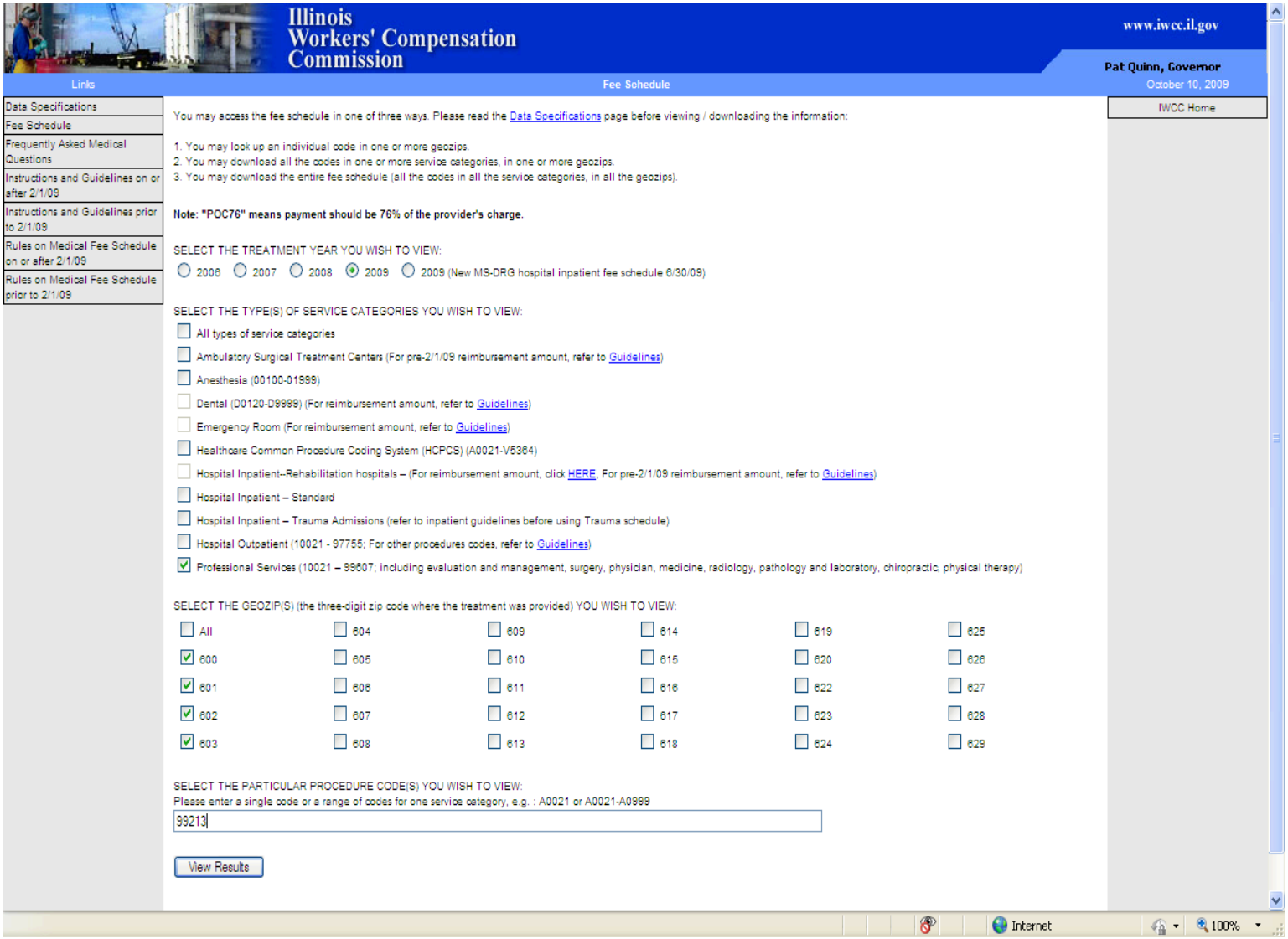
Greetings and Introductions

- Amy Masters, Acting Chairman, IWCC
  amy.masters@illinois.gov
- Susan Piha, Manager of Research & Education, IWCC
  susan.piha@illinois.gov
- Glen Boyle, Project Manager, True Course MDCS
  glen.boyle@truecoursemdcs.com
- Guest Coder – To be announced @ each seminar.
- IWCC website: http://www.iwcc.il.gov
- Fee schedule: http://iwcc.ingenixonline.com/IWCC.asp
- FAMQ: http://www.iwcc.il.gov/faqmed.htm

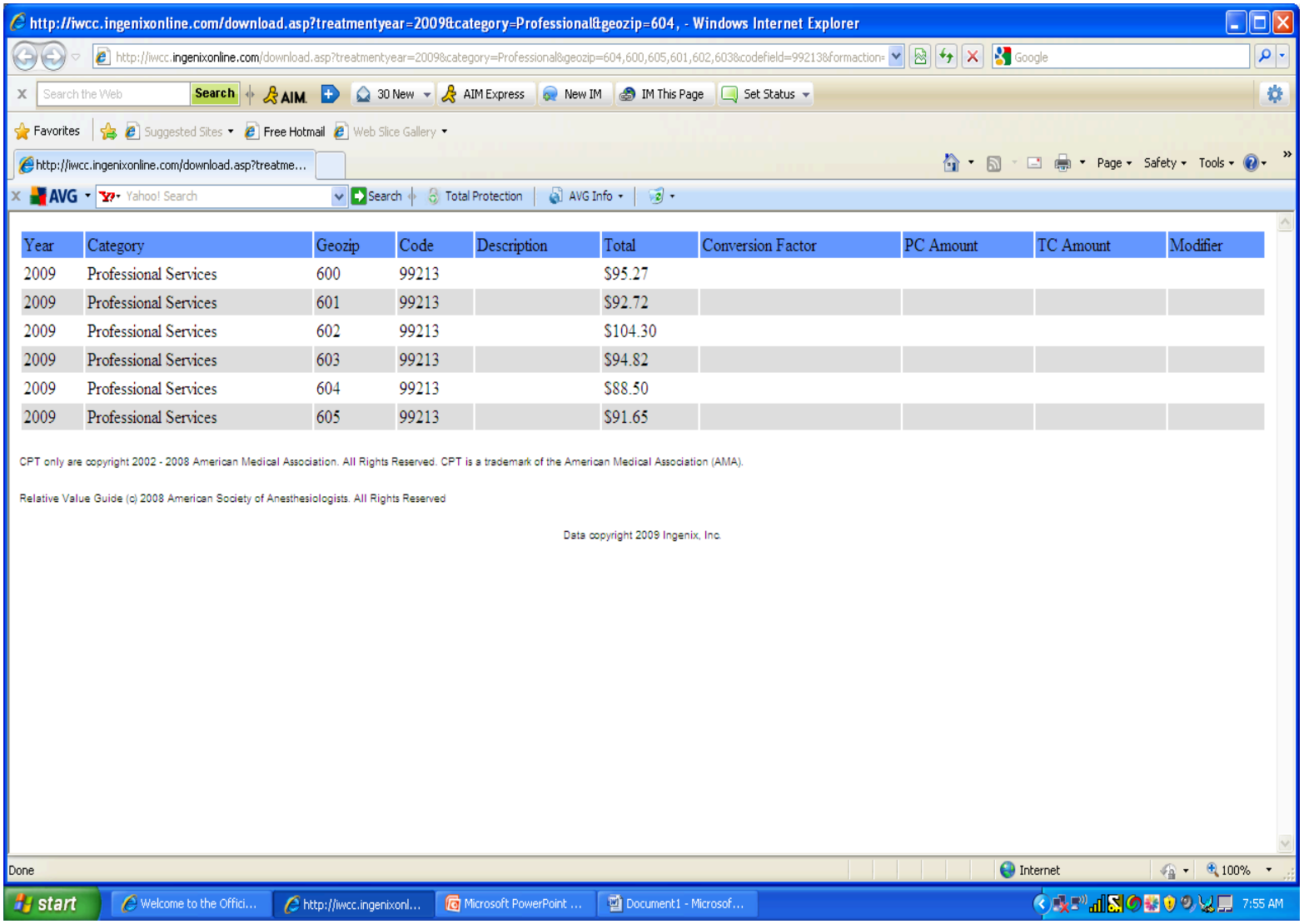
Screen Shot IWCC Website – Fee Schedule



Fee Schedule Control Panel



Results Page



Year	Category	Geozip	Code	Description	Total	Conversion Factor	PC Amount	TC Amount	Modifier
2009	Professional Services	600	99213		$95.27				
2009	Professional Services	601	99213		$92.72				
2009	Professional Services	602	99213		$104.30				
2009	Professional Services	603	99213		$94.82				
2009	Professional Services	604	99213		$88.50				
2009	Professional Services	605	99213		$91.65				

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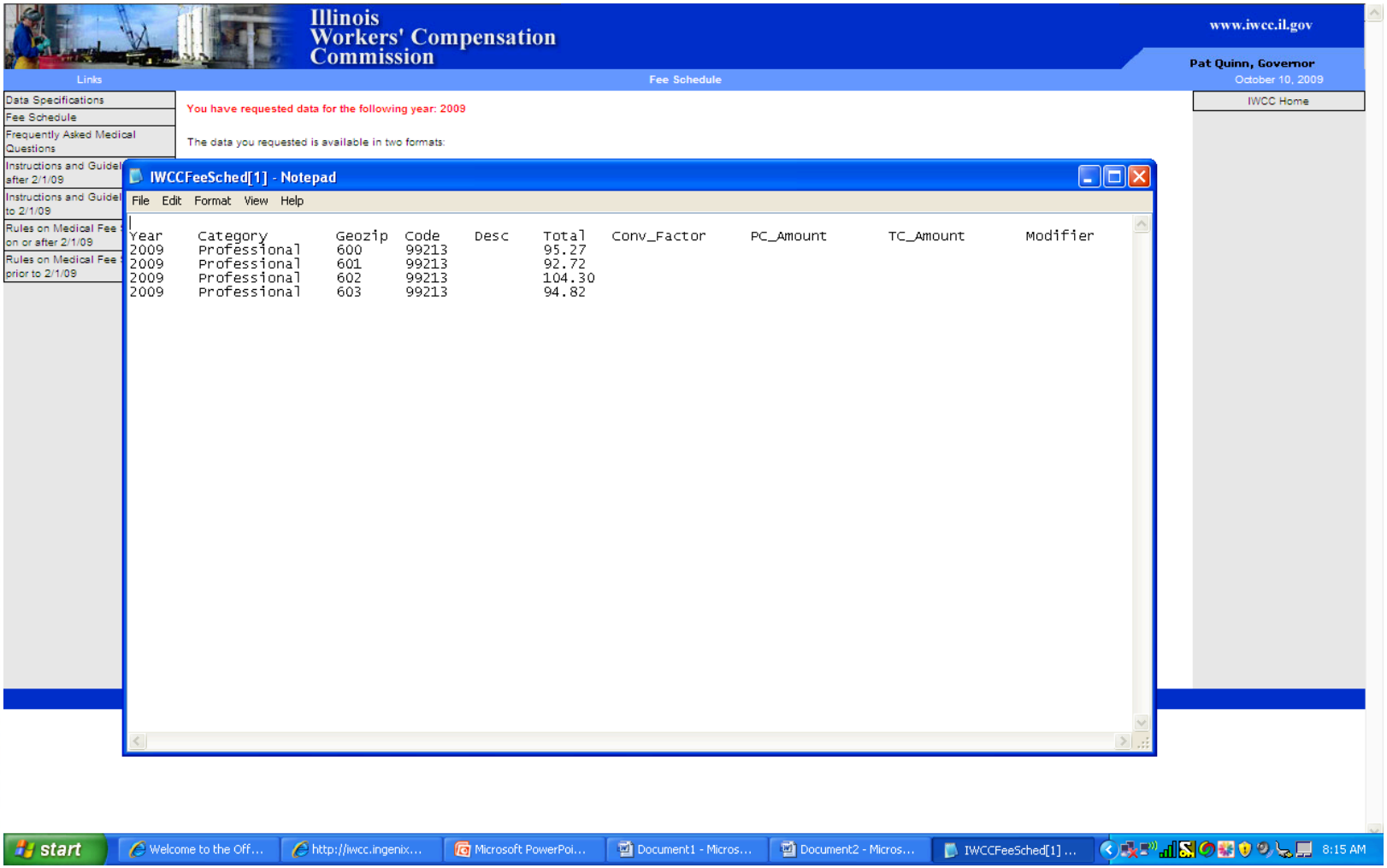
Data copyright 2009 Ingenix, Inc.

