



**Rod R. Blagojevich, Governor**  
**Barry S. Maram, Director**

## **Illinois Department of Public Aid**

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Springfield, Illinois 62763-0001

**Telephone:** (217) 782-5565  
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March 10, 2004

### **INFORMATIONAL NOTICE**

**TO:** Enrolled Hospitals: Chief Executive Officers, Chief Financial Officers, Patient Accounts Managers, and Health Information Management Directors; and Ambulatory Surgical Treatment Centers (ASTCs)

**RE:** Update to Expensive Drugs or Devices Provided in an Outpatient Setting

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Since November 1, 1999, a hospital or ASTC has been eligible for additional payment termed an "outlier payment" for specified expensive drugs and devices provided in conjunction with a procedure from the Ambulatory Procedures Listing (APL). The purpose of this notice is to communicate changes regarding the expensive drugs and devices listing.

- The department is eliminating local code usage for HIPAA compliance, effective for dates of service on and after April 1, 2004. The "W" codes (W7274 and W7275) used to denote pacemakers and cardioverters/defibrillators will be eliminated. These device codes will be replaced by HCPCS codes effective for dates of service on and after April 1, 2004. Prior approval is not required for pacemakers and cardioverters/defibrillators.
- The prior approval requirement for the injectable drug Remicade (J3490) has been removed effective with dates of service on and after January 1, 2004.
- Device code E0751 is obsolete and has been replaced with device code E0756, effective with dates of service on and after April 1, 2004.
- Device code E0786 for a replacement of an implantable programmable infusion pump has been added effective for dates of service on and after April 1, 2004.

The department has updated the list of drugs and devices eligible for an outlier payment. The drugs and devices along with the ICD-9-CM APL codes are identified in a table on the department's Web site at <<http://www.dpaininois.com/reimbursement/>>. The table also identifies the drugs and devices that require prior approval.

Instructions regarding the prior approval and billing process for the outlier payment are attached to this notice. The prior approval and billing requirements have not changed, but the instructions have been updated to include information regarding electronic transactions.

Medicare/Medicaid outpatient crossover claims are not eligible for an outlier payment. The reimbursement level for the **procedure** will remain at the amount assigned to the highest payable APL procedure billed.

Following conversion of the APL from ICD-9-CM codes to HCPCS codes, additional information regarding the expensive drugs and devices listing will be distributed. Any questions regarding this notice may be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

Anne Marie Murphy, Ph.D.  
Administrator  
Division of Medical Programs

## **PRIOR APPROVAL AND BILLING PROCESS FOR EXPENSIVE DRUGS AND DEVICES**

For a hospital or ASTC to be eligible for an outlier payment, the drug or device:

- Must be medically necessary for the patient; and
- May be subject to prior approval by the department.

For drugs and devices requiring prior approval, requests for prior approval must be submitted on form DPA 1409, Prior Approval Request, or via the 278 Health Care Services Review – Request for Review and Response, when that electronic transaction becomes available. The request must include an explanation of the medical necessity (see below for additional required attachments to the prior approval request). No telephone requests for prior approval will be accepted. Refer to the Handbook for Physicians for instructions for the completion of form DPA 1409, or Chapter 300, Topic 308 regarding the 278 that is available on the Web site at <http://www.dpainline.com/handbooks>.

### **ATTACHMENTS TO THE PRIOR APPROVAL**

The prior approval request for drugs must include:

- The patient's clinical history, with the diagnosis and previous drugs used for the treatment of this condition; and
- The prescribing practitioner's name, address and telephone number.

The prior approval request for devices must include:

- The patient's clinical history with a narrative history and physical, which must include the patient's diagnosis;
- A copy of the invoice for the device, with the manufacturer's name, model number, and wholesale price, and
- The prescribing practitioner's name address and telephone number.

### **SUBMISSION OF PAPER PRIOR APPROVAL REQUESTS**

The DPA 1409 requests for prior authorization for drugs and devices should be directed to:

Illinois Department of Public Aid  
Attn: Prior Approval Unit  
P.O. Box 19124  
Springfield, Illinois 62763  
Fax 217-524-0099

The provider will receive notification of the department's decision regarding approval of the drug or device. An approved service, or the first treatment in a series of approved treatments, must be rendered within 30 days from the date of approval by the department. Requests for post approval will be accepted for consideration by the department, but approval is not guaranteed.

## **BILLING PROCEDURES**

The drug or device must be billed along with the appropriate APL procedure using the institutional claim format as follows:

- The provider should bill the APL procedure codes(s) and all diagnosis and procedure codes for that patient for that date of service.
- For devices, use revenue code 279 (Other supplies and devices); for pacemakers use revenue code 275 (Pacemakers).
- For drugs, use revenue code 636 (Drugs requiring detailed coding).

The HCPCS code for the drug or device must be reported in HCPCS/Rates (FL 44) of the paper UB-92 across from the appropriate revenue code (see above) or in Loop ID 2400 of the 837I electronic claim format, when that claim format becomes available.

## **CALCULATION OF THE OUTLIER PAYMENT**

The outlier payment worksheet that follows can be used to calculate the amount of the additional payment. Each cost reporting hospital has its cost to charge ratio that should be inserted in line 5. The cost to charge ratio for all other facilities is 0.50.

## OUTPATIENT COST OUTLIER

- Line 1 Obtain the drug or device from the approved list. \_\_\_\_\_  
If the drug or device is not on the approved list,  
then STOP. The claim is not subject to the  
outpatient cost outlier methodology.
- Line 2 Enter the total charges (FL 47) from the claim. \_\_\_\_\_
- Line 3 Enter the noncovered charges (FL 48) from the claim. \_\_\_\_\_
- Line 4 Net Charges (line 2 minus line 3) \_\_\_\_\_
- Line 5 Enter your hospital's cost to charge ratio. Each cost  
reporting hospital received its cost to charge  
ratio that should be used. The cost to charge  
ratio for all other facilities is 0.50. \_\_\_\_\_
- Line 6 Net covered cost is line 4 times line 5. \_\_\_\_\_
- Line 7 Enter and multiply by 4 the APL rate for the  
highest payable procedure being billed. \_\_\_\_\_
- Line 8 Gross outlier is line 6 minus line 7. If the result  
is less than or equal to zero, then stop. The claim is  
not subject to reimbursement for cost outlier.  
Go to line 10 and enter zero. \_\_\_\_\_
- Line 9 Marginal cost factor is 0.80. \_\_\_\_\_.80  
This factor is used for all providers.
- Line 10 Cost outlier adjustments is line 8 times line 9. \_\_\_\_\_
- Line 11 Enter the reimbursement rate for the highest  
payable APL procedure being billed. \_\_\_\_\_
- Line 12 Total payment line 10 plus line 11. \_\_\_\_\_