

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE

October 5, 2009

EFFECTIVE DATE

October 5, 2009

NUMBER

99-09-09

SUBJECT

Revisions to the Medical Assistance Program Fee
Schedule Rates for Select Services

BY



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Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to inform providers of revisions to the fees for selected medical, surgical, laboratory, durable medical equipment, and radiological services on the Medical Assistance (MA) Program Fee Schedule.

SCOPE:

This bulletin applies to all providers enrolled in the MA Program who provide services under the Fee-for-Service delivery system, including ACCESS Plus. Providers rendering services under the Managed Care delivery system should address any rate-related questions to the appropriate managed care organization.

BACKGROUND/DISCUSSION:

Pennsylvania's 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. MA regulations at 55 Pa.Code §1150.62(a) (relating to payment levels and notice of rate setting changes) also specify that MA fees may not exceed the Medicare upper limit.

The Department of Public Welfare (Department) has determined that MA fees for approximately 320 medical, surgical, laboratory, durable medical equipment and radiological procedure codes, or combinations of procedure codes and modifiers, are above the Medicare upper limit for the same procedure codes. The Department is adjusting the fees on the MA

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

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Program Fee Schedule for these combinations of procedure codes and modifiers to equal the Medicare upper limit. Revision of these fees is necessary to comply with MA regulation and the State Plan, and to avoid a federal disallowance. When adjusting the assistant surgeon fee (modifier 80), the Department followed the Medicare guidelines of paying 16% of the maximum allowable payment to a primary surgeon, as MA fees may not exceed the Medicare upper limit.

PROCEDURE:

As set forth in the attached document, the Department has revised the MA Program fees for select services. Revisions have been made to total fee (billed with no modifier) and, as applicable, the professional component fee (billed with modifier 26), the technical component fee (billed with modifier TC), the assistant surgeon fee (billed with modifier 80), and the fee when billing for the purchase (NU) or rental (RR) of Durable Medical Equipment.

ATTACHMENTS:

Fee Schedule Revision-Fees for Procedure Code and Modifier Combinations, Effective October 5, 2009.