Results Page Text Doc - Downloadable



Professional Services
Anesthesia
HCPCS
Fee Schedules

Fee Schedule Methodology

Defined in Section 8.2 of WC Act

- Use database with 12 million charges

  Anesthesia, Prof Services, HCPCS: only Ingenix qualified. It created and hosts the website.

  Facility FS: Except for Radiology, Pathology & Laboratory and Physical Medicine, all based on IL Dept of Public Health data.

- Use charges (not paid amounts) from 8/1/02 - 8/1/04.
- If insufficient data to calculate a fee, payment defaults to 76% of charge (POC76). Historical use of data limits FS to those codes existing in 2004. New codes since 2004 paid at POC76.
- Calculate fee for each of 29 geozips
- Fee based on site of treatment
- Payment shall be the LESSER of provider's charge OR fee schedule amount. This payment represents full payment.
- A contract prevails over the fee schedule.

Fee Schedule Methodology, Page 2

Step 1: Fee = 90% of the 80th percentile (8th of 10 data points)…

EXAMPLE

1	2	3	4	5	6	7	8	9	10
50	50	55	70	80	95	115	115	120	130

Fee = .90 X $115 = 103.50…

Fee Schedule Methodology, Page 3

Step 2: Adjust fee UP or DOWN by CPI-U

CPI Adjustments to Medical Fees		
Eff. Date	**CPI-U**	**CPI-M**
2/1/06	**4.90%**	**4.37%**
1/1/07	**3.80%**	**4.26%**
1/1/08	**1.97%**	**4.52%**
1/1/09	**5.37%**	**3.26%**
1/1/10	**-1.48%**	**3.31%**
Total	**14.56%**	**19.72%**

2010 Fee = .90 X 115 = 103.50 X 1.1456 = $118.57

With CPI-M, fee would be 103.50 X 1.1972 = $123.91

5% savings

Balance Billing

Balance billing = provider bills worker for unpaid medical charges

Effective July 20, 2005, balance billing is prohibited.

If employer notifies provider that it does not consider injury compensable, provider may bill worker.

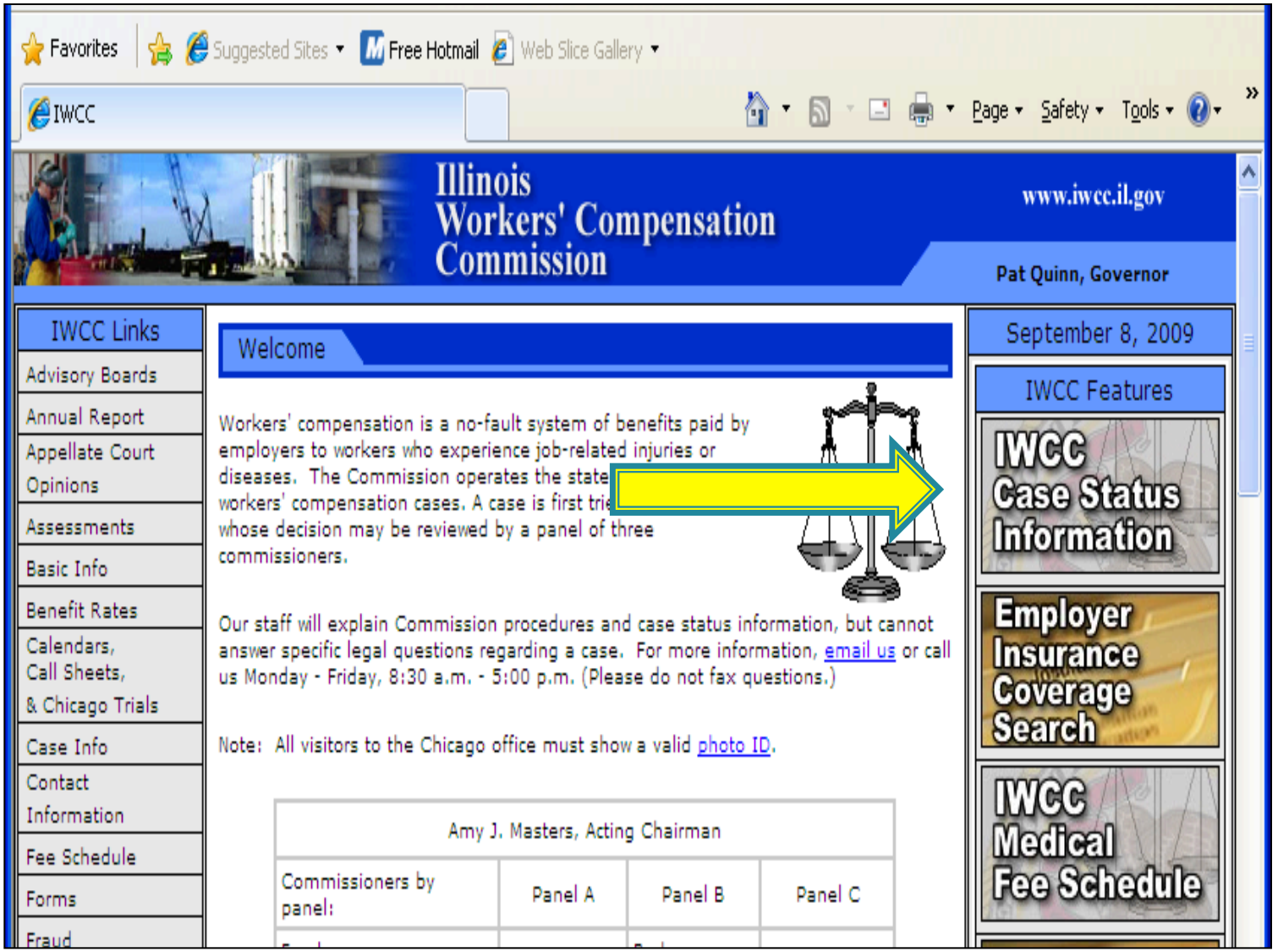
If employee informs provider that claim is on file at IWCC, provider must stop billing worker.

While claim is pending, provider may mail employee reminders and request case information. If employee does not provide info within 90 days, provider may resume billing.

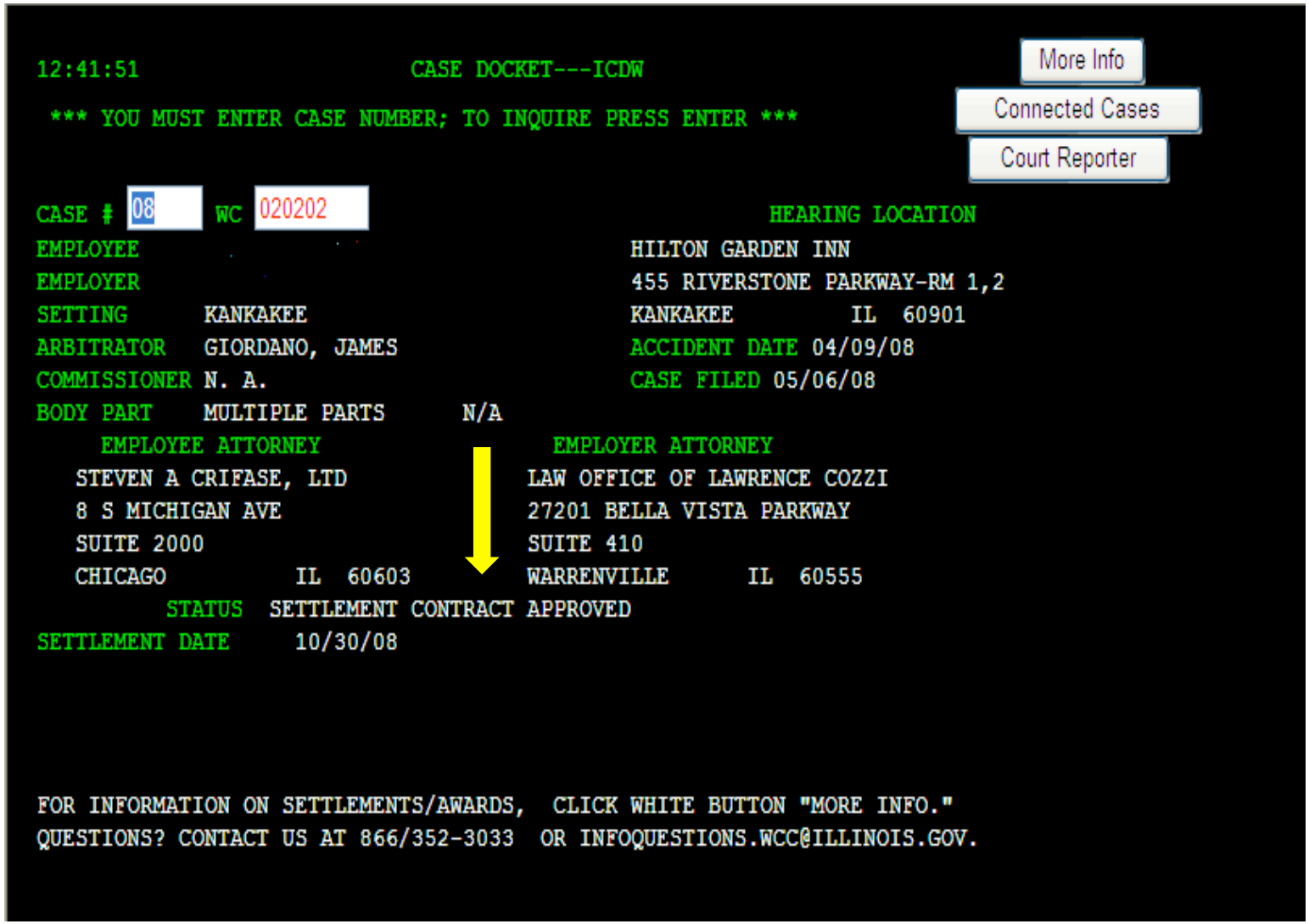
Upon final award, provider may be able to resume collection efforts from employee up to FS amt.

Case status info available at http://www.iwcc.il.gov/caseinfo.htm
Information staff can explain case status: toll-free 866/352-3033

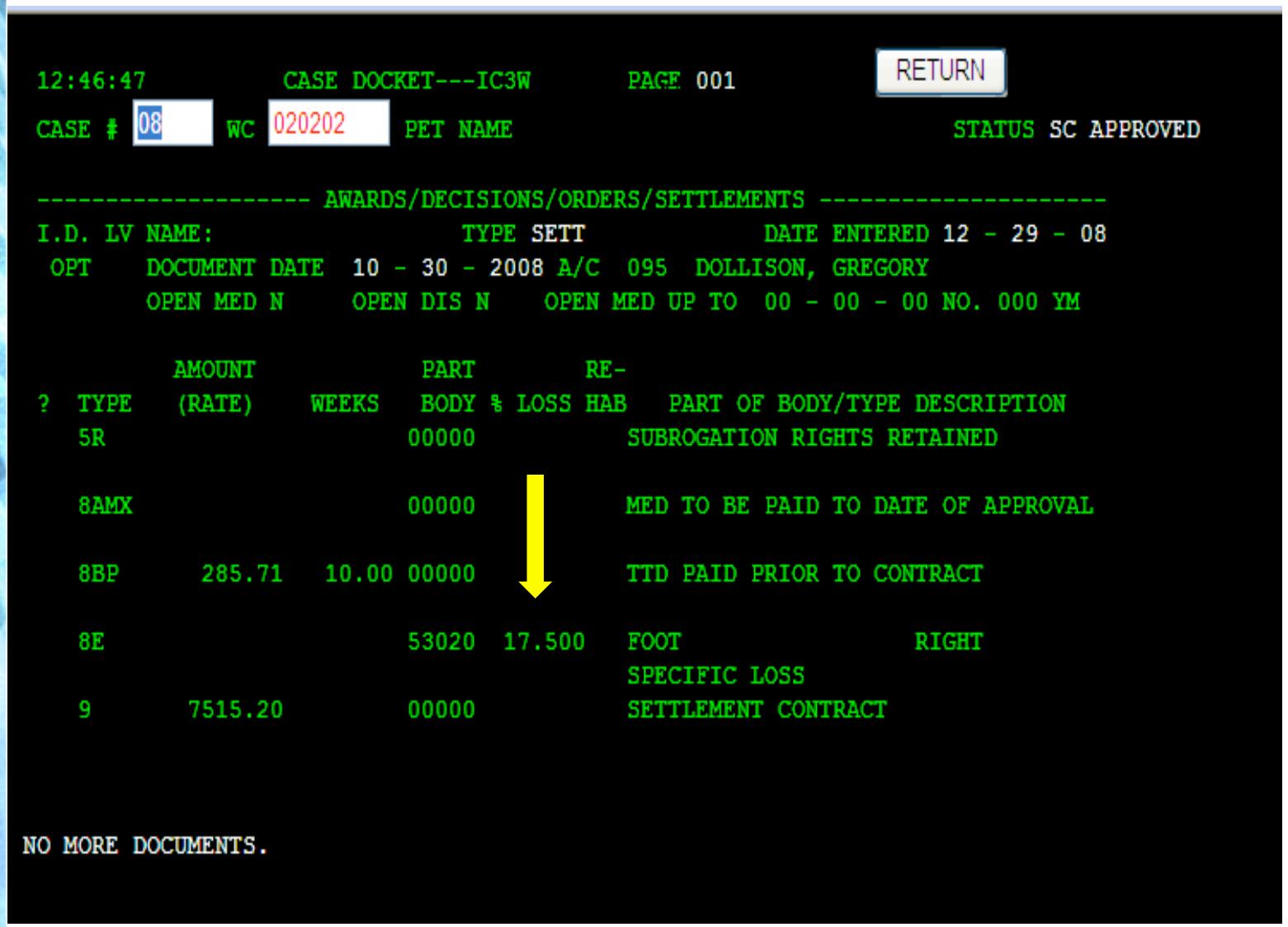
Screen Shot IWCC Website – Case Status Info



Case Status Information: Settlement/Awards/Orders



Case Status Information: Settlement/Awards/Orders



Anesthesia Services

Conversion factor created from total charges in a geozip

Geozip	Conversion factor
600	110.63
601	99.96

Base Value + Time Units + Modifying Units = Total Units

Total Units X Conversion Factor = Fee

Refer to ASA “2006 Relative Value Guide”

Anesthesia Bill Example

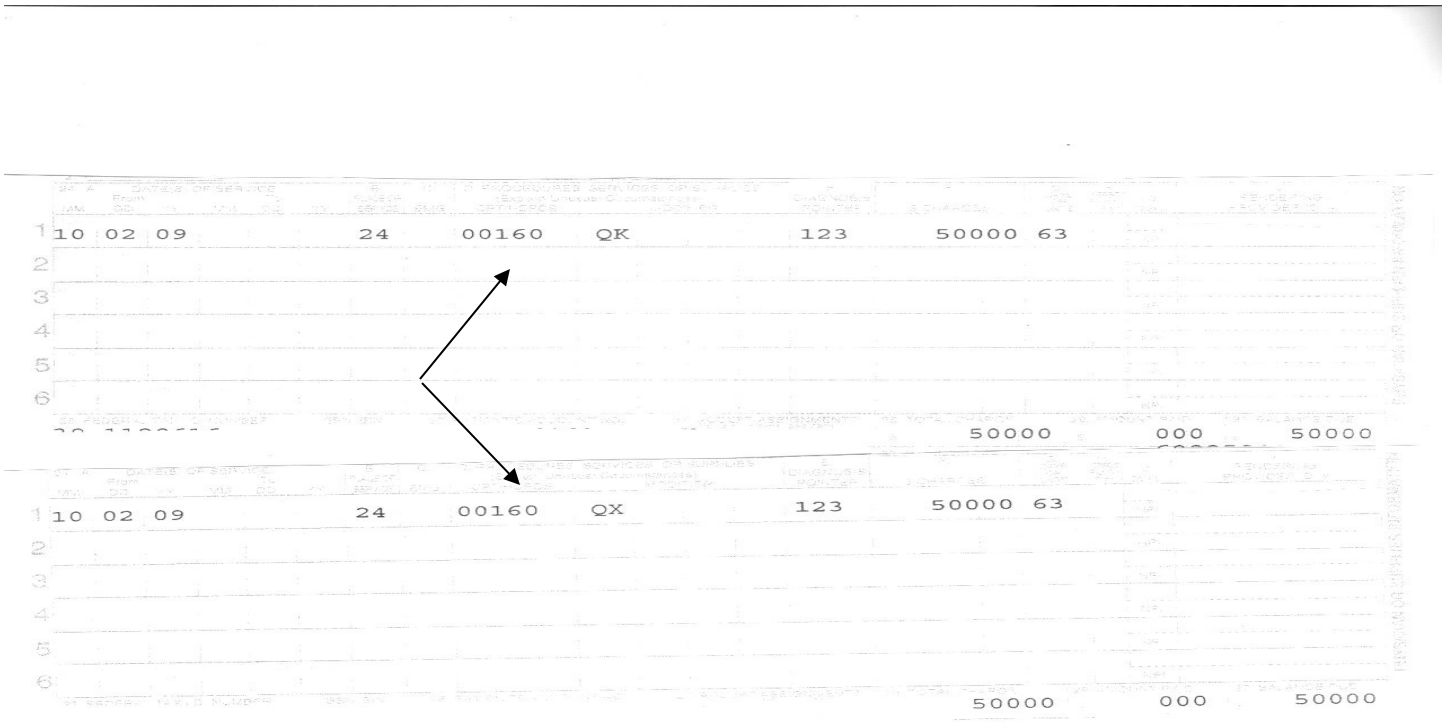
Procedure CPT 01744:
Anesthesia for open/surgical arthroscopic procedures—elbow
Geo-zip 600 Conversion factor = $110.63

Time of Anesthesia Services: 1 hour 15 minutes
Physical Status: P1
Qualifying Circumstances: None

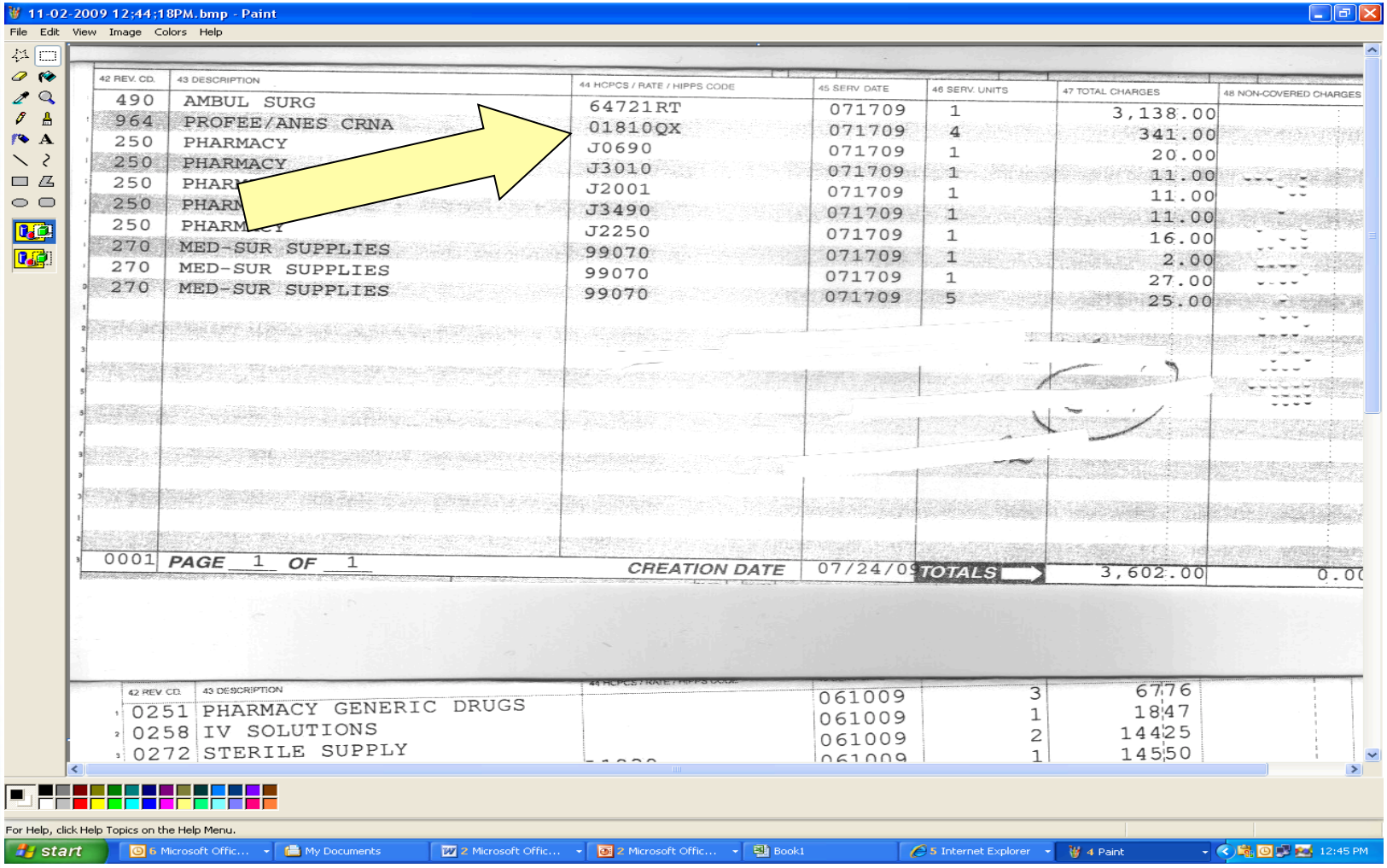
Base Value for 01744	5 units
Time (75 minutes divided by 15)	+ 5 units
Physical Status (P1)	+ 0 units
Qualifying Circumstances-none	+ 0 units
Total Units	10 units

