

RULES GOVERNING PRACTICE
BEFORE THE
ILLINOIS WORKERS' COMPENSATION COMMISSION

PART 7110 MISCELLANEOUS

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

PART 7110
MISCELLANEOUS

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EMERGENCY

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

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Section 7110.10 Vocational Rehabilitation

- a) The employer or his representative, in consultation with the injured employee and, if represented, with his or her representative, shall prepare a written assessment of the course of medical care, and, if appropriate, rehabilitation required to return the injured worker to employment when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which engaged at the time of injury, or when the period of total incapacity for work exceeds 120 continuous days, whichever first occurs.
- b) The assessment shall address the necessity for a plan or program which may include medical and vocational evaluation, modified or limited duty, and/or retraining, as necessary.
- c) At least every 4 months thereafter, provided the injured employee was and has remained totally incapacitated for work, or until the matter is terminated by order or award of the Commission or by written agreement of the parties approved by the Commission, the employer or his or her representative in consultation with the employee, and if represented, with his or her representative shall:
 - 1) if the most recent previous assessment concluded that no plan or program was then necessary, prepare a written review of the continued appropriateness of that conclusion; or
 - 2) if a plan or program had been developed, prepare a written review of the continued appropriateness of that plan or program, and make in writing any necessary modifications.
- d) A copy of each written assessment, plan or program, review and modification shall be provided to the employee and/or his or her representative at the time of preparation, and an additional copy shall be retained in the file of the employer and, if insured, in the file of the insurance carrier, to be made available for review by the Commission on its request until the matter is terminated by order or award of the Commission or by written agreement of the parties approved by the Commission.
- e) The rehabilitation plan shall be prepared on a form furnished by the Commission.

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

Section 7110.20 Petitions under Sections 19(h), 8(a), and 7(a) of the Act

Petitions filed under Section 19(h) of the Act, alleging change in disability, or Section 8(a), asking reimbursement of medical expenses, or Section 7(a), seeking modification of a death award, shall be docketed and assigned for hearing in the same manner as a petition for review, except that where practical the cause shall be assigned to the original hearing commissioner.

Section 7110.30 Commission Meetings: Minutes

The Commission shall keep a record of the minutes of all its duly convened meetings, exclusive of deliberations on cases pending before the Commission. The minutes shall be open to the public for inspection.

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

Section 7110.40 Petition to Suspend Compensation for Failure to Submit to Proper Medical Treatment

Petitions to suspend compensation, as provided in Section 19(d) of the Act, shall be docketed and set for hearing as soon as possible, except that, if an emergency is alleged in the petition, it shall immediately be set for hearing. All petitions shall give the nature of the injury and the treatment required. Reasonable notice of the time and place of hearing shall be served upon the injured party either personally or by registered mail.

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

Section 7110.50 Petitions under Section 19(o) of the Act

- a) A petition filed under Section 19(o) of the Act alleging that the insurer made payments in a case that was not compensable shall provide the following information:
 - 1) name and address of the employer;
 - 2) name and address of the employee;
 - 3) name and address of the insurance carrier;
 - 4) date of the alleged accident giving rise to the petition;
 - 5) benefits paid by the insurance carrier and the dates of the payment;
 - 6) whether Application for Adjustment of Claim was filed with the Commission and the Commission number assigned to the application;
 - 7) a brief statement of the basis for the insured's claim that the case was not compensable.
- b) Consideration of a Section 19(o) Petition
 - 1) The Commission, on receipt of the 19-o petition, shall docket the petition and forward a copy of the petition to the insurance carrier and the attorney of record, together with notice of a hearing date not less than 30 days nor more than 60 days from the date the petition is filed.

- 2) The insurance carrier may answer the 19-o petition by filing with the Commission and serving the employer with a copy of its answer within 30 days after receipt of the petition. The answer shall bear the same heading as the 19-o petition and shall respond to the allegations on a paragraph-by-paragraph basis.
- 3) The 19-o matter shall, on the hearing date, be assigned to an Arbitrator in the same manner as an arbitrated case. The Arbitrator shall then hold an informal hearing with the employer and the insurance company in an attempt to resolve the dispute or narrow the issues. If the dispute cannot be resolved at the informal hearing, the Arbitrator shall file a written statement of the issues to be resolved by a Commissioner and the positions of each party. If possible, the statement should be agreed to by each party. The matter will then be assigned for hearing before a Commissioner in the same manner as reviews are assigned.

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

Section 7110.60 Distribution of Industrial Commission Handbook

An employer, upon receiving notice of an accident reportable pursuant to Section 6(b) of the Act, shall deliver the Commission Handbook to the injured employee, or determine that the employee has the handbook. An employer, individually or by his or her agent, service company or insurance carrier shall indicate, upon filing a first report of injury as provided in Section 6(b) of the Act, that a copy of the handbook has been delivered to the injured employee.

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

Section 7110.70 Explanation of Basis of Non-Payment, Termination or Suspension of Temporary Total Compensation or Denial of Liability or Further Responsibility for Medical Care

- a) When an employee becomes unable to work due to an accidental or occupational disease arising out of or in the course of his or her employment, or alleges that he or she is unable to work, the employer, individually or by his or her agent, service company or insurance carrier, shall, within 14 calendar days after notification or knowledge of such inability or alleged inability to work:
 - 1) begin payment of temporary total compensation, if any is then due; or
 - 2) if the employer denies liability for payment of temporary total compensation for whatever reason, provide the employee with a written explanation of the basis for the denial; or
 - 3) if the employer has insufficient information to determine its liability for payment of temporary total compensation, advise the employee in writing of the information needed to make that determination and provide in a written explanation why the requested information is necessary.
- b) When an employer begins payment of temporary total compensation and later terminates or suspends further payment before an employee in fact has returned to work, the employer shall provide the

employee with a written explanation of the basis for the termination or suspension of further payment no later than the date of the last payment of temporary total compensation.

- c) When an employer takes the position that it has insufficient medical information to determine its liability for the initial payment of temporary total compensation, or the continuation of such payment, the employer shall have the initial responsibility to promptly seek the desired information from those providers of medical, hospital and surgical services of which the employer has knowledge. The employee shall have the responsibility to provide or execute authorizations for release of medical information as the employer may reasonably request from time to time, and the employer shall promptly provide the employee or his or her representative, upon request, with copies of the complete medical records and reports it obtains with the authorizations.
- d) When an employer denies liability for payment of the cost of all or a part of an employee's medical care, or initially accepts liability but subsequently declines further responsibility for providing or paying for all or a part of such care (for any reason including but not limited to the necessity or propriety of the care, or continuing care, or the unreasonableness of the cost of care), the employer shall promptly notify the employee with a written explanation of the basis for the denial of liability or further responsibility.
- e) Failure by either party to comply with the provisions of subsection (a), (b), (c) or (d) of this Section, without good and just cause, shall be considered by the Commission or an Arbitrator when adjudicating a petition for additional compensation pursuant to Section 19(l) of the Act, or a petition for assessment of attorneys' fees and costs pursuant to Section 16 of the Act.

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

Section 7110.80 Rate Adjustment Fund and Second Injury Fund Contributions: Compliance

a) Employers Required to Make Payments to Rate Adjustment Fund and Second Injury Fund

Any employer who shall come within the provisions of Section 3 of the Act or any employer who shall elect to provide and pay the compensation provided for in the Act and the Workers' Occupational Diseases Act [820 ILCS 310] shall pay into the Rate Adjustment Fund and the Second Injury Fund in accordance with the provisions of Section 7(f) of the Act.

b) Penalties

- 1) *If the Commission finds, after reasonable notice and hearing in accordance with subsection (e), that an employer or insurance carrier on behalf of the employer has wilfully and knowingly failed to pay any obligations accruing after December 18, 1989 into the Rate Adjustment Fund or the Second Injury Fund as required by Section 7(f) of the Act or if such payments are not made within the time periods prescribed by Section 7(f) of the Act, the employer shall, in addition to such payments, pay a penalty of 20% of the amount required to be paid or \$2,500, whichever is greater, for each year or part thereof of such failure to pay. (Section 7(f) of the Act)*

