**Section 140.400 Payment to Practitioners**

a) This Section applies to physicians, dentists, Advanced Practice Registered Nurses (APRN) (see Section 140.435), optometrists, podiatrists, chiropractors, Licensed Clinical Psychologists (LCP) (see Section 140.423) and Licensed Clinical Social Workers (LCSW) (see Section 140.424).

1) Practitioners are required to bill the Medical Assistance Program at the same rate they charge patients paying their own bills and patients covered by other third party payers.

2) A practitioner may bill only for services the practitioner personally provides or that are provided, under the practitioner's supervision, or by the practitioner's staff, except as provided in subsection (f). An APRN, as described in Section 140.435, LCP, as described in Section 140.423, or LCSW, as described in Section 140.424, may bill only for the services the practitioner personally provided.

3) Payment will be made only in the practitioner's name or a Department approved alternate payee.

4) Except as described otherwise in this Section, payments will be made according to a schedule of statewide pricing screens established by the Department, except that LCP and LCSW will be reimbursed for covered services at 75% of the physician reimbursement rate. Covered services provided by qualifying providers under the Maternal and Child Health Program will be reimbursed at enhanced rates as described in subsection (b). The pricing screens are to be established based on consideration of the market value of the service. In considering the market value, the Department will examine the costs of operations and material. Input from advisory groups designated by statute, generally recognized provider interest groups and the general public will be taken into consideration in determining the allocation of available funds to rate adjustments. Increases in rates are contingent upon funds appropriated by the General Assembly. Reductions or increases may be affected by changes in the market place or changes in funding available for the Medical Assistance Program. Screens will be related to the average statewide charge. Except as described otherwise in this Section, the upper limit for services shall not exceed the lowest Medicare charge levels.

b) Practitioners who meet the qualifications for and enter into a Primary Care Provider Agreement for participation in the Maternal and Child Health Program, as described in Subpart G, will receive enhanced reimbursement in accordance with Section 140.930(a)(1).

c) For services rendered on or after June 1, 2013, a practitioner (radiologist) that meets the qualifications for and participates in the Department's Breast Cancer Quality Screening and Treatment Initiative shall be paid for mammography services at the effective Chicago Metropolitan Area Medicare Level established rate (Established Rate). To qualify for this Established Rate, a practitioner shall:

1) Enter into a Supplemental Provider Agreement with the Department; and

2) Provide mammography services to participants in the Department's Medical Programs with the same timeliness as the practitioner provides to patients with other forms of insurance;

3) Within 30 days after submitting the Supplemental Provider Agreement, and annually thereafter on or before August 31, submit a completed radiologist survey, using the Department's survey form; and

4) Assist the Department with the development and implementation of improved quality standards and services.

d) The Department will distribute (initially and upon revision of the amounts) to practitioners the maximum allowable amounts for the most commonly billed procedures codes. Interested individuals may request a copy of the maximum allowable amounts from the Department by directing the request to the Bureau of Professional and Ancillary Services, Prescott E. Bloom Building, 201 South Grand Avenue East, Springfield, Illinois 62763-0001. In addition, a participating individual practitioner may request the maximum allowable amounts for less commonly billed specific procedures that relate to the individual's practice. This request must be in writing and identify specific procedure codes and associated descriptions.

e) Supplemental payments to universities for certain practitioner services

1) Supplemental payments are available for services that are provided by practitioners who are employed by an Illinois public university and are providing services eligible for payment under Titles XIX and XXI of the Social Security Act.

A) For dates of service on or after September 1, 2020, supplemental payment will be made on a quarterly basis as described in this subsection (e).

B) Supplemental payments under this subsection (e) are subject to federal approval.

C) Supplemental payments shall be funded through cooperative agreements between the Department and the State university.

2) Definitions

A) "Average Commercial Rate" means the average contractually defined payment amount 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 CPT services.

B) "Average Commercial Payment Ceiling" means the following computation:

i) Multiplying the Average Commercial Rate by the number of paid claims provided in a quarter and paid to the university for clients eligible under Titles XIX and XXI of the Social Security Act.

ii) Summing the products for all procedure codes as described in subsection (e)(2)(B)(i).

3) The supplemental payments shall be determined as follows:

A) 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.

B) The sum of payments made for each qualifying CPT service shall not exceed the Average Commercial Rate Ceiling.

4) Periodic Updates to the Base Period Medicare Equivalent of the Average Commercial Rate: The Department shall update the Average Commercial Rate annually, using the most recent data available.

f) The Department will make payment to a provider for services provided by a substitute physician when the substitute physician is performing the duties of a qualified attending physician, and all of the following conditions are met:

1) The attending physician is ill, on vacation, or otherwise unavailable because of an emergency situation;

2) The substitute physician is a Doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a license to practice medicine in all its branches;

3) The substitute practitioner is not terminated, suspended, barred or otherwise excluded from participation or has not voluntarily withdrawn from the Medical Assistance Program as part of a settlement agreement; and

4) The substitution does not exceed 14 days for a single incident and up to a maximum of 90 days per year for the attending physician. If the substitute period extends beyond the 14 days per single incident, the substitute physician must enroll with the Department.

(Source: Amended at 47 Ill. Reg. 16385, effective November 3, 2023)