10 Units X $110.63 = $1106.30

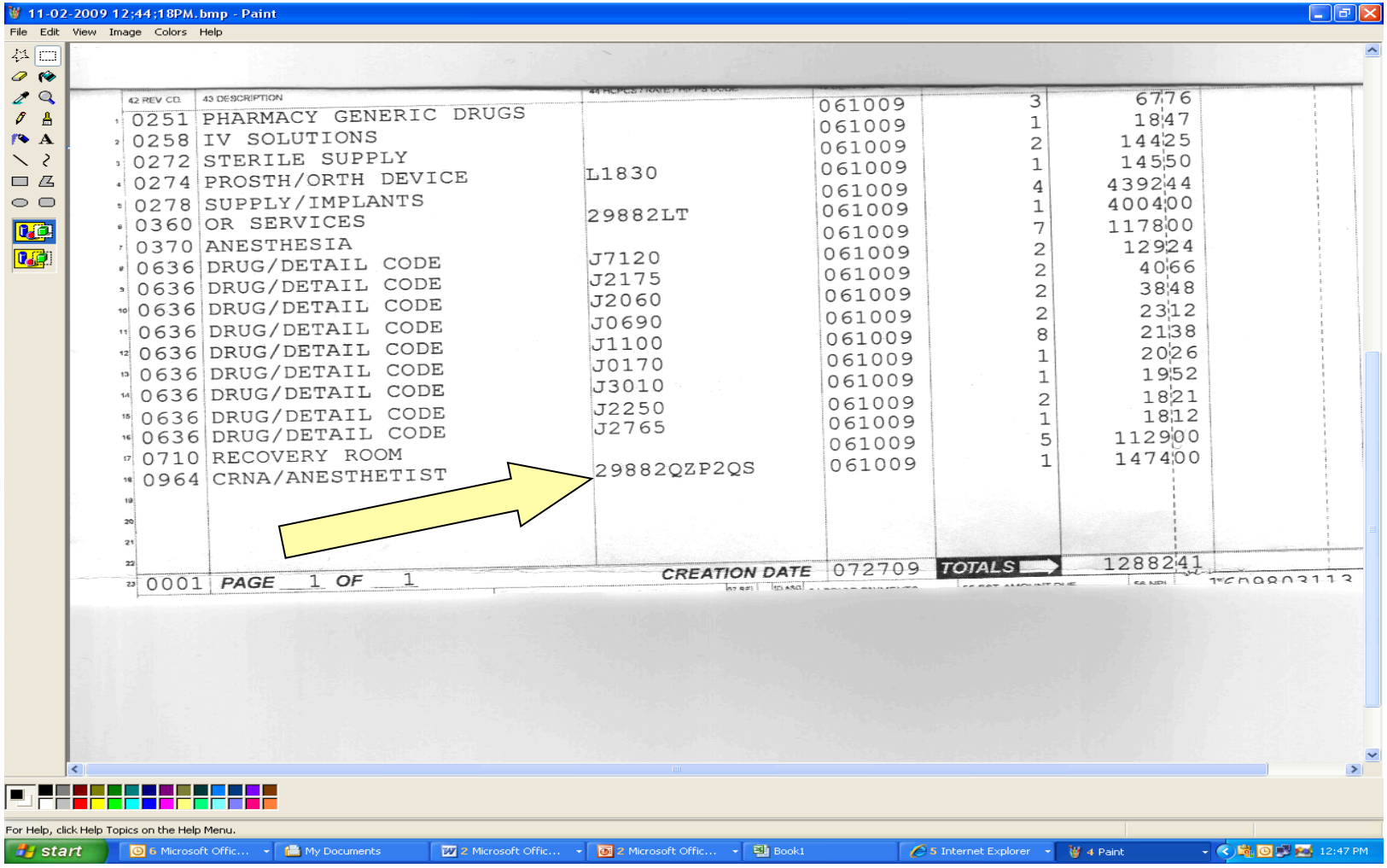
Anesthesia – Split Billing Example



Professional “Buried” on UB



Professional @ Bottom of UB



Dental Services

- Fee schedule amounts could not be calculated so payment defaults to 76% of charges.
- If dental services are reported using CPT or HCPCS codes, those fees apply.

Emergency Room – Professional Services

ER doc's Professional Services:

If billed using doctor's tax ID#, follow Prof Serv FS.

If billed using hospital's tax ID#, POC76.

Facility fees addressed in Session 2
(POC76 plus FS for Rad/Path & Lab/Phys Med & Rehab)

HCPCS Level II

FS for Equipment, Ambulance, etc. (A0021-V5364)

Common Issues:

- Section 8.2 is silent on pharmacy. There is no prescription pharmacy FS. Pay U&C (not defined by IWCC). Don't use a code (e.g., J3490 unclassified drug) to get around this.

- Apply these codes to home healthcare (not skilled nursing facility) bills.

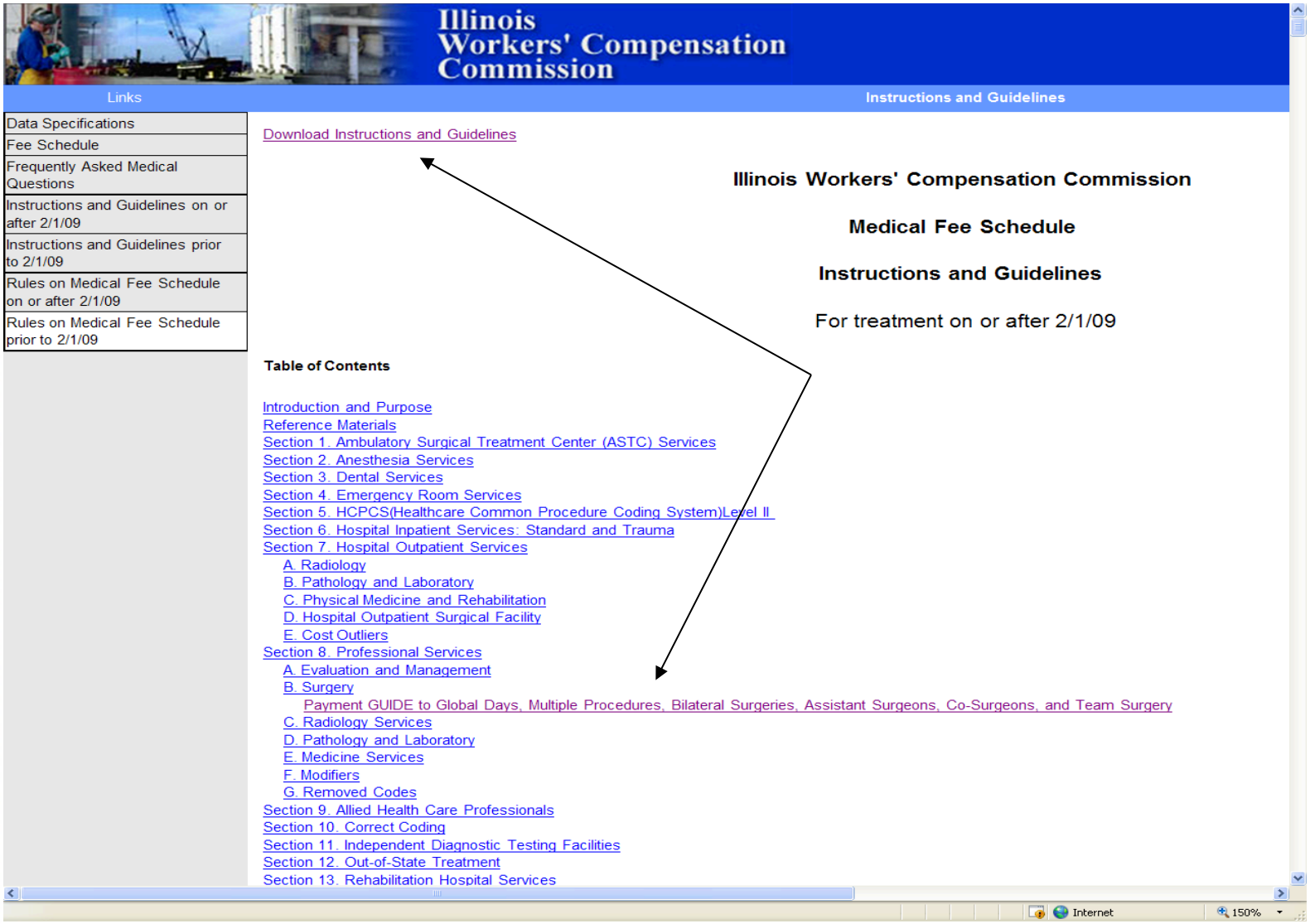
Professional Services

Key Components:

- Fee Schedule
- Instructions and Guidelines
- *Payment Guide to Global Days, Multiple Procedures, etc.*
- *National Correct Coding Initiative* (Version 12.3)

Gaps: follow common coding and reimbursement practices

I&G – Closer View



Illinois Workers' Compensation Commission

Links

- Data Specifications
- Fee Schedule
- Frequently Asked Medical Questions
- Instructions and Guidelines on or after 2/1/09
- Instructions and Guidelines prior to 2/1/09
- Rules on Medical Fee Schedule on or after 2/1/09
- Rules on Medical Fee Schedule prior to 2/1/09

Instructions and Guidelines

Download Instructions and Guidelines

Illinois Workers' Compensation Commission

Medical Fee Schedule

Instructions and Guidelines

For treatment on or after 2/1/09

Table of Contents

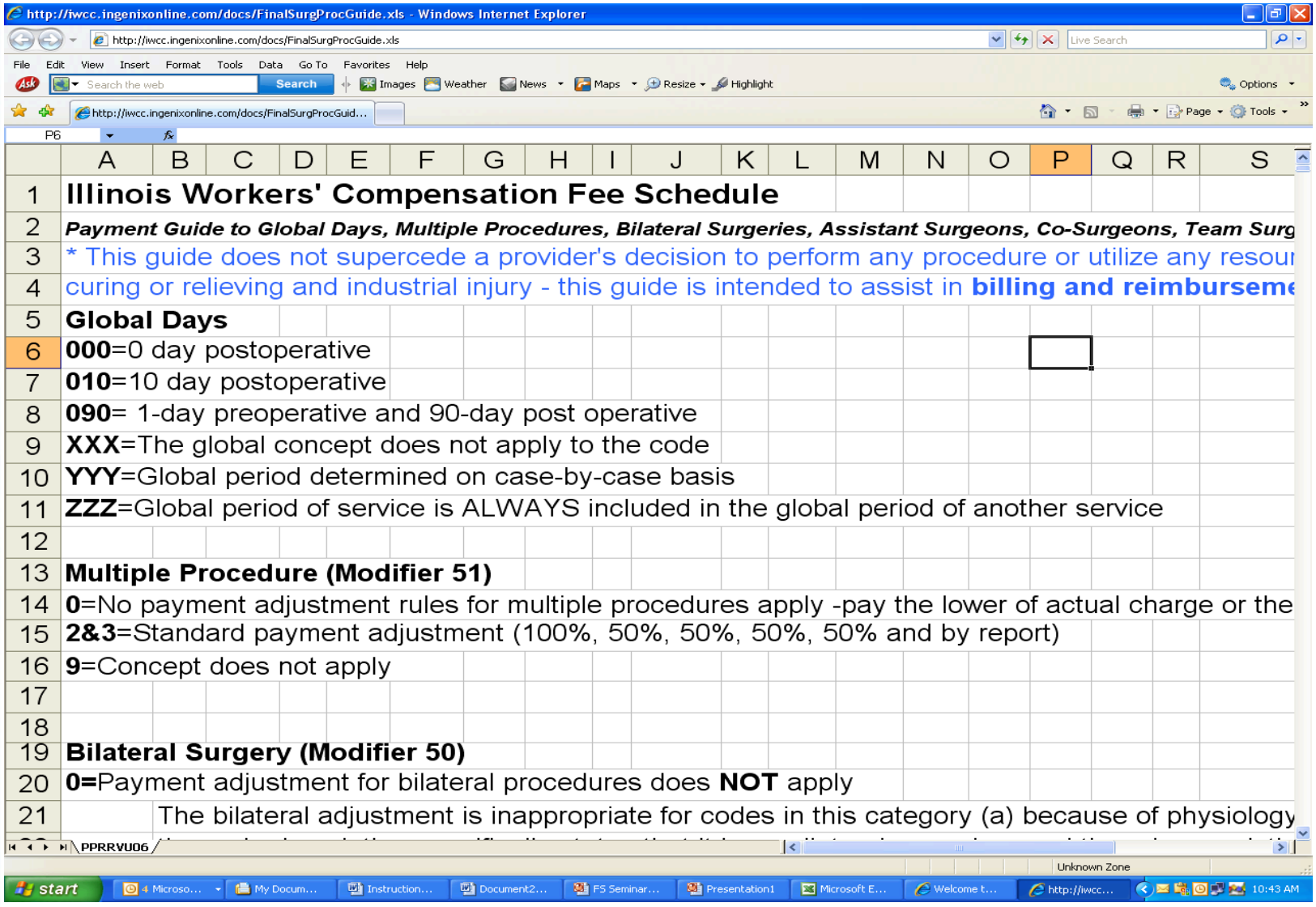
Introduction and Purpose
Reference Materials
Section 1. Ambulatory Surgical Treatment Center (ASTC) Services
Section 2. Anesthesia Services
Section 3. Dental Services
Section 4. Emergency Room Services
Section 5. HCPCS(Healthcare Common Procedure Coding System)Level II
Section 6. Hospital Inpatient Services: Standard and Trauma
Section 7. Hospital Outpatient Services
- A. Radiology
- B. Pathology and Laboratory
- C. Physical Medicine and Rehabilitation
- D. Hospital Outpatient Surgical Facility
- E. 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. Removed Codes