- 2) Obligations accruing prior to December 18, 1989:
 - A) *Any obligations of an employer or insurance carrier to the Rate Adjustment Fund or the Second Injury Fund accruing prior to December 18, 1989 shall be paid in full by such employer within 5 years of December 18, 1989, with at least one-fifth of such obligation to be paid during each year following December 18, 1989. (Section 7(f) of the Act)*
 - i) Such obligations shall be paid pursuant to an agreement signed by the employer or by the insurance carrier on behalf of the insured employer.
 - ii) The agreement shall include the amount of the obligation and the date each payment is due.
 - B) *If the Commission finds, after reasonable notice and hearing in accordance with subsection (e), that an employer or insurance carrier has failed to make timely payments of any obligation accruing in subsection (b)(2)(A), the employer shall, in addition to all other payments required, be liable for a penalty equal to 20% of the overdue obligation or \$2,500, whichever is greater, for each year or part thereof, that the obligation is overdue. (Section 7(f) of the Act)*
 - 3) *The Commission may for good cause shown waive all or part of any penalty assessed. The decisions of the Commission under Section 7(f) of the Act shall serve as precedents in determining good cause.*
- c) Verification of amounts paid by employers into the Rate Adjustment Fund and Second Injury Fund.
- 1) *The Chairman shall by May 1 of each year furnish to the Director of the Illinois Department of Insurance a list of the amounts paid into the Second Injury Fund and the Rate Adjustment Fund by each insurance company on behalf of their insured employers. The Director shall verify to the Chairman on or before September 1 of each year that the amounts paid by each insurance company are accurate as best the Director can determine from the records available to the Director.*
 - 2) *The Chairman shall verify that the amounts paid by each self-insurer are accurate as best as the Chairman can determine from records available to the Chairman. (Section 7(f) of the Act) The Chairman may, upon written notice, require that each self-insurer provide the following:*
 - A) *Information on forms provided by the Commission concerning the total compensation payments made upon which contributions to the Rate Adjustment Fund and Second Injury Fund are predicated, and*
 - B) *Any additional information establishing that payments have been made into the Rate Adjustment Fund and the Second Injury Fund. (Section 7(f) of the Act) Such additional information shall include, but not be limited to, cancelled checks or other proof of payment.*
 - 3) Any information requested under subsection (c)(2) shall be provided to the Commission by the self-insurer within 30 days after the date of the notice.
- d) Notice of Deficiency -- Informal Conference

1) Notice of Deficiency

- A) When the records of the Commission or the Department of Insurance show that a deficiency exists regarding payment into the Rate Adjustment Fund or the Second Injury Fund, the Commission shall give notice of the deficiency to the insurance carrier or the self-insured employer. Service of the Notice of Deficiency shall be by United States registered or certified mail, addressed to the insurance company or the self-insured employer at the last known address, or to a representative thereof, and to the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund.
- B) The Notice of Deficiency shall be a written statement setting forth, but not limited to, the following information:
 - i) the name and address of the insurance carrier, or the self-insured employer or representative;
 - ii) a statement of the statute alleged to be violated, the dates of non-payment or underpayment, the amount of deficiency and the penalty that may be imposed;
 - iii) a statement that the self-insured employer or insurance carrier must cure the deficiency or otherwise respond in writing within 30 days after the receipt of the Notice;
 - iv) a statement that the failure to respond to a Notice of Deficiency within the prescribed time period shall cause the Commission to set the matter for hearing in accordance with subsection (e).

2) Informal Conference

- A) When a Notice of Deficiency has been sent, the Commission may, at the request of the self-insured employer or insurance carrier, or on its own initiative, schedule the matter for an informal conference at which a designated representative of the Commission shall meet with the self-insured employer or the insurance carrier in an attempt to resolve the matter. An informal conference will not be scheduled when the self-insured employer or the insurance carrier cures the deficiency within 30 days of receipt after the Notice of Deficiency.
- B) A request by the self-insured employer or the insurance carrier for an informal conference shall be included in the response to the Notice of Deficiency.
- C) The Commission shall send written notice of the time and place of the conference to the self-insured employer or the insurance carrier and State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund at least 15 days prior to the scheduled conference.
- D) The conference shall be held at a site designated by the Commission.
- E) If the matter cannot be resolved at the conference, the Commission shall set the matter for hearing in accordance with subsection (e).

e) Hearings

1) Notice of Hearing; Locations

- A) Any matter under this Section is commenced by the Commission by service of a Notice of Hearing upon the insurance carrier or self-insured employer, and the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund. Notice of Hearing shall be given at least 30 days prior to the time fixed for hearing. Service of the

Notice of Hearing shall be by United States registered or certified mail, addressed to the insurance carrier or the self-insured employer at the last known address, or to a representative thereof, and to the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund.

- B) The Notice of Hearing shall be a written statement setting forth, but not limited to, the following information:
 - i) the name and address of the insurance carrier or self-insured employer;
 - ii) the time, date and place of hearing;
 - iii) the name of the hearing Commissioner;
 - iv) a statement of the statute alleged to be violated and the penalty that may be imposed;
 - v) a statement of the amount of the deficiency and the dates of non-payment or underpayment;
 - vi) a statement that failure to appear at the hearing, where no continuance has been obtained from the Commissioner prior to the hearing, shall constitute a default and will result in a finding that there has been a wilful and knowing failure to comply with Section 7(f) of the Act, and an assessment of penalties.
 - C) The hearing shall be set at a site designated by the assigned Commissioner.
- 2) Assignment
- A) In cases in which the employer is principally located in Cook County, a matter to be scheduled for hearing under this Section shall be randomly assigned to a Commissioner.
 - B) In all other cases, a matter to be scheduled for hearing under this Section shall be assigned to a Commissioner who serves the territory within which the employer is principally located.
- 3) Conduct of Hearings
- A) A representative of the Commission shall have the opportunity to introduce evidence, to call and examine witnesses and to cross-examine witnesses. The records of the Commission and the Department of Insurance regarding deficiency in payment shall be considered prima facie evidence of failure to comply with Section 7(f) of the Act.
 - B) At the hearing, the insurance carrier or self-insured employer, or its attorney, shall be given the opportunity to rebut the evidence of deficiency.
 - C) Any party, including the State Treasurer as ex-officio Custodian of the Rate Adjustment Fund and the Second Injury Fund, shall have the right to introduce evidence, to call and examine witnesses and to cross-examine witnesses. The representative of the Commission shall have the right of rebuttal.
 - D) *The Commission, or any member thereof, shall have the power to administer oaths, to subpoena and examine witnesses and to issue subpoena duces tecum requiring the production of such books, papers, records or documents as may be evidence to determine the issue of non-compliance. (Section 16 of the Act)*
 - E) The Illinois common law rules of evidence and Article VIII of the Code of Civil Procedure [735 ILCS 5/Art. VIII] shall apply at the hearing except to the extent they conflict with the Act, the Workers' Occupational Diseases Act and the Rules Governing Practice Before the Illinois Workers' Compensation Commission (50 Ill. Adm. Code Ch. II).

f) Decision

The Commission, after the hearing is concluded, shall issue a decision in accordance with Section 7(f) of the Act, which shall include:

- 1) the findings of the Commission;
- 2) where applicable, the amount of the penalty assessed and the basis for the amount;
- 3) the payment procedures as provided in subsection (g);
- 4) a statement of the conditions for a judicial review of the Commission decision in accordance with the requirement of 50 Ill. Adm. Code 7060.

g) Payment Procedure

When the Commission assesses a penalty against an employer in accordance with Section 7(f) of the Act, payment shall be made according to the following procedure:

- 1) payment of the penalty shall be made by certified check or money order made payable to the State of Illinois.
- 2) payment shall be mailed or presented within 30 days after the final order of the Commission or the order of the court on review after final adjudication to:

Illinois Workers' Compensation Commission
Fiscal Office
100 West Randolph Street
Suite 8-328
Chicago, Illinois 60601
312/814-6625

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

**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 for hospital or facility-based billing) are to be 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 (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), 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 revenue codes identified in subsection (e) above shall be 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)
 - 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 (AAHC)

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. Charges for non-implantable items billed under the revenue codes identified in subsection (e) above shall be 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) $\text{Base Value} + \text{Time Units} + \text{Modifying Units} = \text{Total Units}$
 $\text{Total Units} \times \text{Conversion Factor} = \text{Total Fee}$
 - 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
- 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. Charges for non-implantable items billed under the revenue codes identified in subsection (e) above shall be 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 shall be 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. Charges for non-implantable items billed under the revenue codes identified in subsection (e) above shall be 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. Charges for non-implantable items billed under the revenue codes identified in subsection (e) above shall be reimbursed at 65% of 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 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: Amended at 33 Ill. Reg. 2850, effective February 1, 2009)

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