



# MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE December 21, 2007	EFFECTIVE DATE January 1, 2008	NUMBER 99-07-21
SUBJECT Medical Assistance Program Fee Schedule Revision	 Michael Nardone, Deputy Secretary Office of Medical Assistance Programs	

## **PURPOSE:**

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

## **SCOPE:**

This bulletin applies to all providers enrolled in the Pennsylvania MA Program and providing services under the fee-for-service and ACCESS Plus delivery systems. 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.

The Department of Public Welfare (Department) has determined that MA payment rates for approximately 2100 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 MA Program Fee Schedule payment rates for these combinations of procedure codes and modifiers to equal the Medicare upper limit. Revision of these fees is necessary to comply with the State Plan and to avoid a federal disallowance.

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 website at [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap)

**PROCEDURE:**

In reviewing the MA payment rates for these procedure codes, the Department discovered several procedure codes that should not be billed with modifiers TC (technical component) and 26 (professional component). The Department will be removing the TC and 26 modifiers from the following procedure codes:

<b>Procedure Code</b>	<b>Procedure Description</b>
<b>77261</b>	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; SIMPLE
<b>77262</b>	THERAPEUTIC RADIOLOGY TREATMENT PLANNING; INTERMEDIATE
<b>77263</b>	THERAPEUTIC RADIOLOGY SIMULATION-AIDED FIELD SETTING; THREE-DIMENSIONAL
<b>77336</b>	CONTINUING MEDICAL PHYSICS CONSULTATION, INCLUDING ASSESSMENT OF TREATMENT PARAMETERS, QUALITY ASSURANCE OF DOSE DELIVERY, AND REVIEW OF PATIENT TREATMENT DOCUMENTATION IN SUPPORT OF THE RADIATION ONCOLOGIST, REPORTED PER WEEK OF THERAPY
<b>77417</b>	THERAPEUTIC RADIOLOGY PORT FILM(S)
<b>92516</b>	FACIAL NERVE FUNCTION STUDIES (EG, ELECTRONEUROGRAPHY)
<b>92586</b>	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS SYSTEM; LIMITED
<b>94660</b>	CONTINUOUS POSITIVE AIRWAY PRESSURE VENTILATION (CPAP), INITIATION AND MANAGEMENT
<b>94662</b>	CONTINUOUS NEGATIVE PRESSURE VENTILATION (CNP), INITIATION AND MANAGEMENT

The Department has also determined that for the following procedure code, the sum of the professional and technical component rates did not equal the total component rate. The Department has adjusted the rates by decreasing the professional component fee to equal the Medicare rate and increasing the total component fee.

<b>Procedure Code</b>	<b>Procedure Description</b>	<b>Fees</b>
<b>88318</b>	DETERMINATIVE HISTOCHEMISTRY TO IDENTIFY CHEMICAL COMPONENTS (EG, COPPER, ZINC)	\$ 24.37 (Total Component Fee) \$ 20.83 (26 -Professional Comp) No Change (TC-Technical Comp)

When adjusting the assistant surgeon fee rate (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.

As set forth in the attached document, the Department will revise the 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), the fee when billing with pricing modifiers U6, U7, U8, U9, SU and TH, and the fees when billing with modifiers NU (new) and RR (rental).

**ATTACHMENTS:**

Fee Schedule Revision- Procedure Code and Modifier Combinations