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

Internet 150%

Payment Guide Key



Payment Guide Sample

CPT/ HCPCS	MOD	GLOB DAYS	MULT PROC	BILAT SURG	ASST SURG	CO-SURG	TEAM SURG
49492		090	2	1	2	1	0
49495		090	2	1	2	1	0
49496		090	2	1	2	1	0
49500		090	2	1	2	1	0
49501		090	2	1	2	1	0

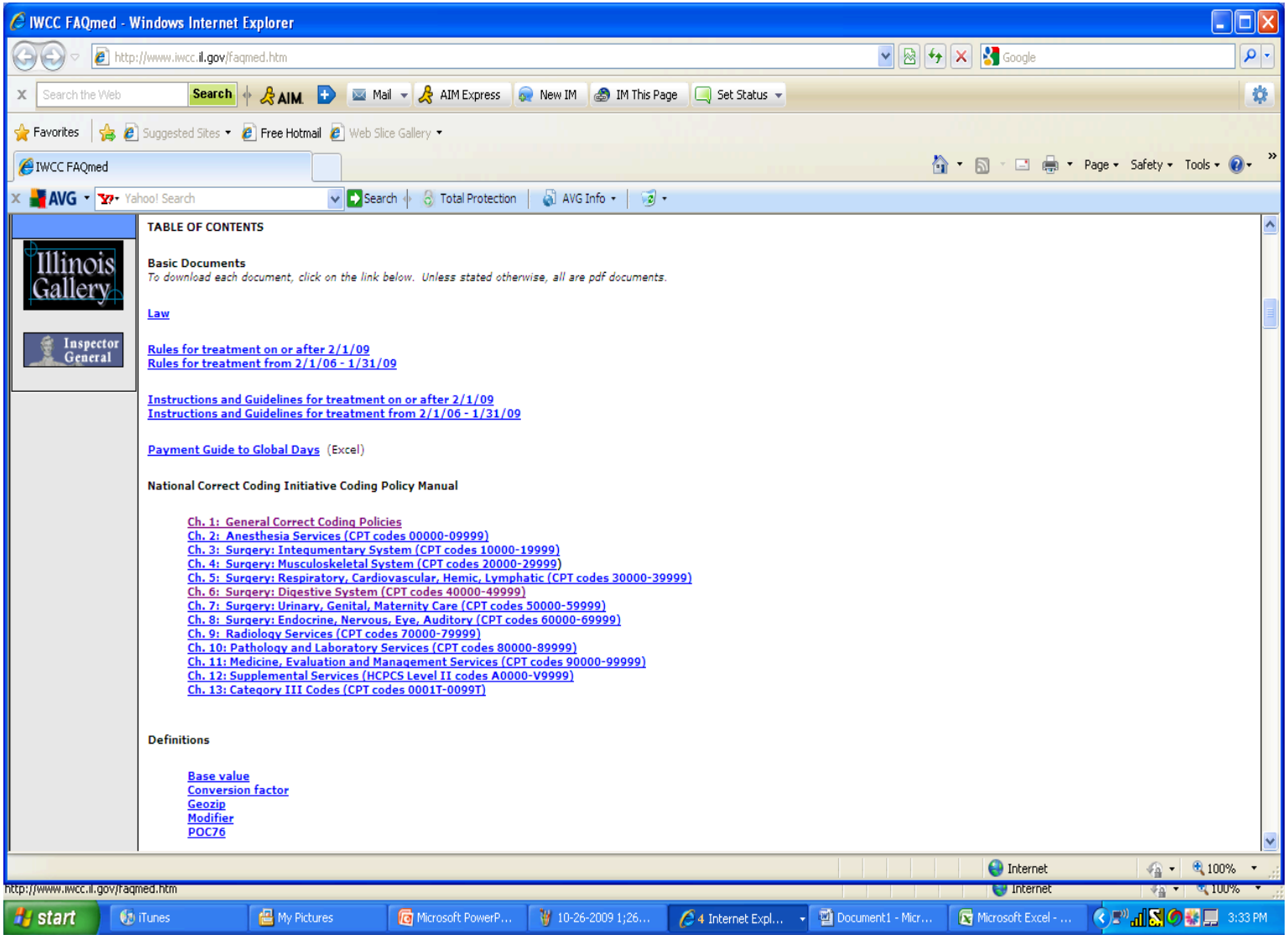
Payment Guide: CPT 97010 (Hot/Cold Packs)

- NCCI publisher has clarified that 97010 is included in other physical medicine procedures and should not be unbundled.

New CPT Codes Not Found in *Payment Guide*

- By law, FS is tied to 2002-2004 charges
- For new codes, follow common coding and reimbursement practices EXCEPT if an updated guideline conflicts with a posted guideline, you must follow the posted guideline.

National Correct Coding Initiative



NCCI
Column One/Column Two & Mutually Exclusive Edits

"There are two NCCI edit tables: "Column One/Column Two Correct Coding Edit Table" and "Mutually Exclusive Edit Table." Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together…"

Version 12.3

I-1

NCCI
Column 1/Column 2: Example

Column1/Column 2 Edits					
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
29826	29805		20020101	*	1
29826	29806		20020701	20040630	1
29826	29815		19970101	20020331	1
29826	29819		19960101	19960101	9
29826	29820		19960101	*	1
29826	29821		19960101	19960101	9
29826	29822		19960101	19960101	9
29826	29822		20011001	*	1
29826	29823		19960101	19960101	9
29826	29825		19960101	*	1
29826	36000		20021001	*	1
29826	36400		20090401	*	1
29826	36405		20090401	*	1
29826	36406		20090401	*	1
29826	36410		20021001	*	1
29826	36420		20090401	*	1
29826	36425		20090401	*	1
29826	36430		20090401	*	1
29826	36440		20090401	*	1
29826	36600		20090401	*	1

NCCI
Mutually Exclusive Edits: Example

Mutually Exclusive Edits					
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
29820	11012		19980101	*	1
29827	11010		20040701	*	1
29827	11011		20040701	*	1
29827	11012		20040701	*	1
29828	11010		20090401	*	1
29828	11011		20090401	*	1
29828	11012		20090401	*	1
29830	11012		19980101	*	1
29834	11012		19980101	*	1
29835	11012		19980101	*	1
29837	11012		19980101	*	1
29840	11012		19980101	*	1
29843	11012		19980101	*	1
29844	11012		19980101	*	1
29846	11012		19980101	*	1
29848	11012		19980101	*	1
29867	29866		20060401	*	1

Modifiers
Section 8F of Instructions and Guidelines

F. Modifiers

Modifier	AMA Description/Illinois Instructions	Payment Policy/ Documentation Requirements
	Due to copyright restrictions, the actual modifier descriptions are not listed. Please refer to *Current Procedural Terminology (CPT®)*, American Medical Association, 2006.	
21	Please refer to CPT.	125 percent of fee schedule amount. Appropriate documentation includes cover letter detailing how evaluation exceeded highest-level code.
22	Specific instructions for the Illinois fee schedule: Clinical examples include, but are NOT limited to following:	125 percent of fee schedule amount. Appropriate documentation includes cover letter and/or photos for documentation.

Modifiers & POC76

- First determine/identify the actual full charge for a code, multiply by 76%, then make an adjustment for other factors (e.g., modifier 80):

  Payment = Full charge X 76% X 20%.

- If bill has already been reduced to 20% of surgeon's charge, then just multiply by 76%.

- OK to reduce a bill if, say, an assistant surgeon submits a fee @ 25% of the primary surgeon's fee, reduce to 20% of the primary surgeon's fee, and then apply FS amount/POC76.

Modifier 59 (Distinct Procedure)

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/ services that are not normally reported together, but are appropriate under the circumstances.

Modifier 59 (con.)

http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf

"From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitute a single anatomic site."

Section 12 Exams (Independent Medical Exams)

- NOT treatment so not subject to FS
- Paid at amount agreed to by provider and payer
- CPT codes in FS are for consultations that are part of treatment

Allied Healthcare Professionals

Section 9, Instructions & Guidelines:

Allied health care professional, such as CRNA, PA, and NP, will be reimbursed at same rate as physician when performing same services as physician.

Out-of-State Treatment

IWCC has jurisdiction only on cases filed in Illinois

Section 12, Instructions and Guidelines:

Payment for out-of-state treatment on IL wc claims is the GREATER of
76% of the charged amount
OR
The amount set forth in that state's FS, if there is a FS

Subject to the other Instructions and Guidelines in FS

Pay 65% of charge for implants, etc.

Questions from the Attendees

Hospital/Facility
Fee Schedules

Fee Schedule Methodology

- Facility fees were calculated the same way as Prof Serv FS
- IDPH data was used
- Professional Services and carve-out charges were removed before calculating Facility fees
- Pay Professional Services billed on hospital bills at POC76.

Carve-outs for implants, etc.

- Subtract and pay at 65% of charge for these revenue codes:

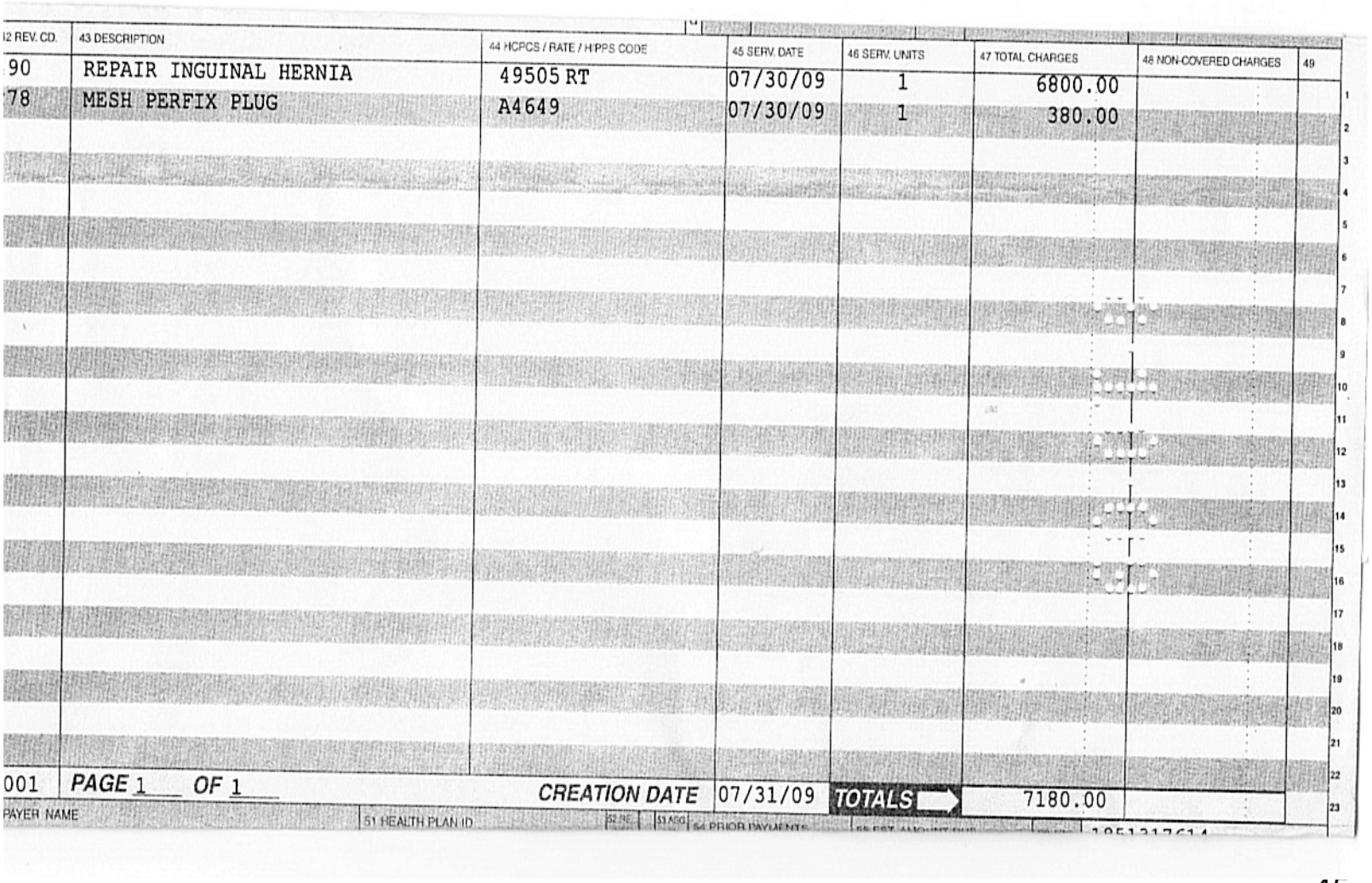
  0274 (prosthetics/orthotics)
  0275 (pacemaker)
  0276 (lens implants)
  0278 (implants)
  0540 and 545 (ambulance)
  0624 (investigational devices)
  0636 (drugs requiring detailed coding)

- **Except for carve-outs, do not apply FS on a line-item basis.**
- Charges shall be at a provider's normal rates under its standard chargemaster.

Ambulatory Surgical Treatment Center (ASTC) Services

- CMS code template used: if code not listed--not covered
- Facility fees only paid to ASTCs licensed by IDPH; list at http://www.idph.state.il.us/healthcarefacilities/astc.htm
- FACILITY FS only: does NOT cover Professional Services, radiology, pathology and laboratory.
- Bill Professional Services charges separately
- Subtract carve-outs, pay at 65%, then apply FS
- Follow Sections 8(B) (only multiple and bilateral procedure modifiers apply) and 8(F) of Instructions & Guidelines
- No cost outlier provision for ASTC FS

ASTC Sample Bill



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
90	REPAIR INGUINAL HERNIA	49505 RT	07/30/09	1	6800.00		
78	MESH PERFIX PLUG	A4649	07/30/09	1	380.00		
001	PAGE 1 OF 1		CREATION DATE	07/31/09	TOTALS	7180.00	

PAYER NAME | 51 HEALTH PLAN ID | 52 RE | 53 ASG | 54 PRIOR PAYMENTS | 55 EST AMOUNT DUE | 1951217614

ASTC FS Amount

Year	Category	Geozip	Code	Total
2009	ASTC	605	49505	$7,868.75

ASTC FS Calculation (in absence of contract)

$7,180.00 Total charges

- 380.00 Subtract rev code 278 charges

$6,800.00

Since $6,800 < FS amt of $7,868.75, pay **$6,800**

Pay carve-out: $380.00 @ 65% = **$247.00**

Pay $6,800.00

+ 247.00

$7,047.00

Emergency Room Services

ER Facility: Pay POC76 + FS where available:

- Subtract carve-outs, pay at 65%, then apply FS
- Rad/Path & Lab/Phys Med & Rehab paid per Hospital Outpatient FS
- Prof Services
  - If billed by hospital with hospital tax ID: POC76
  - If billed by physician: Prof Services FS
- Urgent Care Centers
  - If billed by hospital with hospital tax ID: POC76
  - Otherwise: Prof Services FS

Emergency Room Bill Example

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges/FS Amount
250	Pharmacy		091008	7	$950.00
250	Pharmacy		091008	10	$305.56
270	Med Sur-Supplies		091008	27	$1,170.00
300	**Laboratory**	**80048**	**091008**	**1**	**$105.00/FS $120.98**
300	**Laboratory**	**82962**	**091008**	**2**	**$84.00/FS $68.00**
300	**Laboratory**	**85025**	**091008**	**1**	**$82.00/FS $69.73**
300	**Laboratory**	**82962**	**091008**	**1**	**$42.00/FS 34.00**
312	**Pathol/Histol**	**88304**	**091008**	**1**	**$248.00/FS $204.97**
320	**DX X-Ray**	**73090LT**	**091008**	**1**	**$292.00/FS $255.95**
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	20103LT	091008	1	$1,459.00
370	Anesthesia		091008	1	$259.00
450	**Emerg Room**	**9928525**	**091008**	**1**	**$676.00**
450	**Emerg Room**	**90765**	**091008**	**1**	**$268.00**
450	**Emerg Room**	**90775**	**091008**	**1**	**$165.00**
710	Recovery Room		091008	5	$501.00
762	Observation Rm		091008	15	$705.00
762	Observation Rm		091008	6	$94.00
	Total Charges				$11,751.39

Emergency Room Bill FS Calculation

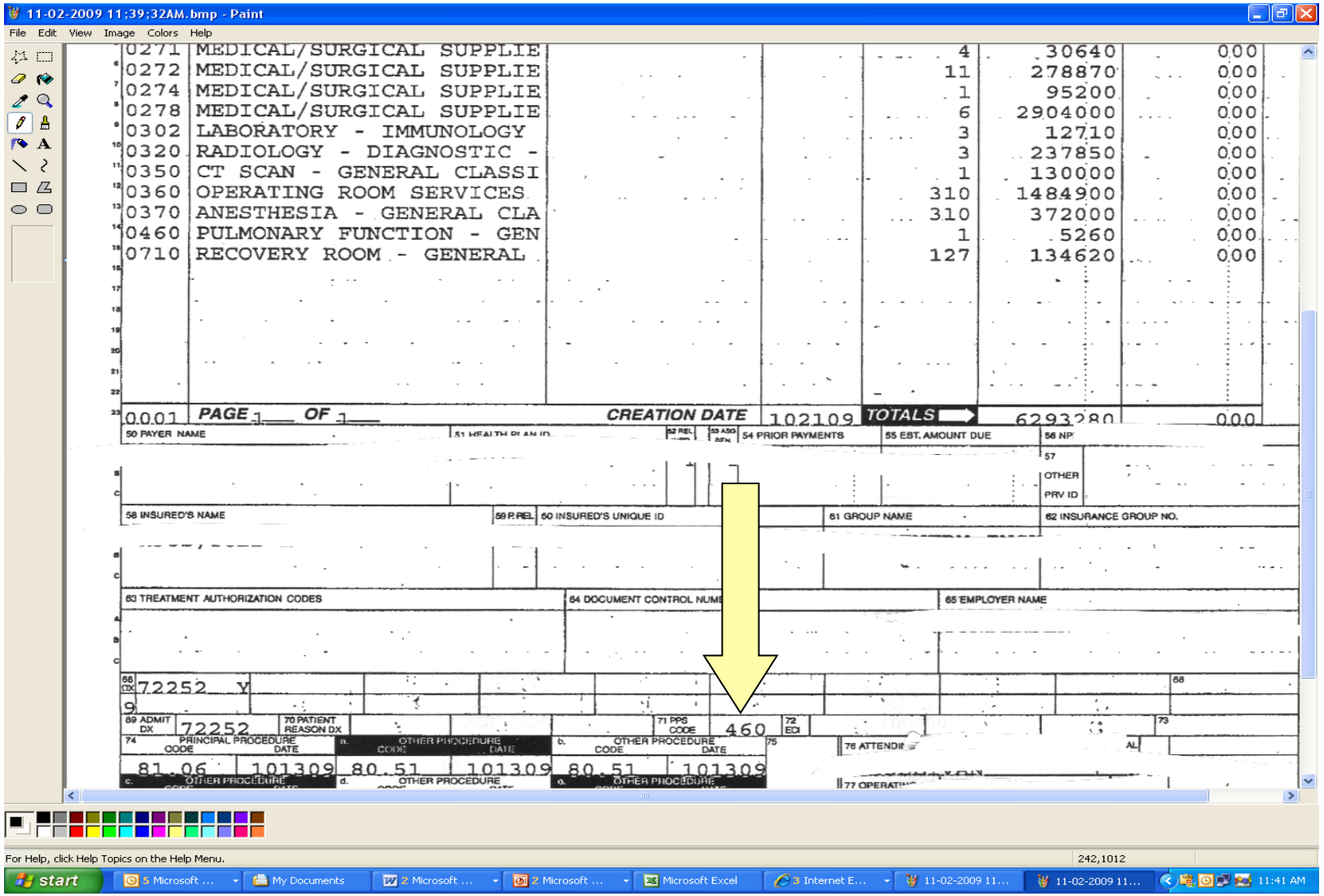
Billed	**$11,751.39**
Lab/Path/Rad charges	**- $853.00**
Remaining ER amount	**$10,898.39**

Fee schedule amount ($10,898.30 X 76%)	**$8,282.78**
Lab/Path/Rad fees (per FS)	**+ $737.65**
Paid	**$9,020.43**

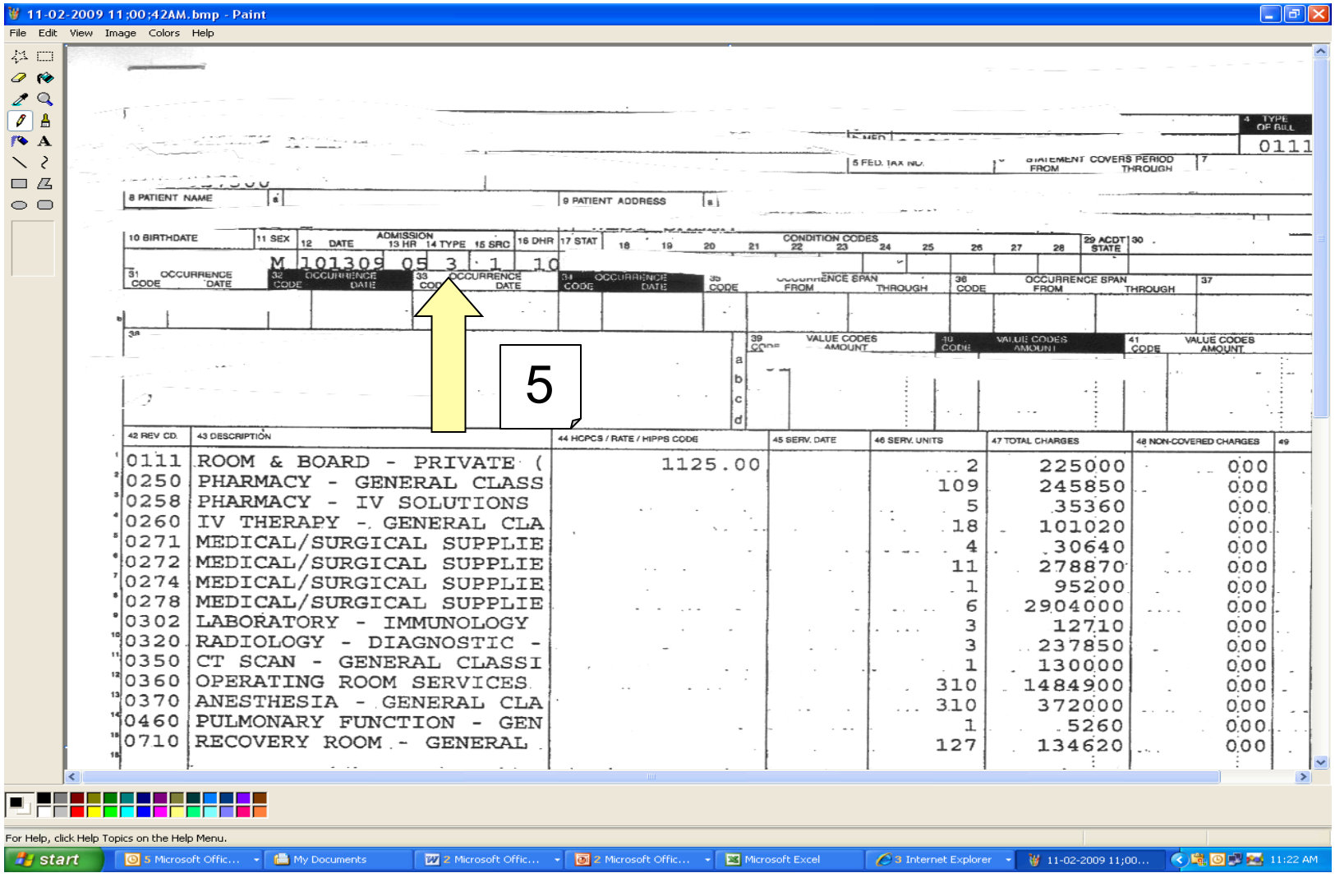
Hospital Inpatient Services

- DRG (Diagnosis-Related Group) and, as of 6/30/09, IWCC adopted MS-DRG system
  (delay due to regrouping, rule-making)
- Prof Services
  If billed by hospital with hospital tax ID: POC76
  If billed by physician: Prof Services FS
- Trauma FS applies only to rare trauma “Type 5” admissions at Level I & II trauma centers listed at
  http://www.idph.state.il.us/ems/traumaregions.htm

Hospital bill: Look for MS-DRG (6-30-09)



Standard vs. Trauma FS? Look at admission type



Hospital Inpatient FS: Standard v. Trauma amounts

Year	Category	Geozip	Code	Description	Total
6/30/09	Hosp Inpat-Standard	606	493	Lower extrem & humer proc	$49,116.15
6/30/09	Hosp Inpat-Trauma	606	493	Lower extrem & humer proc	$74,238.63

Cost Outliers

Applies only to Hospital Inpatient & Outpatient Surgical

Formula:

1) Subtract Prof Serv and carve-out charges from bill

2) Cost outlier if remaining balance > (FS amt X 2)

3) Pay FS amount
   + (Excess amt X .76)
   + Prof Serv
   + Carve-outs
   Total

Cost Outlier Example

Total hospital charge = $31,000
Prof Serv = $5,000
Carve-outs = $1,000
FS Amt = $10,000

1. Subtract PS & carve-outs: $31,000 - $5,000 - $1,000 = $25,000
2. Find FS amount for code: = $10,000
3. Do outlier calculation: $25,000 > $20,000 ($10,000 X 2) so this is an outlier.
4. Subtract FS amt from balance: $25,000 balance - $10,000 FS amt = $15,000
5. Pay excess amount at 76%: $15,000 X .76 = $11,400
6. Pay Prof Serv at 76%: $5,000 X .65 = $3,800
7. Pay carve-outs at 65%: $1,000 X .65 = $650
8. Payment = $10,000 + $11,400 + $3,800 + $650 = $25,850

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
- Scheduled Surgical Services performed in a hospital outpatient setting

Radiology

- FS sets the maximum payment for radiological services performed in a hospital outpatient setting for codes 70010 – 79999.

- Prof Services billed by hospital: POC76
  Prof Services billed by physician: Prof Services FS

Example: One Use of H-Radiology FS

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges/FS Amount
250	Pharmacy		091008	7	$950.00
250	Pharmacy		091008	10	$305.56
270	Med Sur-Supplies		091008	27	$1,170.00
300	**Laboratory**	**80048**	**091008**	**1**	**$105.00/FS $120.98**
300	**Laboratory**	**82962**	**091008**	**2**	**$84.00/FS $68.00**
300	**Laboratory**	**85025**	**091008**	**1**	**$82.00/FS $69.73**
300	**Laboratory**	**82962**	**091008**	**1**	**$42.00/FS 34.00**
312	**Pathol/Histol**	**88304**	**091008**	**1**	**$248.00/FS $204.97**
320	**DX X-Ray**	**73090LT**	**091008**	**1**	**$292.00/FS $255.95**
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	20103LT	091008	1	$1,459.00
370	Anesthesia		091008	1	$259.00
450	**Emerg Room**	**9928525**	**091008**	**1**	**$676.00**
450	**Emerg Room**	**90765**	**091008**	**1**	**$268.00**
450	**Emerg Room**	**90775**	**091008**	**1**	**$165.00**
710	Recovery Room		091008	5	$501.00
762	Observation Rm		091008	15	$705.00
762	Observation Rm		091008	6	$94.00
	Total Charges				$11,751.39

Pathology and Laboratory

- Sets the maximum payment for pathology and laboratory services performed in a hospital outpatient setting for codes 80048-89356.

- Prof Services billed by hospital: POC76
  Prof Services billed by physician: Prof Services FS

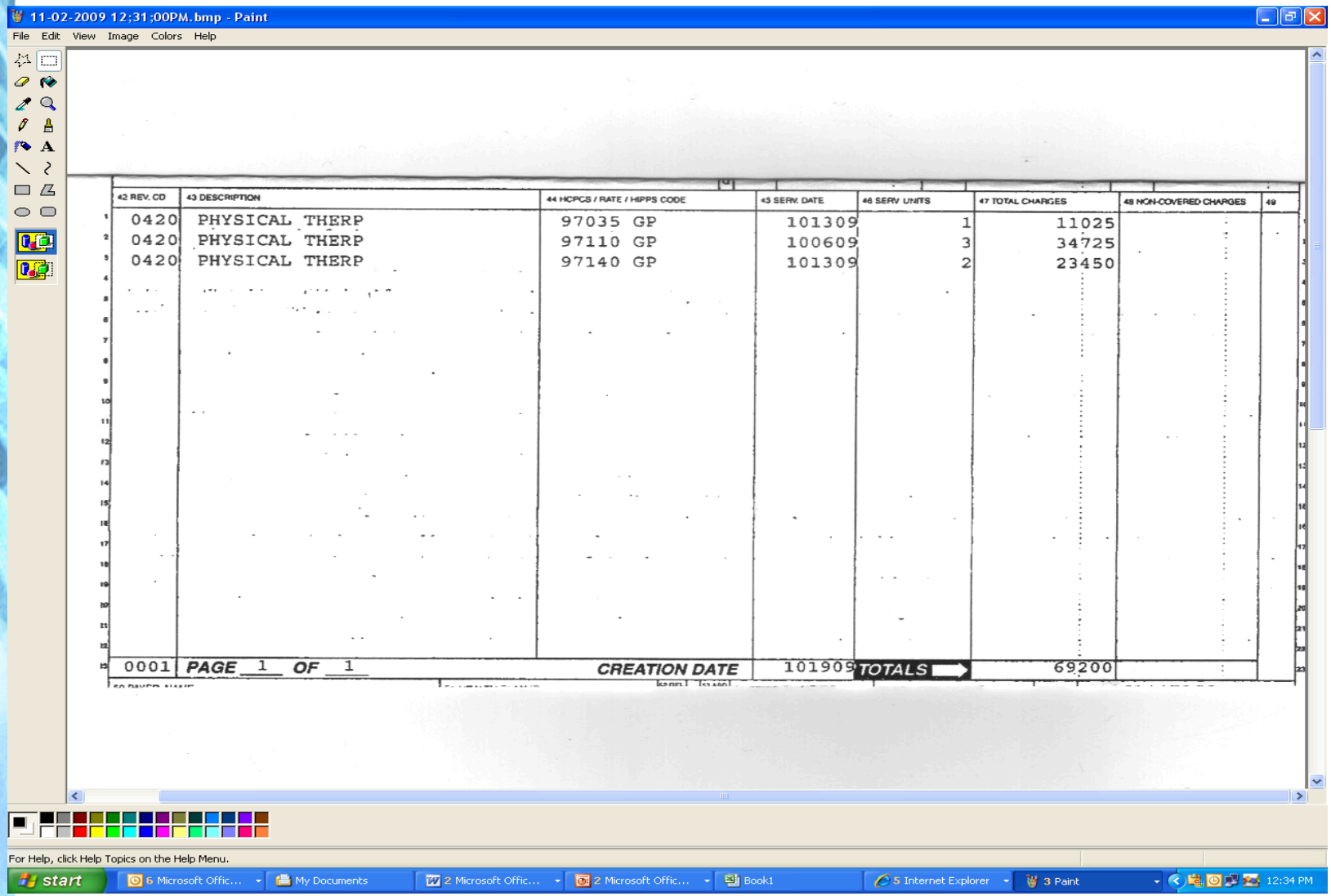
Example: One Use of Path & Lab FS

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges/FS Amount
250	Pharmacy		091008	7	$950.00
250	Pharmacy		091008	10	$305.56
270	Med Sur-Supplies		091008	27	$1,170.00
300	**Laboratory**	**80048**	**091008**	**1**	**$105.00/FS $120.98**
300	**Laboratory**	**82962**	**091008**	**2**	**$84.00/FS $68.00**
300	**Laboratory**	**85025**	**091008**	**1**	**$82.00/FS $69.73**
300	**Laboratory**	**82962**	**091008**	**1**	**$42.00/FS 34.00**
312	**Pathol/Histol**	**88304**	**091008**	**1**	**$248.00/FS $204.97**
320	**DX X-Ray**	**73090LT**	**091008**	**1**	**$292.00/FS $255.95**
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	24341LT	091008	1	$1,459.00
360	OR Services	20103LT	091008	1	$1,459.00
370	Anesthesia		091008	1	$259.00
450	**Emerg Room**	**9928525**	**091008**	**1**	**$676.00**
450	**Emerg Room**	**90765**	**091008**	**1**	**$268.00**
450	**Emerg Room**	**90775**	**091008**	**1**	**$165.00**
710	Recovery Room		091008	5	$501.00
762	Observation Rm		091008	15	$705.00
762	Observation Rm		091008	6	$94.00
	Total Charges				$11,751.39

Physical Medicine and Rehabilitation

- Sets the maximum payment for physical medicine and rehab services performed in a hospital outpatient setting for codes 97001-97799.
- Does not apply when the bill type requires the application of the hospital inpatient or hospital outpatient surgical facility FS.
- Applies to all other hospital outpatient settings including ER visits.

Hospital-based PT Example



Hospital Outpatient Surgical Facility

- Global FS for codes 10021 - 69990. Not for surgical sessions initiated as part of an ER visit (revenue codes 450 to 459)
- Follow multiple procedure and bilateral surgery modifiers in 8(B) and applicable modifiers in 8(F).
- When an outpatient surgical procedure is not recognized/found in the HOSF fee schedule, all charges are to be paid at 76% of the charged amount subject to the 65% carve-out categories discussed above.
- Professional Services (e.g., CRNA services)
  - If billed by a hospital-—remove and pay POC76
  - If billed by professional—follow Prof Serv or HCPCS FS
- Cost outlier methodology applies.

Example #1: Hospital Outpatient Surgical Facility Fee Schedule (HOSFFS) Single Procedure With No Carve-outs– Geozip 616

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		092208	003	$61.80
258	IV Solution		092208	001	$78.25
270	Med/Surg Supplies and De		092208	006	$142.00
272	Sterile Supply		092208	006	$525.00
300	Laboratory	81025	092208	001	$116.00
300	Laboratory	36415	092208	001	$14.00
360	**Operating Room Services**	**64721RT**	**092208**	**001**	**$2,627.00**
370	Anesthesia		092208	002	$2,446.00
710	Recovery Room		092208	002	$247.00
	Total Charges				**$6,259.05**

Example #1: FS Disposition

The relevant amount as contained in the HOSF fee schedule:

		Geozip 616
64721	Carpal Tunnel Surgery	**5818.89**

Billed: **$6,259.05**

Paid **$5,818.89**

Example #2: HOSFFS Single Procedure with Several Revenue Code Carve-outs – Geozip 616

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		091008	012	$352.10
258	IV Solution		091008	014	$1,368.50
270	Med/Surg Supplies and De		091008	023	$1,238.00
272	Sterile Supply		091008	005	$354.00
278	**Other Implants**		**091008**	**005**	**$2,664.00**
360	**Operating Room Services**	**29807RT**	**091008**	**001**	**$6,207.00**
370	Anesthesia		091008	006	$4,748.00
636	**Drugs Req Detailed Codin**	**J2405**	**091[illegible]**	**004**	**$68.35**
636	**Drugs Req Detailed Codin**	**J3010**	**091008**	**00[illegible]**	**$17.50**
637	Self Administratable Drugs		091008	001	$3.65
710	Recovery Room		091008	006	$1,485.00
	Total Charges				**$18,506.10**

Example #2: FS Disposition

The relevant amount as contained in the HOSF fee schedule:

		Geozip 616
29807	Repair of SLAP Lesion	**14833.43**

Billed		**$18,506.10**
Minus carve-out	**-**	**$2,749.85**
Amount to be applied to fee schedule		**$15,756.25**
Fee schedule amount		**$14,833.43**
Plus carve-out @ 65%	**+**	**$1,787.40**
Paid		**$16,620.83**

Example #3: HOSFFS Multiple Surgical Procedure with Carve-outs and Prof Serv– Geozip 606

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy				$842.77
270	Med Sur-Supplies				$2,208.00
312	Pathol/Histol	88304	092108	6	$248.00
312	Pathol/Histol	88311	092108	42	$82.00
360	**OR Services**	**11044**	**092108**	**1**	**$1,948.00**
360	**OR Services**	**14040**	**092108**	**1**	**$1,948.00**
360	**OR Services**	**14040**	**092108**	**1**	**$1,948.00**
360	**OR Services**	**15240**	**092108**	**1**	**$1,948.00**
370	Anesthesia		092108	1	$259.00
636	**Drug/Detail Code**	**J7030**	**092108**	**1**	**$100.00**
636	**Drug/Detail Code**	**J7120**	**092108**	**1**	**$100.00**
636	**Drug/Detail Code**	**J0690**	**092108**	**2**	**$87.04**
636	**Drug/Detail Code**	**J1885**	**092108**	**2**	**$75.00**
636	**Drug/Detail Code**	**J2250**	**092108**	**2**	**$75.00**
636	**Drug/Detail Code**	**J3010**	**092108**	**3**	**$75.00**
710	Recovery Room		092108	1	$229.00
730	EKG/ECG	93005	092108	1	$145.00
964	**Pro Fees Anesthesia CRNA**		**092108**	**115**	**$2,415.00**
985	**Prof Fees EKG**	**93010**	**092108**	**1**	**$25.00**
	Total Charges				**$14,757.81**

Example #3: FS Disposition

Per *Payment Guide* & modifiers, pay the most expensive procedure at 100%, the rest at 50%:

		Geozip 606	Adjusted
11044	Debridement, Skin, Partial Thickness	2,381.79	1,190.90
14040	Adj. Tissue Transfer	4,856.39	4,856.39
14040	Adj. Tissue Transfer	4,856.39	2,428.20
15240	Full Thickness Graft	4,856.39	2,428.20
		16,950.96	10,903.68

Billed	**$14,757.81**
Minus Professional Services	**- $2,440.00**
Minus carve-out	**- $512.04**
Balance to be applied to FS	**$11,805.77**
Pay lesser of Balance or FS	**$10,903.69**
Professional Services @ 76%	**+ $1,854.40**
Plus carve-out @ 65%	**+ $332.83**
Paid	**$13,090.92**

Example #4: HOSFFS One or More Procedures Not Found in FS – Entire Bill Minus Carve-outs Defaults to POC76

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		090608	14	$585.00
250	Pharmacy		090608	3	$176.45
258	IV Solution		090608	6	$560.50
270	Med/Surg Supplies and De		090608	17	$1,014.00
272	Sterile Supply		090608	12	$1,137.00
360	Operating Room Services	29826RT	090608	1	$5,329.00
360	Operating Room Services	2981959RT	090608	1	$0.00
360	**Operating Room Services** ★	**2347259RT**	**090608**	**1**	**$0.00**
370	Anesthesia		090608	5	$4,173.00
636	Drugs Req Detailed Codin	J2405	090608	4	$68.35
636	Drugs Req Detailed Codin	J3010	090608	15	$102.05
637	Self Administrable Drugs		090608	6	$404.40
637	Self Administrable Drugs		090608	2	$1.00
710	Recovery Room		090608	3	$1,270.00
762	Observation Room		090608	25	$858.00
	Total Charges				$15,679.05

Example #4: FS Disposition—Code 23472 not listed

Year	Category	Geozip	Code	Description	Total
2009	Outpatient	600	29819		$8,449.09
2009	Outpatient	600	29826		$13,431.03

Billed	$15,679.05
Minus carve-out (636 Rev Code)	- $170.40
Amount applied to fee schedule	$15,508.65
Paid at 76%	$11,786.57
Plus carve-out paid @ 65%	+ $110.76
Paid	$11,897.33

Example #5: HOSFFS Multiple Bilateral Procedures – Entire Bill Minus Carve-outs – Geozip 600

Rev.	Description	HCPCS/Rates	Serv.	Serv. Units	Total Charges
250	Pharmacy		60508	6	$172.10
258	IV Solution		60508	1	$90.75
270	Med/Surg Supplies and De		60508	3	$593.00
272	Sterile Supply		60508	3	$584.00
360	**Operating Room Services**	**2739350**	**60508**	**1**	**$30,727.00**
360	**Operating Room Services**	**2769150**	**60508**	**1**	**$0.00**
360	**Operating Room Services**	**2769250**	**60508**	**1**	**$0.00**
370	Anesthesia		60508	3	$3,237.00
636	**Drugs Req Detailed Codin**	**J2405**	**60508**	**4**	**$21.05**
636	**Drugs Req Detailed Codin**	**J3010**	**60508**	**1**	**$18.90**
637	Self Administrable Drugs		60508		$3.70
710	Recovery Room		60508	7	$1,820.00
	Total Charges				$37,267.50

Example #5: FS Disposition

		Geozip 600
27393	Lengthening of hamstring tendon; single tendon	7039.55
27691	Transfer or transplant of single tendon, deep	11510.35
27692	Transfer or transplant of single tendon, each additional	11510.35

Bundling edits for 27692 block multiple procedure modifier.

Billed	**$37,267.50**
Minus carve-out (Rev. Code 636)	**- $39.95**
Balance applied to Fee Schedule	**$37,227.55**
Fee Schedule Amount for 27691.50 ($11,510.35 x 150%)	**$17,265.53**
Fee Schedule Amount for 27692.50 ($11,510.35 x 150%)	**$17,265.53**
Fee Schedule Amount for 27393.50 ($7,039.55 x 150% x 50%)	**$5,279.66**
Total fee schedule amount allowed	**$39,836.69**
Take lesser of Balance or FS amt	**$37,227.55**
Plus carve-out paid @ 65% (65% x $39.95)	**+ $25.97**
	$37,253.52

Independent Diagnostic Testing Facilities

All fees from independently operated diagnostic testing facilities (e.g., freestanding MRI centers) will be subject to the Professional Services and HCPCS fee schedules.

Rehabilitation Hospital Services

- Per diem (a fixed amount paid for all services provided during the course of the day) for ONLY the following three hospitals:

  Marianjoy Rehabilitation Hospital
  26W171 Roosevelt Road
  Wheaton, IL 60187

  Schwab Rehabilitation Center - Anixter Center
  1401 S. California Ave.
  Chicago, IL 60608

  Rehabilitation Institute of Chicago
  345 E. Superior St.
  Chicago, IL 60611

Rehabilitation Hospital Services (cont.)

- Match the primary diagnosis code with a corresponding fee schedule amount. 2009 per diem amounts for each medical condition appear below.
- A list of ICD-9-CM diagnosis codes associated with each medical condition is available at http://www.iwcc.il.gov/ICD9.xls.
- Only issue to date: dialysis not normally part of service—how to pay? POC76

Geozip	ICD-9-CM Grouping	601	606
601	Amputation	POC76	POC76
601	Brain Injury	1,812.42	2,465.13
601	Burns	2,286.64	2,286.64
601	Congenital Deformities	2,144.57	2,269.31
601	Hip Fracture	1,511.60	2,039.42
601	Major Multiple Trauma	1,810.40	1,889.07
601	Neurological Disorders	1,723.71	2,272.56
601	Osteoarthritis	1,444.21	1,782.00
601	Rheumatoid Arthritis	1,800.59	1,800.59
601	Spinal Cord Injury	1,837.52	2,212.64
601	Stroke	1,664.89	2,193.54
601	Systemic Vasculidities	POC76	POC76
601	Joint Replacements	1,752.58	2,102.39
601	All Other	POC76	POC76

Questions from Attendees

Other Questions Submitted with Registrations

Does the fee schedule authorize denials based on utilization (e.g.," only 3 modalities per day per body part")?

FS only sets reimbursement levels per service unit. It does not address utilization of services: See Section 8.7 of the Act.

Other Questions Submitted with Registrations (cont.)

Why are hospitals and ASTCs paid differently for the same procedures in the same zip code?

ASTCs are paid roughly 80% of the hospital rate, based on the premise that services in an ASTC are less costly.

Other Questions Submitted with Registrations (cont.)

Can you negotiate medical costs?

Section 8.2(f) allows parties to contract for reimbursement levels different from the FS.

Other Questions Submitted with Registrations (cont.)

Is there anything I can do if we do not receive prompt medical payment?

Section 8.2(d) authorizes the medical provider to charge interest on unpaid amounts. Payments are due within 60 days of the date the payer receives substantially all the information needed to adjudicate a bill. Unpaid bills accrue interest of 1% per month. Proceed as you would with any other unpaid bill by submitting a statement for accrued interest as part of the overall bill.

Other Questions Submitted with Registrations (cont.)

Do all employers have to carry workers' compensation insurance?

Yes, with few exceptions. Almost everyone who is hired, injured, or whose employment is localized in Illinois is covered by Illinois law. Overall, it is estimated that 91% of Illinois employees are covered under the Act. For more info, see

http://www.iwcc.il.gov/insurance.htm

Other Questions Submitted with Registrations (cont.)

How are work hardening, work conditioning, and functional capacity evaluations covered under the fee schedule?

These services are normally covered under the Professional Services FS. If provided in a hospital , then the Hospital Outpatient FS applies.

Other Questions Submitted with Registrations (cont.)

Is there a better way to access and match a service with a fee?

Currently, the IWCC website is the only way that services and fees can be matched.

Other Questions Submitted with Registrations (cont.)

Is there a resource for calculating FS amounts?

The IWCC does not have a calculation worksheet.

Other Inquiries Submitted with Registrations (cont.)

How are disputes regarding whether or not a payment was correct resolved?

The only way to obtain a binding legal decision on a dispute is for the employer or employee to take the issue before an arbitrator. Providers and insurance companies do not have standing to file a hearing, so they need to work through the employer/ employee. The IWCC posts common questions at http://www.iwcc.il.gov/faqmed.htm