



CHAPTER 1150. MA PROGRAM PAYMENT POLICIES

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Authority

The provisions of this Chapter 1150 issued under sections 403(a) and (b), 443.2(1) and (2), 443.3(2)(i)—(v), 443.4 and 509 of the Public Welfare Code (62 P. S. § § 403(a) and (b), 443.2(1) and (2), 443.3(1), 443.3(2)(i)—(v), 443.4 and 509), unless otherwise noted.

Source

The provisions of this Chapter 1150 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 51.44 (relating to payment policies); 55 Pa. Code

§ 51.44 (relating to payment policies); 55 Pa. Code § 52.42 (relating to payment policies); 55 Pa. Code § 1101.61 (relating to reimbursement policies); 55 Pa. Code § 1101.67 (relating to prior authorization); 55 Pa. Code § 1123.1 (relating to policy); 55 Pa. Code § 1123.12 (relating to outpatient services); 55 Pa. Code § 1123.51 (relating to general payment policy); 55 Pa. Code § 1123.54 (relating to orthopedic shoes, molded shoes and shoe inserts); 55 Pa. Code § 1123.62 (relating to method of payment); 55 Pa. Code § 1126.51 (relating to general payment policy); 55 Pa. Code § 1127.1 (relating to policy); 55 Pa. Code § 1127.51 (relating to general payment policy); 55 Pa. Code § 1127.52 (relating to payment criteria); 55 Pa. Code § 1128.51 (relating to general payment policy); 55 Pa. Code § 1129.1 (relating to policy); 55 Pa. Code § 1130.2 (relating to policy); 55 Pa. Code § 1140.1 (relating to purpose); 55 Pa. Code § 1140.51 (relating to general payment policy); 55 Pa. Code § 1141.1 (relating to policy); 55 Pa. Code § 1141.51 (relating to general payment policy); 55 Pa. Code § 1141.59 (relating to noncompensable services); 55 Pa. Code § 1142.1 (relating to policy); 55 Pa. Code § 1142.51 (relating to general payment policy); 55 Pa. Code § 1143.1 (relating to policy); 55 Pa. Code § 1143.51 (relating to general payment policy); 55 Pa. Code § 1143.57 (relating to limitations on payment); 55 Pa. Code § 1143.58 (relating to noncompensable services and items); 55 Pa. Code § 1144.1 (relating to policy); 55 Pa. Code § 1144.51 (relating to general payment policy); 55 Pa. Code § 1144.53 (relating to noncompensable services); 55 Pa. Code § 1145.1 (relating to policy); 55 Pa. Code § 1145.51 (relating to general payment policy); 55 Pa. Code § 1145.54 (relating to noncompensable services); 55 Pa. Code § 1147.1 (relating to policy); 55 Pa. Code § 1147.2 (relating to definitions); 55 Pa. Code § 1147.12 (relating to outpatient services); 55 Pa. Code § 1147.13 (relating to inpatient services); 55 Pa. Code § 1147.51 (relating to general payment policy); 55 Pa. Code § 1149.1 (relating to policy); 55 Pa. Code § 1149.21 (relating to scope of benefits for the categorically needy); 55 Pa. Code § 1149.22 (relating to scope of benefits for the medically needy); 55 Pa. Code § 1149.23 (relating to scope of benefits for State Blind Pension recipients); 55 Pa. Code § 1149.51 (relating to general payment policy); 55 Pa. Code § 1149.52 (relating to payment conditions for various dental services); 55 Pa. Code § 1149.54 (relating to payment policies for orthodontic services); 55 Pa. Code § 1151.41 (relating to general payment policy); 55 Pa. Code § 1153.1 (relating to policy); 55 Pa. Code § 1153.51 (relating to general payment policy); 55 Pa. Code § 1163.59 (relating to noncompensable services, items and outlier days); 55 Pa. Code § 1163.451 (relating to general payment policy); 55 Pa. Code § 1163.455 (relating to noncompensable services and items); 55 Pa. Code § 1221.1 (relating to policy); 55 Pa. Code § 1221.43 (relating to participation requirements for hospital clinics and emergency rooms for higher reimbursement rate); 55 Pa. Code § 1221.51 (relating to general payment policy); 55 Pa. Code § 1223.1 (relating to policy); 55 Pa. Code § 1223.12 (relating to outpatient services); 55 Pa. Code § 1223.14 (relating to noncovered services); 55 Pa. Code § 1223.51 (relating to general payment policy); 55 Pa. Code § 1223.54 (relating to noncompensable services and items); 55 Pa. Code § 1225.1 (relating to policy); 55 Pa. Code § 1225.51 (relating to general payment policy); 55 Pa. Code § 1230.1 (relating to policy); 55 Pa. Code § 1230.51 (relating to general payment policy); 55 Pa. Code § 1230.52 (relating to payment conditions for various services); 55 Pa. Code § 1241.1 (relating to policy); 55 Pa. Code § 1243.1 (relating to policy); 55 Pa. Code § 1243.51 (relating to general payment policy); 55 Pa. Code § 1245.1 (relating to policy); 55 Pa. Code § 1245.2 (relating to definitions); 55 Pa. Code § 1245.21 (relating to scope of benefits for the categorically needy); 55 Pa. Code § 1245.22 (relating to scope of benefits for the medically needy); 55 Pa. Code § 1245.23 (relating to scope of benefits for State Blind Pension recipients); 55 Pa. Code § 1245.51 (relating to general payment policy); 55 Pa. Code § 1247.1 (relating to policy); 55 Pa. Code § 1249.1 (relating to policy); 55 Pa. Code § 1249.51 (relating to general payment policy); 55 Pa. Code

§ 1251.21 (relating to scope of benefits for the categorically needy); and 55 Pa. Code § 4300.115 (relating to Department established fees).

GENERAL PROVISIONS

§ 1150.1. Policy.

The MA Program provides payments for specific medically necessary medical services and items covered by the Program and furnished to eligible recipients by approved providers enrolled in the Program. Payment for these services and items is subject to the provisions and limitations of this chapter, Chapter 1101 (relating to general provisions), and the specific chapters for each provider type. To the extent that this chapter conflicts with the regulations that relate to reimbursement for various services or items contained in the specific MA provider chapters in effect on January 1, 1983, this chapter will control. To the extent that this chapter does not address a reimbursement question answered by a regulation contained in a specific provider chapter, the regulation in the specific provider chapter controls.

Source

The provisions of this § 1150.1 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305.

§ 1150.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Adult—A person 21 years of age or older, unless otherwise specified in the MA Program Fee Schedule which is contained in the Provider's Handbook or in the specific provider regulations.

Anesthesia—The loss of feeling or sensation, especially the loss of tactile sensibility, or the loss of any of the senses.

Assistant surgeon—A licensed physician who assists another licensed physician with a surgical procedure.

Child—A person 20 years of age or younger, unless otherwise specified in the MA Program Fee Schedule which is contained in the Provider's Handbook or in the specific provider regulations.

Diagnostic services—Tests performed to make a diagnosis or to recognize or establish the nature of an illness. This service consists of medical diagnostic procedures—for example, electrocardiogram and electroencephalogram; surgical diagnostic procedures—for example, biopsies and amniocentesis; diagnostic radiology—for example, chest x-rays; nuclear medicine; and pathology—for example, examination of blood, urine, feces and tissue.

Elective admission—A preplanned admission to a hospital, short procedure unit or

ambulatory surgical center. The term includes an admission in which scheduling options may be exercised by the attending practitioner, facility or recipient without unfavorably affecting the outcome of the treatment. The term does not include emergency or urgent admissions.

Emergency admission—An admission to a hospital for a condition in which immediate medical care is necessary to prevent death, serious impairment or significant deterioration of the health of the patient.

Experimental procedure—A procedure that deviates from customary standards of medical practice, is not routinely used in the medical or surgical treatment of a specific illness or condition or is not of proven medical value.

General anesthesia—The production of complete unconsciousness, muscular relaxation and absence of pain sensation used in performing surgical operations.

High risk delivery—A delivery in which the medical condition of the fetus or mother, or complications of pregnancy or delivery are life-threatening or significantly increase the likelihood of fetal or maternal morbidity or mortality.

Initial comprehensive visit—An inpatient hospital or nursing facility visit which includes the recording of the chief complaint, the description of the present illness, family history, past medical history, personal history, system review, a complete physical examination, treatment plan and the ordering of appropriate diagnostic tests.

Initial limited visit—An inpatient hospital or nursing facility visit which includes the recording of the chief complaint, the description of the present illness or current medical history, an appropriate physical examination related to the acute or active problem in a patient who has a previously documented evaluation that is current and available to the physician, the treatment plan and the ordering of appropriate diagnostic tests.

Local anesthesia—Anesthesia produced by local infiltration, digital block or topical application of an anesthetic agent.

Maternity admission—An admission of a pregnant woman that is intended to result in the delivery of at least one infant.

Medical care—The attention and treatment of a patient by a practitioner responsible for the medical management of the patient on an inpatient or outpatient basis.

Newborn—An infant born in the hospital or born on the way to a hospital who has not been discharged or transferred from that hospital since birth.

PSR—Place of Service Review—A process by which the Department reviews elective admissions to determine the compensability of the admission and the appropriate setting for the treatment for which the Department will make payment. PSRs take place prior to the admission of the patient.

Practitioner—A person currently licensed under the law of a state to practice medicine, osteopathy, dentistry, podiatry, optometry, chiropractic or midwifery.

Prolonged medical attention—Care of a patient whose condition requires the continuous presence of the physician by direct encounter with the patient for at least 1 hour; supportive documentation shall be recorded in the patient's medical record to indicate the medical necessity for the prolonged attention, the specific care provided and the actual time spent with the patient.

Radiation therapy—The treatment of a condition by use of x-ray, gamma ray, accelerated particle, mesons or neutrons.

Regional anesthesia—The production of insensibility of a part by interrupting the sensory nerve conductivity of a region of the body; it may be produced by one of the following:

(i) A field block, the creation of walls of anesthesia encircling the operative field by means of injections of a local anesthetic.

(ii) A nerve block, the making of extraneural or paraneural injections in proximity to the nerves where conductivity is to be cut off.

Second opinion program—A process through which MA recipients receive the opinion of a second practitioner when there is a question as to the medical necessity or appropriateness of a procedure or if the procedure appears on the Department's list of procedures that automatically requires a second opinion as published as a statement of policy in the *Pennsylvania Bulletin*.

Urgent admission—An admission where medical care shall be administered promptly and cannot be delayed.

Visit—A face-to-face encounter between a patient and practitioner, except as otherwise stated in this part, for the purpose of furnishing medically necessary services.

Authority

The provisions of this § 1150.2 amended under sections 443.1(1) and (4), 443.2(2)(ii) and 443.4 of the Public Welfare Code (62 P. S. § § 443.1(1) and (4), 443.2(2)(ii) and 443.4).

Source

The provisions of this § 1150.2 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended August 11, 1989, effective immediately and applies retroactively to March 1, 1988, 19 Pa.B. 3391. Immediately preceding text appears at serial pages (130985) to (130987).

Cross References

This section cited in 55 Pa. Code § 1101.31 (relating to scope); and 55 Pa. Code § 1150.59 (relating to PSR program).

PAYMENT FOR SERVICES

§ 1150.51. General payment policies.

(a) Payment will be made to providers. Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment will be made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. Practitioners who render services at eligible provider hospitals, either through direct employment or through contract, may direct that payment be made to the eligible provider hospital. Payment will be made for medical services or items covered by the program, furnished by enrolled providers subject to the conditions and limitations established in this chapter, Chapter 1101 (relating to general provisions) and the specific chapters for each provider type. Payment will not be made for a covered medical service or item if payment is available from another agency or another insurance or health program. Payment will not be made for services that are not medically necessary.

(b) To the extent that this chapter conflicts with the regulations that relate to reimbursement for various services or items contained in the specific MA provider chapters which were in effect on January 1, 1983, this chapter controls. To the extent that this chapter does not address a reimbursement question answered by a regulation contained in a specific provider chapter, the regulation in the specific provider chapter controls.

(c) This chapter shall be used by practitioners, hospitals providing outpatient and emergency room services, facilities and practitioners rendering services which require a PSR or second opinion, or both; independent clinics; and other noninstitutional providers including medical supplies, independent laboratories, ambulance companies, pharmacies, portable X-ray providers, funeral directors and home health agencies.

(d) Each section of the MA Program Fee Schedule which is contained in the Provider's Handbook includes the following:

- (1) An all-inclusive listing of covered services and items.
- (2) The provider type eligible under MA to bill for each service and item.
- (3) The appropriate procedure code for each service or item.
- (4) The appropriate type of service for each procedure code.
- (5) The applicable limitations for each service or item.
- (6) The maximum allowable fee for each service or item.
- (7) For surgical and obstetrical procedures, the allowable number of postoperative or postpartum days during which no additional payment will be made for office or home visits for a purpose other than early and periodic screening, diagnosis and treatment visits to the practitioner who performed the procedure. This policy does not apply to other members of a group practice of a different specialty.
- (8) The maximum allowable fee for anesthesia for each procedure.

(e) The maximum payment made to a practitioner for all services provided to a patient during any one period of hospitalization will be the lowest of:

(1) The practitioner's usual charge to the general public for the same service.

(2) The MA maximum allowable fee.

(3) A maximum reimbursement limit of \$1,000 unless a procedure provided during the hospitalization has a fee which exceeds \$1,000, in which case that fee is the maximum reimbursement for the period of hospitalization.

(f) Maximum payments to various categories shall be as follows:

(1) The maximum payment made to a provider or practitioner, or their professional corporation or partnership, or a clinic for outpatient procedures provided to a nonhospitalized patient for treatment during 1 day will be the lowest of:

(i) The usual charge to the general public for the same service.

(ii) The MA maximum allowable fee.

(iii) A maximum reimbursement limit of \$500 per day unless the outpatient procedure has a fee which exceeds \$500, in which case the fee is the maximum reimbursement on a daily basis, for that day only.

(2) The maximum payment made to a dentist, medical supplier or pharmacy, or their professional corporation or partnership, or a clinic for outpatient procedures provided to a nonhospitalized patient for treatment during 1 day will be the lower of:

(i) The usual charge to the general public for the same service.

(ii) The MA maximum allowable fee.

(g) Services shall be performed in an efficient and economical manner.

(h) No payment will be made to a provider:

(1) For physical therapy except when provided and billed as an integral part of hospital inpatient, hospital outpatient, rural health clinic, home health agency or nursing home services.

(2) For a surgical procedure and an office or clinic visit for the same patient on the same day.

(3) For standby services except to practitioners for Cesarean sections and high risk deliveries.

(4) For an emergency room visit and a hospital clinic visit for the same patient on the same day for the same condition.

- (5) For the removal of sutures and casts.
- (6) For procedures not listed in the MA Program Fee Schedule, except as specified in § 1150.63 (relating to waivers).

Authority

The provisions of this § 1150.51 amended under sections 201(2), 443.1(1) and (4), 443.2(2)(ii) and 443.4 of the Public Welfare Code (62 P. S. § § 201(2), 443.1(1) and (4), 443.2(2)(ii) and 443.4).

Source

The provisions of this § 1150.51 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305; amended September 30, 1983, effective May 14, 1983, 13 Pa.B. 2975; amended October 28, 1983, effective January 1, 1984, 13 Pa.B. 3303; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended August 11, 1989, effective immediately and apply retroactively to March 1, 1988, 19 Pa.B. 3391; amended July 9, 2004, effective January 1, 2004, 34 Pa.B. 3596. Immediately preceding text appears at serial pages (251207) to (251209).

Cross References

This section cited in 55 Pa. Code § 1150.63 (relating to waivers).

§ 1150.52. Anesthesia services.

(a) Payment will be made for anesthesia services other than local anesthesia provided by an enrolled practitioner qualified to administer anesthesia only if either of the following conditions are met:

- (1) The practitioner personally administered the anesthesia.
- (2) The practitioner directed no more than four anesthesia procedures concurrently and did not perform other services while concurrently directing the procedures. If the physician is involved in more than four anesthesia procedures concurrently, they should be deemed supervision and the costs shall be included as part of the hospital's costs.

(b) Payment for inpatient anesthesia includes:

- (1) Preoperative visits.
- (2) Inpatient postoperative visits provided during the number of postoperative or postpartum days specified in the Medical Assistance Program Fee Schedule for each surgical or obstetrical procedure, whether or not the postoperative or postpartum visits are related to the administration of anesthesia.

(c) When two or more surgical procedures are performed and anesthesia is provided by the same anesthesiologist during the same period of hospitalization, the anesthesiologist will be

reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures.

(d) The eligible places of service for physicians are as follows:

- (1) Inpatient hospital.
- (2) Short procedure unit.
- (3) Hospital emergency rooms.

(e) The eligible places of service for dentists are as follows:

- (1) Dentist's office.
- (2) Dental clinic.

(f) Payment for anesthesia services will not be made:

(1) To the practitioner performing the medical or surgical procedure or to an assistant surgeon, with the exception of a dentist who may bill for outpatient general anesthesia performed by a certified nurse anesthetist under the dentist's supervision when provided for a compensable outpatient service and the applicable documentation is submitted to justify payment as described in the Dental handbook;

(2) If the Department denies payment for the medical or surgical procedure.

(3) For local anesthesia.

Source

The provisions of this § 1150.52 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (93506) to (93507).

§ 1150.54. Surgical services.

(a) *Inpatient surgical services.*

(1) A practitioner may bill for any covered surgical procedure performed on an inpatient basis unless the surgical procedure could appropriately and safely be performed on an outpatient basis in an office, clinic, emergency room or in a hospital short procedure unit.

(2) Those surgical procedures designated in the Medical Assistance Program Fee Schedule with an outpatient indicator (OP) are not compensable when performed on an inpatient basis unless the medical condition of the patient is such that to perform the procedure on an outpatient basis, including a short procedure unit, could result in undue risk to the life or health of the patient. Detailed documentation of the condition of risk to the life or health of the patient shall be included in the patient's medical record and on the claim

submitted for payment.

(3) An assistant surgeon may bill only for the surgical procedures designated in the Medical Assistance Program Fee Schedule with the assistant surgeon indicator. The maximum payment to the assistant surgeon will be an amount equal to 20% of the Medical Assistance maximum allowable payment made to the surgeon. See paragraph (4).

(4) The fee for an inpatient surgical procedure includes:

(i) Preoperative inpatient visits.

(ii) Inpatient and outpatient office or home visits provided by the practitioner who performed the procedure for a purpose related to surgery or surgical diagnosis during the number of postoperative days specified in the Medical Assistance Program Fee Schedule for each surgical procedure. During this specified period, the practitioner who performed the surgery is eligible to receive payment for treatment of a medical or surgical condition if the diagnosis necessitating the treatment is different and unrelated to the surgery.

(iii) The removal of sutures and casts.

(5) When two or more surgical procedures are performed by the same practitioner during the same period of hospitalization, the practitioner will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures.

(6) A practitioner who performs a surgical procedure may also bill for medical diagnostic procedures, surgical diagnostic procedures, and radiation therapy for the same patient during the same period of hospitalization.

(7) Payment may be made to a practitioner who performs the surgical procedure and to one other practitioner who is responsible for the medical care of the same patient.

(b) *Outpatient surgical procedures.*

(1) The fee for an outpatient surgical procedure includes:

(i) Postoperative office and home visits provided by the practitioner who performed the procedure for a purpose related to the surgery or surgical diagnosis during the number of postoperative days specified in the Medical Assistance Program Fee Schedule for each surgical procedure. During this specified period, the practitioner who performed the surgery is eligible to receive payment for treatment of a medical or surgical condition if the diagnosis necessitating the treatment is different and unrelated to the surgery.

(ii) The removal of sutures and casts.

(2) When two or more surgical procedures are performed by the same practitioner on the same day, the practitioner will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures.

(3) Payment is made for services performed in an approved short procedure unit only if the service could not be appropriately and safely performed in the practitioner's office, the clinic, or the emergency room of a hospital, because the medical needs of the patient require less than 24-hour care, and the use of inpatient hospital resources, especially an operating room, and in some cases administration of general anesthesia.

Source

The provisions of this § 1150.54 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (93508) and (96131).

Cross References

This section cited in 55 Pa. Code § 1149.52 (relating to payment conditions for various dental services).

§ 1150.55. Obstetrical services.

(a) The fee for a delivery includes:

(1) Antepartum care provided on an inpatient basis.

(2) Inpatient and outpatient office or home visits provided by the practitioner who performed the delivery, for a purpose related to delivery, during the number of postpartum days specified in the Medical Assistance Program Fee Schedule for each obstetrical procedure. During this specified period, the practitioner who performed the delivery is eligible to receive payment for treatment of a medical or surgical condition if the diagnosis necessitating the treatment is different and unrelated to the delivery.

(b) The practitioner performing the delivery may also bill for visits for care of the newborn if that practitioner is the responsible attending physician for the newborn.

(c) In addition to the practitioner performing the delivery, another practitioner may bill for stand-by services but only in the case of Cesarean sections or high risk deliveries. This is in lieu of billing for an initial visit.

Source

The provisions of this § 1150.55 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305; amended September 30, 1988, effective November 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (96131).

§ 1150.56. Medical services.

(a) *Inpatient medical care.*

(1) On any given day, a practitioner may bill for only one of the following:

- (i) An initial comprehensive visit.
 - (ii) An initial limited visit.
 - (iii) Prolonged medical attention.
 - (iv) A consultation.
 - (v) A surgical procedure.
 - (vi) An inpatient hospital visit.
 - (vii) An Early and Periodic Screening, Diagnosis, and Treatment visit.
 - (viii) Stand-by services for high risk deliveries or Cesarean sections.
- (2) Medical visits are not paid to the same practitioner who performs the surgery.
- (3) Only one practitioner is eligible to receive payment for medical care for the same patient on the same day.
- (4) A practitioner who provides medical care may also bill for medical diagnostic procedures, surgical diagnostic procedures, and radiation therapy for the same patient during the same period of hospitalization.
- (5) During a period of hospitalization, payment may be made to one other practitioner responsible for inpatient medical care, if provided, in addition to the practitioner billing for surgical services.
- (6) Payment for consultation is limited to two consultations provided the same patient during the same period of hospitalization.
- (b) *Nonhospital medical care.*
- (1) A practitioner may bill the Department for medical care provided to an outpatient as an office visit, a skilled nursing or intermediate care facility visit, or a home visit.
- (2) In addition to a medical care visit, a practitioner may bill for diagnostic radiology procedures, medical diagnostic procedures, surgical diagnostic procedures, nuclear medicine procedures and radiation therapy.
- (3) On any given day, a practitioner may bill for only one of the following per recipient:
- (i) An initial visit in a skilled or intermediate nursing facility.
 - (ii) A medical visit.
 - (iii) An office visit.
 - (iv) A consultation.

- (v) A surgical procedure.
 - (vi) An EPSDT visit.
 - (vii) A general medical examination.
- (4) For any home visit, a practitioner may bill for no more than two patients.

(5) A practitioner may bill for services performed in an emergency room only in accordance with the arrangement selected by the hospital as specified in Chapter 1221 (relating to clinic and emergency room services) and stated in a letter directed to and approved by the Office of Medical Assistance, Bureau of Provider Relations. Arrangements may not be changed without prior written agreement with the Bureau of Provider Relations.

(6) A visit to a practitioner's office or a hospital outpatient department solely for the purpose of receiving a diagnostic service, administration of chemotherapy, or for an injection of medication or vaccine does not qualify for payment as an office visit, a hospital clinic emergency room visit or for a visit for support services. In this kind of situation, payment will be made only for the diagnostic service, the administration of chemotherapy, or for the injection of medication or vaccine. Payment to a practitioner or hospital outpatient department for a visit includes payment for administering any injections of medication or vaccine.

Source

The provisions of this § 1150.56 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305; amended October 28, 1983, effective January 1, 1984, 13 Pa.B. 3303. Immediately preceding appears at serial pages (79173) and (79174).

§ 1150.56a. Payment policy for consultations—statement of policy.

(a) The Department pays for five levels of inpatient and outpatient consultations. Payment for inpatient consultations is limited to two consultations per hospitalization. The definition of each level is set forth in subsection (b).

(1) A referral to another practitioner does not constitute a consultation. When a patient is referred to another practitioner, the medical record shall indicate the name of the practitioner and the reason for the referral. When a physician transfers the total responsibility for care of the patient to another practitioner, the physician accepting the patient may bill for medical care or surgical procedures. This transfer of responsibility shall be noted in the patient's medical record.

(2) Payment will not be made for a self-referred consultation. A consultation shall be requested by another practitioner.

(3) Payment will not be made for a consultation when it is performed by a surgeon or assistant surgeon regarding the advisability of definitive surgery and surgery is subsequently performed by that surgeon or assistant surgeon. This is not applicable to second opinions mandated by the Department's Second Opinion Program.

(4) Payment will be made for a consultation provided by a surgeon regarding the advisability of definitive surgery when subsequent surgery is not performed.

(5) Payment will not be made for a consultation when it is performed by the same physician or assistant who performs the obstetrical delivery.

(6) Payment will not be made for a consultation provided by an anesthesiologist prior to surgery. This is considered to be a pre-operative work-up and the fee for anesthesia services includes payment for the pre-operative work-up.

(7) Payment will be made for a consultation provided by an anesthesiologist if the consultation results in a decision not to administer anesthesia during the hospitalization.

(8) Payment for an inpatient consultation includes follow-up care; therefore, the consultant is not eligible to bill for daily medical care. Only the attending physician is entitled to bill for daily medical care.

(9) Payment will not be made for consultations which are performed solely to meet a hospital requirement.

(b) The following definitions and procedure codes are provided for clarification of the terms used in conjunction with consultations:

(1) *Limited Consultation (90600)*—The physician confines his service to the examination or evaluation of a single organ system. This procedure includes documentation of the complaints, present illness, pertinent examination, review of medical data and establishment of a plan of management relating to the specific problem. An example would be a dermatological opinion about an uncomplicated skin lesion.

(2) *Intermediate Consultation (90605)*—An examination or evaluation of an organ system, a partial review of the general history, recommendations and preparation of a report. An example would be the evaluation of the abdomen for possible surgery that does not proceed to surgery.

(3) *Extended Consultation (90610)*—The evaluation of problems that do not require a comprehensive evaluation of the patient as a whole. This procedure includes the documentation of a history of the chief complaints, past medical history and pertinent physician examination, review and evaluation of the past medical data, establishment of a plan of investigative or therapeutic management and the preparation of an appropriate report. For example: The examination of a cardiac patient who needs assessment before undergoing a major surgical procedure or general anesthesia.

(4) *Comprehensive Consultation (90620)*—An indepth evaluation of a patient with a problem requiring the development and documentation of medical data (the chief complaints, present illness, family history, past medical history, personal history, system review and physical examination, review of diagnostic tests and procedures that have previously been done), the establishment or verification of a plan for further investigative or therapeutic management and the preparation of a report. For example: A young person with fever, arthritis and anemia; or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of

information with primary physician or nursing personnel or family members and other informants, and preparation of a report with recommendations.

(5) *Complex Consultation (90630)*—An uncommonly performed service that involves an indepth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate report. An example would be acute myocardial infarction with major complications. Another example would be a young psychotic adult unresponsive to extensive treatment efforts under consideration for residential care.

(6) *Attending practitioner*—The practitioner of record who is primarily responsible for the total care and treatment and retains overall responsibility for coordination of the care of the patient.

(7) *Referral*—The transfer of the total or specific care of a patient from one practitioner to another which does not constitute a consultation.

(c) Claims submitted for payments are subject to utilization review.

Source

The provisions of this § 1150.56a adopted April 20, 1990, effective April 21, 1990, 20 Pa.B. 2199.

§ 1150.57. Diagnostic services and radiation therapy.

(a) The fees for diagnostic radiology, nuclear medicine, radiation therapy, pathology and medical diagnostic procedures are comprised of a total fee, which is divided into a professional component fee and a technical component fee.

(b) The technical component of any diagnostic services provided on an inpatient basis will be included in the hospitals' payment for inpatient services. No other payment will be made for the total component or technical component for inpatient services.

(c) Physicians may bill for a visit in addition to the professional component if an appropriate medical care visit is provided. However, a visit to a practitioner's office or the outpatient department of a hospital solely for the purpose of receiving a diagnostic service or radiation therapy does not qualify for payment for a visit and the diagnostic service or radiation therapy. In this kind of situation, payment is made only for the diagnostic service or radiation therapy.

(d) A practitioner may bill for laboratory services performed in the office only if the practitioner is licensed by the Department of Health and enrolled in the MA Program as a laboratory.

(e) A practitioner may bill for medical diagnostic, surgical diagnostic, diagnostic radiology, nuclear medicine and radiation therapy in addition to:

(1) A surgical procedure.

- (2) A medical care visit if the situation described in subsection (c) does not occur.

Authority

The provisions of this § 1150.57 amended under sections 201(2), 403 and 443.3 of the Public Welfare Code (62 P. S. § § 201(2), 403 and 443.3).

Source

The provisions of this § 1150.57 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252; amended September 5, 2008, effective September 6, 2008, 38 Pa.B. 4898. Immediately preceding text appears at serial page (251216).

§ 1150.58. Prior authorization.

Prior authorization is required for those services and items so designated in the MA Program fee schedule with the prior authorization indicator (PA).

Source

The provisions of this § 1150.58 adopted January 7, 1983, effective January 1, 1983, 13 Pa.B. 305.

§ 1150.59. PSR program.

(a) Except as specified in subsection (b), a practitioner or facility shall request a PSR prior to the admission of a MA recipient to a general hospital, freestanding ambulatory surgical center or hospital short procedure unit for surgical or medical treatment.

(b) For the following type of admission, a practitioner is not required to request a PSR:

- (1) An emergency admission as defined in § 1150.2 (relating to definitions).
- (2) An urgent admission as defined in § 1150.2.
- (3) A maternity admission as defined in § 1150.2.
- (4) A newborn admission as defined in § 1150.2.
- (5) The admission of a MA recipient who is also eligible for Medicare Part A benefits and for which the Department is responsible only for the deductible or coinsurance payment amounts.
- (6) A recipient who is enrolled in a comprehensive health services plan or a capitated physician case management program.
- (7) The admission of a MA recipient to a hospital based psychiatric unit, medical rehabilitation unit, drug and alcohol treatment/rehabilitation unit, freestanding rehabilitation hospital or freestanding drug and alcohol rehabilitation hospital as identified under Chapter

1163 (relating to inpatient hospital services) or to a freestanding psychiatric hospital as identified under Chapter 1151 (relating to private psychiatric hospital inpatient services).

(c) For an admission of a patient who is not eligible for MA at the time of the admission, a PSR is not required prior to the admission. If the facility is notified of the patient's eligibility for MA, or PSR will be conducted within 30 days of the notification to determine the compensability of the admission and the appropriate setting for the treatment for which the Department will make payment.

(d) The admission of a MA recipient to a hospital, freestanding ambulatory surgical center or hospital short procedure unit is subject to the Department's retrospective inpatient hospital review procedures as specified in Chapters 1126 and 1163 (relating to ambulatory surgical center services and hospital short procedure unit services; and inpatient hospital services); if exempt from the PSR program under subsection (b).

(e) If a practitioner or facility designates an admission as urgent or emergency but the Department determines, based on a review of the recipient's medical record and the medical data existing at the time of the admission, that the admission was elective, the Department will make payment equal to 50% of the MA approved reimbursement amount for services provided by the admitting practitioner or facility.

(f) The PSR requirements of this section are applicable for admission of a Commonwealth MA recipient regardless of whether the admission is to an in-State or out-of-State facility.

(g) Within 3 working days of receiving a place of service review request, the Department will do one of the following:

(1) Certify the request.

(2) Ask for additional information in order to certify the request as specified under subsection (h).

(3) Request a second opinion as specified under subsection (i).

(h) If the Department requests additional information under subsection (g), the provider will have 14 days to provide the Department with the information to have the PSR process completed. If the requested information is not received by the Department within 14 days, the provider shall reapply for certification.

(i) Before certification of PSR is completed, a second opinion shall be obtained if one of the following conditions exist:

(1) The procedure is on the mandatory second opinion list published by the Department.

(2) After review, the Department's physician questions the medical necessity of performing the procedure.

(j) If a second opinion is required under § 1150.60(a) (relating to second opinion program), a practitioner or facility may not request a PSR until he has documentation available, as specified in the provider handbook, that the recipient has obtained a second

opinion.

(k) To be eligible for payment for an admission or procedure to a PSR, a facility or practitioner shall comply with the instructions in the provider handbook. Failure to comply with PSR procedures and applicable second opinion procedures in § 1150.60 will result in a payment equal to 50% of the MA approved reimbursement amount for services provided by the admitting practitioner and facility.

(l) Payment will not be made for an admission that occurs after the expiration date on the Department's letter notifying the facility, the recipient and the admitting practitioner that certification has been granted. If the admission has not occurred within the 60-day time period, the admitting practitioner or the facility is required to reapply for certification.

(m) The Department will make payment to a facility at the rate established for the certified site. If the setting utilized is different from the one originally certified and costs less, the Department will pay that lesser amount.

(n) If the Department determines that a procedure or treatment is noncompensable, as defined in § 1163.59 (relating to noncompensable services, items and outlier days), or certifies a procedure for a setting other than the one being proposed by the admitting practitioner, the admitting practitioner or the facility will be afforded the opportunity for an informal reevaluation by the Department's medical coordinator within 10 calendar days of the notification. A final decision by the medical coordination may be appealed by the recipient under Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings). A final decision by the medical coordinator may be appealed by the admitting practitioner or facility under § 1101.84 (relating to provider right of appeal). The evaluation process and request for appeal shall be completed within 30 days from the original PSR notification.

(o) When the certification is completed, the Department will send written notification to the physician, the facility and the recipient.

Authority

The provisions of this § 1150.59 issued under sections 443.1(1) and (4), 443.2(2)(ii) and 443.4 of the Public Welfare Code (62 P. S. § 443.1(1) and (4), 443.2(2)(ii) and 443.4).

Source

The provisions of this § 1150.59 adopted August 11, 1989, effective immediately and apply retroactively to March 1, 1988, 19 Pa.B. 3391.

Cross References

This section cited in 55 Pa. Code § 1150.60 (relating to second opinion program).

§ 1150.60. Second opinion program.

(a) Except as specified in subsection (g), a practitioner is required to refer a recipient to the Department to arrange an appointment for a second opinion when the proposed procedure is

one that automatically requires a second opinion.

(b) The Department may require a recipient to obtain a second opinion if the Department's physicians question the medical necessity of performing the procedure through the PSR program under § 1150.59 (relating to PSR program).

(c) The Department will provide the recipient with the names of practitioners within the recipient's vicinity who are approved to provide a second opinion. The Department will arrange an appointment with the practitioner the recipient chooses. The arrangement for the appointment will be completed no later than 6 working days after the request by the recipient or the recipient's agent.

(d) After the recipient obtains a second opinion, the final decision on whether or not to have the procedure performed will be made by the recipient, even if the second opinion is contrary to the opinion of the attending practitioner. If the recipient decides to undergo the procedure, the Department will make payment in accordance with the Department's applicable payment regulations.

(e) If the recipient fails to obtain a second opinion required in subsection (a) or (b), the Department will not precertify the admission.

(f) A second opinion is not required if one of the following conditions applies:

(1) The procedure is documented in the recipient's medical record as an emergency or urgent admission by the attending practitioner and that immediate or prompt surgery is medically indicated.

(2) The patient is enrolled in a comprehensive health services plan or a capitated physician case management program.

(3) The patient is also covered by another health insurance and has obtained a second opinion under that program for the procedure for which MA coverage is sought.

(4) Another health insurance is expected to make payment for the service and MA is not expected to make an additional payment.

(5) The patient was not eligible for MA at the time the procedure was performed but subsequently became eligible.

(6) The Department has approved the admission of a recipient to a hospital and during the hospital stay it is determined that the recipient needs a surgical procedure that would otherwise require a second opinion under subsection (a) or (b).

(g) The Department will grant a waiver of the second opinion requirement specified in subsection (a) if the Department determines that one of the following applies:

(1) No qualified practitioner is available to give a second opinion.

(2) The recipient would have to travel more than 50 miles to obtain a second opinion.

(3) The recipient's medical condition is such that the travel to obtain a second opinion would result in a medical hardship for the recipient, such as when the recipient's medical condition confines the recipient to his home environment.

Authority

The provisions of this § 1150.60 issued under sections 443.1(1) and (4), 443.2(2)(ii) and 443.4 of the Public Welfare Code (62 P. S. § § 443.1(1) and (4), 443.2(2)(ii) and 443.4).

Source

The provisions of this § 1150.60 adopted August 11, 1989, effective immediately and apply retroactively to March 1, 1989, 19 Pa.B. 3391.

Cross References

This section cited in 55 Pa. Code § 1150.59 (relating to PSR program).

§ 1150.60a. [Reserved].

Source

The provisions of this § 1150.60a adopted August 11, 1989, effective immediately and apply retroactively to March 1, 1989, 19 Pa.B. 3421; amended March 29, 1991, effective April 1, 1991, 21 Pa.B. 1334; reserved February 10, 1995, effective February 11, 1995, 25 Pa.B. 538. Immediately preceding text appears at serial pages (157142) and (166131).

Cross References

This section cited in 55 Pa. Code § 1150.60 (relating to second opinion program).

§ 1150.61. Guidelines for fee schedule changes.

(a) Notice will be published in the *Pennsylvania Bulletin* when fees are changed and when procedures, services or items are added to, or deleted from, the MA Program Fee Schedule.

(b) Procedures, services and items requested by providers, the MA Advisory Committee, the Senate Public Health and Welfare Committee, and the House Health and Welfare Committee, the Department or other interested parties may be added to the MA Program Fee Schedule on the basis of the following:

(1) The procedure, service or item is determined to be medically necessary by the Department after consultation with the MA Advisory Committee, other third-party payors and the Department's medical consultants.

(2) The procedure, service or item is accepted as a standard practice by the medical community.

(3) The procedure, service or item is not prohibited by Federal or State statute or

regulation.

(c) Individual procedures, services or items will be deleted from the MA Program fee schedule, in consideration of recommendations by the MA Advisory Committee, and on the basis of one or more of the following:

(1) The procedure, service or item is replaced by a generally accepted new technique or more definitive procedure.

(2) The procedure, service or item is no longer accepted as a standard practice by the medical community.

(3) The MA Advisory Committee recommends to the Department that a procedure, service or item should be deleted from the fee schedule as not medically necessary.

(d) The following guidelines will be considered in establishing a prior authorization requirement for a procedure, service or item to avoid misutilization:

(1) Article IV(f) and section 509 of the Public Welfare Code (62 P. S. § § 441.1—447 and 509).

(2) Chapter 1101 (relating to general provisions) and 42 CFR Part 440 (relating to services; general provisions).

(3) Usage and quality of the procedure, service or item.

(4) To the extent consistent with paragraphs (1)—(3), policies followed by Medicare, other third-party payors, provider associations, other state Medicaid agencies and Federal agencies.

Source

The provisions of this § 1150.61 adopted September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418.

§ 1150.62. Payment levels and notice of rate setting changes.

(a) The Department will establish maximum payment rates for MA covered services. The established maximum payment rates will not exceed the Medicare upper limit.

(b) The Department will issue public notice of changes in Statewide methods and standards for setting payment rates as required by Federal law.

Authority

The provisions of this § 1150.62 amended under sections 201(2), 403(b), 443.4 and 454 of the Public Welfare Code (62 P. S. § § 201(2), 403(b), 443.4 and 454).

Source

The provisions of this § 1150.62 adopted September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended August 5, 2005, effective August 10, 2005, 35 Pa.B. 4309. Immediately preceding text appears at serial page (251222).

Cross References

This section cited in 55 Pa. Code § 1126.52 (relating to payment criteria); and 55 Pa. