3. OTHER LABORATORY AND X-RAY SERVICES

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

4a. SKILLED NURSING FACILITIES (OTHER THAN SERVICES IN AN INSTITUTION FOR MENTAL DISEASES) FOR INDIVIDUALS 21 YEARS OF AGE OR OLDER

A preadmission screening assessment is required.

4b. EARLY AND PERIODIC SCREENING AND DIAGNOSIS TREATMENT SERVICES

Clients shall be referred for dental screenings beginning at age 2 if the client is not in the continuing care of an enrolled dental provider.

All medically necessary diagnosis and treatment services will be furnished to EPSDT (Healthy Kids) clients to treat conditions detected by periodic and inter-periodic screening services even if the services are not included in the State Plan.

In addition to services provided under this State Plan, covered Medicaid (Section 1905(a) of the *Social Security Act*) services for individuals under age 21 include: case management, personal care services, Christian Science nurse and respiratory care services.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments, including organ transplants which are "medically necessary", to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

5.a. PHYSICIANS' SERVICES

Covered services, when performed by fully licensed residents, are limited according to the following conditions:

- that the resident provides services within a Family Practice Residency Program approved by the Department and accredited by the LCGME (Liaison Committee on Graduate Medical Education).
- that the resident provides services within a Family Practice Residency Program recognized by Medicare as either a Free Standing Program or a Provider Based Program.
- that, in those instances where the resident provides services within a Provider Based Family Practice Residency Program, such services will be covered only through a related provider (hospital).

01/93 In order for a physician's services to be covered for children under age 21, the physician must:

1) Be certified in pediatrics or family practice by the medical specialty board recognized by the American Board of Medical Specialties; or
2) Be employed by or affiliated with a federally qualified health center; or
3) Have admitting privileges at a hospital; or
4) Be a member of the National Health Service Corps; or
5) Document a current, formal consultation and referral arrangement with a pediatrician or family practitioner who has the certification described in 1) for the purpose of specialized treatment and admission to a hospital; or

7. HOME HEALTH SERVICES

a. b and c.

04/09 Home health services include the following required services provided in compliance with the federal regulations at 42 CFR 440.70:

1) Nursing services provided on a part-time or intermittent basis by a home health agency; or, in the absence of such an agency, a registered nurse.

2) Home health aide services provided by a home health agency.

3) Medical supplies, equipment, and appliances suitable for use in the home.

Services are provided on a short-term, intermittent basis. Services must be provided only on direct order of a physician, and require prior approval unless the client is eligible for these benefits under Medicare.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under age 21.

d.

04/09 Physical therapy, occupational therapy, and speech pathology are provided as optional home health services. Therapists providing these services must meet the provider qualifications at 42 CFR 440.110.

Services available only when provided by a Home Health Agency, or by a registered nurse when no home health agency exists in the area. Services require a direct order of a physician, and prior approval unless the client is eligible for these benefits under Medicare.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under age 21.

5. OVER-THE-COUNTER DRUGS: Lesser of the usual and customary charge to the general public or the Wholesale cost plus up to 50 percent.

04-09 6. OTHER LABORATORY AND X-RAY SERVICES: Lesser of the usual and customary charge to the general public or statewide maximums established by the Department not to exceed the upper limits specified in federal regulations. Reimbursement is based upon the applicable modifier billed by the provider, and will be either for the technical component, the professional component or a global amount.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Other Laboratory and X-ray services. The agency's fee schedule rate was set as of February 1, 2010, and is effective for services provided on or after that date. All rates are published on the Department's website in Practitioner Fee Schedule located at www.hfs.illinois.gov/feeschedule/.

04-09 7. PHYSICIAN's SERVICES: Reimbursement for physician services are at the physician's usual and customary charges, not to exceed the maximum established by the Department. Initially, maximum fee-for-service rates were established in 1978 when the Department reviewed the average charges for each of the allowable services. The Department agreed to set the statewide maximum amount at 70 percent of the average charge by physician. Annually the Department analyzes cost information and procedure code utilization of physician bills presented for Medicaid reimbursement of services rendered. The rate maximums are periodically adjusted based upon the above factors.

04-09 Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician services. The agency's fee schedule rate was set as of February 1, 2010, and is effective for services provided on or after that date. All rates are published on the Department's website in the Practitioner Fee Schedule located at www.hfs.illinois.gov/feeschedule/.

Providers, including practitioners working under the supervision of the physician and billing under the physician's name and provider number, statewide who meet the participation requirements for the Maternal and Child Health Program receive enhanced reimbursement rates for services provided to pregnant women and children through age 20 who are participants in the MCH Program. The enhanced rates, which are detailed on the practitioner fee schedule and paid in combination with the maximum fee-for-service rates, include:

- payment for performing a prenatal risk assessment ($15);
- payment for performing risk assessments on children ($15);
- increased reimbursement for deliveries ($400 additional);
- a $10 increase in the EPSDT screening rate; and
- an 8 percent increase in the reimbursement rate for office visits for children.

04-09 The rate for all physician services provided on or after July 1, 2002, shall be the rate in effect June 30, 2002, less 2.6 percent.

04-09 Physicians employed by government-operated entities other than hospitals, long term care facilities, and cost-reporting clinics.

For services provided by salaried physicians employed by a government-operated entity that is not a hospital, long term care facility, or cost-reporting clinic, the State or local government

agency operating that entity may elect to enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to physician services provided by the entity and the funding thereof, including

04/09 supplemental payments to universities for certain physician services. This methodology also applies to podiatric services in item 10 and chiropractic services in item 11.

a. Effective April 1, 2009, supplemental payments are available for services, eligible under Title XIX of the *Social Security Act*, that are provided by physicians who are employed by either the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Chicago, the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Rockford, the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Peoria, or the SIU Physicians and Surgeons, Inc at the Southern Illinois University School of Medicine at Springfield.

   i. Physician services eligible for supplemental payments shall include:

      A. services provided by an Advanced Practice Nurse (APN) or Physician's Assistant (PA) when billed under the collaborating physician's name and provider ID, and

      B. services provided by interns and residents when billed under the teaching physician's name and provider ID.

   ii. Physician services eligible for supplemental payments shall not include services provided by contracting physicians nor any other non physician not specified in the state plan.

   iii. Such supplemental payments will be made on a quarterly basis as described below.

b. Definitions

   i. Average Commercial Fee Schedule means, the average commercial fee schedule paid to the university for practitioner services, including patient share amounts, for each CPT code. This average shall be based on the participating university's payments from the five largest private insurance carriers for the CPT services.

ii. Base Period means State Fiscal Year 2008 (July 1, 2007-June 30, 2008) for the initial calculation of the supplemental payments. The Base Period will be updated in accordance with subsection d. below

iii. Base Period Average Commercial Payment Ceiling means the following computation:
   A. Multiplying the Average Commercial Fee Schedule by the number of paid claims provided in the based period and paid to the university for clients eligible under Titles XIX of the Social Security Act.
   B. Summing the products for all procedure codes as described in subsection b.iii.A. above.

iv. Base Period Medicare Equivalent Payment Ceiling means the following computation:
   A. Multiplying the Medicare allowed rate as reported in the April release of the Resource Based Relative Value Scale (RBRVS) for the Medicare Part B non facility rate, by the number of paid claims provided in the based period and paid to the university for clients eligible under Title XIX of the Social Security Act.
   B. Summing the products for all procedure codes as described in subsection b.iv.A. above.

v. Base Period Medicare Equivalent of the Average Commercial Rate, means the Base Period Average Commercial Payment Ceiling divided by the Base Period Medicare Equivalent Payment Ceiling.

c. The supplemental payments shall be determined as follows:

i. The Medicare Equivalent of the Average Commercial Rate for a physician service will be determined by multiplying the Base Period Medicare Equivalent of the Average Commercial Rate by the Medicare payment at the non-facility rate per CPT Code for the current period. Rates for clinical diagnostic laboratory services will be capped at the Medicare Upper Payment Limit (UPL) amount as defined in 1903(i)(7) of the Social Security Act.

ii. The rates determined in subsection c.i. are multiplied by the number of claims for the current period, as reported through the Medicaid Management Information System, to determine the current period supplemental payment ceiling.

iii. The supplemental payment to the university shall equal the current period payment ceiling at the Medicare Equivalent of the Average Commercial Rate less all payments otherwise made by the department for the same services, for procedure codes rendered in the current period and paid to the university. These supplemental payments shall be based on all available payments and adjustments on file with the department at the time the payment amount is determined.

d. Periodic Updates to the Base Period Medicare Equivalent of the Average Commercial Rate: The department shall update this ratio at least every three years, with the first update to be effective on July 1, 2012.

8. DENTAL SERVICES: Reimbursement will be made for eligible recipients at the lesser of the usual and customary charge to the general public or statewide maximums established by the Department. The usual and customary charges are verified through post-payment audits. During these audits, private pay records are reviewed to determine the amount billed for similar procedures. If it is discovered that private pay individuals are charged less than the Medicaid population, recoupment action is taken.

04/09 Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Dental services. The agency's fee schedule rate was set as of July 1, 2009, and is effective for services provided on or after that date. All rates are published on the Department's website within the Dental Office Reference Manual located at www.hfs.illinois.gov/reimbursement/dental.html.

04/09 9. EYEGLASSES: Same as 6. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Eyeglasses. The agency's fee schedule rate was set as of February 1, 2009, and is effective for services provided on or after that date. All rates are published on the Department's website in the Optometric Fee Schedule located at www.hfs.illinois.gov/reimbursement/.

04/09 10. PODIATRIC SERVICES: Same as 6. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Podiatric services. The agency's fee schedule rate was set as of February 1, 2010, and is effective for services provided on or after that date. All rates are published on the Department's website in the Podiatrist Procedure Code located at www.hfs.illinois.gov/reimbursement/.

For Illinois public universities, supplemental payments are available for services provided by podiatrists employed by the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Chicago. The payments will be determined using the methodology detailed in section 7. of this attachment, as it applies to podiatric services.

04/09 11. CHIROPRACTIC SERVICES: Same as 6. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Chiropractic services. The agency's fee schedule rate was set as of January 1, 2010, and is effective for services provided on or after that date. All rates are published on the Department's website in the Chiropractor fee schedule located at www.hfs.illinois.gov/reimbursement/.

For Illinois public universities, supplemental payments are available for services provided by chiropractors employed by the Medical Practice Plan – Physicians at the University of Illinois College of Medicine at Chicago. The payments will be determined using the methodology detailed in section 7. of this attachment, as it applies to chiropractic services.

12. HOME HEALTH CARE SERVICES: Home Health Care Services rates are based on the following:

a) Effective for services on or after July 1, 2002, home health providers shall be paid an all inclusive, per visit rate which shall be the lowest of:

1) the provider's usual and customary charge to the general public for the service. The usual and customary charges are verified through post-payment audits. During these audits, private pay records are reviewed to determine the amount billed for similar procedures. If it is discovered that private pay individuals are charged less than the Medicaid population, recoupment action is taken;

2) the provider's Medicare rate; or

04/09 3) the Department's allowable rate of $61.34.

b) The rate methodology is uniform for governmental and private providers.