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SUBJECT Medical Assistance Program Fee Schedule Revisions		BY  Michael Nardone, Deputy Secretary Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to announce changes to the Medical Assistance (MA) Program Fee Schedule. These changes are effective for dates of service on and after March 1, 2010.

SCOPE:

This bulletin applies to all MA enrolled providers who render services to recipients in the MA Fee-for-Service delivery system, including ACCESS Plus. Providers rendering services to recipients in the MA managed care delivery system should address any coding or billing questions to the appropriate managed care organization.

BACKGROUND:

The Department of Public Welfare (Department) is making updates to the MA Program Fee Schedule in response to requests received from providers and clinical reviews conducted by Department staff related to standards of practice, provider type/specialties, places of service and procedure code/modifier combinations.

DISCUSSION:

Procedure Code and Procedure Code/Modifier End-Dates and Additions

The Department is end-dating the following radiological procedure codes because the radiopharmaceutical administration costs are included in the technical component fee for service:

Procedure Codes		
79005	79101	79445

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The Appropriate Toll-Free Number for Your Provider Type

Visit the Office of Medical Assistance Programs Web site at www.dpw.state.pa.us/PartnersProviders

The Department is end-dating the following diagnostic procedure codes because they are experimental procedures. MA regulations at 55 Pa.Code § 1141.59 (relating to noncompensable services) set forth that payments will not be made for experimental procedures:

Procedure Codes	
95060	95065

The Department is end-dating the following computerized 3-D rendering procedure codes because the costs for these services are included in the technical component fee for the radiology service:

Procedure Codes	
76376	76377

The Department is end-dating the following procedure code for overnight oxygen saturation monitoring because the procedure is integral to the service being provided or included in the support component fee and should not be billed separately:

Procedure Code
94762

The following radiological and diagnostic procedure codes will have the total component (no modifier) end-dated since the technical component fee for the service is included in the Diagnosis Related Group (DRG), Hospital Short Procedure Unit (SPU), the Ambulatory Surgical Center (ASC), or Special Treatment Room (STR) support component payment:

Procedure Codes		
76001	93640	93641

The following radiological procedure code will have the technical component (TC modifier) end-dated since the technical component fee for the service is included in the DRG, ASC/SPU or STR support component payment:

Procedure Codes
76001

The following surgical and diagnostic procedure codes will have provider type (PT)/specialty (Spec) combinations end-dated because the procedures are outside the provider's scope of practice or beyond their scope of education or training:

Procedure Codes		
21181 (27-All)	21282 (27-All)	69710 (31-322, 338)
70557 (31-318, 322, 338)	70558 (31-318, 322, 338)	70559 (31-318, 322, 338)

95863 (14-All)	95869 (14-All)	95930 (31-339)
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The following radiological procedure codes will have PT/Spec combinations end-dated because the procedure is included in the facility support component payment:

Procedure Codes	
70300 (02-All)	73530 (01-All)

The following physical therapy procedure codes will have PT/Spec combination 01/016 end-dated because this emergency room (ER) arrangement can only bill for the facility support component payment:

Procedure Codes		
97597	97598	97602

The following diagnostic and durable medical equipment (DME) procedure codes will have PT 03 end-dated, as explained below:

Procedure Codes	PT	Explanation
73110	03	Equipment necessary to perform this procedure is not available in a nursing home setting.
E1802	03	Does not meet the definition of exceptional DME.

The following surgical procedure codes will have PT 02 (ASC) end-dated because invasive surgical procedures on major vessels, if performed as an outpatient service, should only occur in an outpatient hospital setting due to the potential for complications that require immediate inpatient hospital support services:

Procedure Code	
36561	36580

The Department is end-dating places of service (POS) 11 (office), 22 (outpatient hospital clinic), 23 (ER), 49 (independent clinic) or 99 (special treatment room (STR)), as indicated below, for the following surgical procedure codes because the procedure codes can only be safely provided in an ASC, SPU or inpatient setting:

Procedure Codes	POS	Procedure Codes	POS
15820	11, 22, 23, 49, 99	15822	11, 22, 23, 49, 99
15823	11, 22, 23, 49, 99	21125	11, 22, 23, 49, 99
21181	11, 22, 23, 49, 99	21282	11, 22, 23, 49, 99
25111	11, 22, 23, 49, 99	26160	11, 22, 23, 49, 99
31535	11, 22, 23, 49, 99	36561	11, 22, 23, 49
36580	11, 22, 23, 49	58120	11, 22, 23, 49, 99
67901	11, 22, 49, 99	67908	11

67909	11, 22, 23, 49, 99	67911	11
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Additionally, the Department is end-dating POS 11, 22, 23, 31 (skilled nursing facility), 32 (nursing facility) and 49 for the following radiological procedure code because the procedure is performed as a component of a surgical procedure and can only be safely provided in an ASC, SPU or inpatient setting:

Procedure Code
73530

The Department is end-dating POS 11, 22, 23, 24 (ASC/SPU) or 99 for the following surgical procedure codes because these services can only be safely provided in an inpatient setting:

Procedure Codes	POS	Procedure Codes	POS
21160	11, 22, 23, 24, 99	58605	24

The Department is end-dating POS 11, 21, 22, 23, 24, 49 or 99 for the following surgical, diagnostic or physical therapy procedure codes as explained below:

Procedure Codes	POS	Explanation
58340	22	This is a physician service and physicians cannot receive payment in a clinic setting.
	23, 99	Necessary equipment is not available in the ER setting or STR.
75901 75902	22, 49	These are professional components of radiological services and physicians cannot receive payment in a clinic setting.
	11, 23	These should not be performed in an office or ER setting due to the invasive nature of the related surgical procedure.
77417	21, 22	This is a technical only service and physicians cannot receive payment in these POS.
88182	11	Opened in error for the office setting.
97597 97598 97602	24	These are non-surgical procedures and can be safely provided outside and ASC or SPU.

The following surgical and diagnostic procedure codes will have PT/Spec combinations end-dated, as indicated below, when the procedures are performed in an emergency room (POS 23) because they do not represent emergency medical care:

Procedure Codes	PT	Spec	Procedure Codes	PT	Spec
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38500	01	017	55250	01	017
	31	All		31	All
64475	31	338	95865	31	332
95866	31	332	95867	01	All
95868	01	All		31	All
	31	All	95869	01	All
		31		All	

The following diagnostic procedure codes will have POS 31 and 32 end-dated, as indicated below, because the equipment necessary to perform these procedures is not available in a nursing home setting:

Procedure Codes	POS	Procedure Codes	POS
70300	31, 32	95865	31
95866	31		

The following surgical procedure code will have PT/Spec combinations, in the indicated POS, end-dated because it is an invasive procedure requiring sedation and cannot be safely performed in these settings:

Procedure Codes	PT	Spec	POS
43260	01	183	22
	08	082	49
	31	All	11

The following diagnostic procedure codes will have PT 31 end-dated in POS 21, 22, 23, and 49 because there is no professional component and the technical component fee for the service is included in the clinic or ER support component or the inpatient DRG payment as reflected in this bulletin:

Procedure Codes	
94760	94761

The Department is end-dating PT/Spec combination 01/012 in POS 23 for the following procedure code because Medical Rehabilitation Hospitals do not have ERs:

Procedure Code
95860

The following surgical procedure codes will have the 80 modifier end-dated since the services do not require an assistant surgeon:

Procedure Codes		
36561	58671	69710

The following physical therapy procedure codes will have the SG modifier end-dated because they are non-surgical procedures and may be safely provided outside an ASC or SPU:

Procedure Codes		
97597	97598	97602

The following surgical procedure codes will have the U7 modifier end-dated because it is no longer used and payment is the same as the default rate when billed with no modifier:

Procedure Codes	
58340	58605

The following surgical procedure codes will have the SU modifier end-dated since they are not office procedures and can only be safely provided in ASC/SPU or inpatient settings:

Procedure Codes				
25111	26160	31535	43260	58120

The following pulse oximetry procedure code will have the technical component (TC) and the professional component (26) pricing modifiers end-dated as this code represents only the technical component of the procedure consistent with the *Current Procedural Terminology, 2009 Standard Edition*, code book:

Procedure Code
94761

The following surgical and diagnostic procedure codes will have the Rt/Lt/50 modifiers end-dated because the procedures cannot be performed bilaterally:

Procedure Codes		
36580	55250	95865

The Department is end-dating PT 31 for procedure code 95990 because it was opened in error. The Department is adding the following PT/Spec combinations in the identified POS because they were inadvertently omitted:

Procedure Codes	PT	Spec	POS
95990	01	010 183	22
	08	082	49

The Department is end-dating POS 23 for procedure code 95991 because this procedure does not represent emergency medical care. The Department is adding the following PT/Spec combination in POS 11, 21 (inpatient hospital) and 99 because they were inadvertently omitted:

Procedure Codes	PT	Spec	POS
95991	31	345	11 21 99

The pricing modifiers (SG) and (26) are being added to the following surgical and diagnostic services currently designated as inpatient services, but which can safely be performed in SPU or ASC, or both, depending on the procedure:

Procedure Codes and Modifiers					
11983 (SG)	64475 (SG)	93640 (SG)	93641 (SG)	93640 (26)	93641 (26)

The following surgical, radiological, diagnostic and durable medical equipment procedure codes will have the Rt/Lt/50 modifiers added because the services may be performed bilaterally:

Procedure Codes					
15820	15821	15822	15823	21280	21282
24346	24920	25111	26160	36561	38500
65210	65880	67901	67908	67909	67911
68420	73110	73530	95866	E1802	

The following surgical procedure code will have the FA, F1, F2, F3, F4, F5, F6, F7, F8, and F9 modifiers added because the service may be performed on the individual fingers.

Procedure Code
26160

The following procedure codes will have PT/Spec combinations added in the identified POS based upon provider requests and the Department's clinical review:

Procedure Codes	PT	Spec	POS	Procedure Codes	PT	Spec	POS
11983	31	All	11, 23, 24, 99	15340	01	010 183	22
58555	01	010 183	22		08	082	49
	08	082	49	58563	01	010 183	22
	31	319	99		08	082	49

		328			31	319 328	11
73110	01	016 017	23	88187	31	318 333	22
88188	31	318 333	22	88189	31	318 333	22

The following procedure codes will have PT/Spec added in the identified POS because they were inadvertently omitted:

Procedure Codes	PT	Spec	POS	Procedure Codes	PT	Spec	POS
65210	01	021	24	95930	18	180	11
	18	180	11		31	330	11, 21, 22, 49
V2784	24	240 241 242 243 245	11 12	V2770	24	240, 241, 242, 243, 245	11, 12
	25	250	11 12		25	250	11, 12

Fee Changes

The Pennsylvania Medicaid State Plan (State Plan) specifies that maximum fees for services covered under the MA Program are to be determined on the basis of the following: fees may not exceed the Medicare upper limit when applicable; fees must be consistent with efficiency, economy and quality of care; and fees must be sufficient to assure the availability of services to recipients. The regulations at 55 Pa.Code §1150.62(a) (relating to payment levels and notice of rate setting changes) also specify that the MA fees may not exceed the Medicare upper limit. Effective for dates of service on and after March 1, 2010, the following procedure codes will have the fee related to the SU modifier decreased to comply with these requirements:

Procedure Code	Description	Current MA Fee (with SU modifier)	MA Fee Effective March 1, 2010 (with SU modifier)
20220	Biopsy, bone, trocar, or needle; superficial (e.g., ilium, sternum, spinous process, ribs)	\$683.80	\$155.01
38500	Biopsy or excision of lymph node(s); open, superficial	\$638.80	\$279.49
46230	Excision of external hemorrhoid tags and/or multiple papillae	\$660.80	\$218.20

55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	\$815.80	\$419.73
68420	Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)	\$694.30	\$255.44

Effective for dates of service on and after March 1, 2010, the following diagnostic procedure code must be billed with modifier (26) with the associated fee of \$327.25:

Procedure Code	Description	Current MA Fee (with no modifier)	MA Fee Effective March 1, 2010 (with 26 modifier)
93641	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator	\$574.79	\$327.25

PROCEDURE:

The MA Program Outpatient Fee Schedule will be updated to reflect these changes. Providers may access the on-line version of the fee schedule under the Office of Medical Assistance Programs website at:

<http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/Schedules/003675734.htm>.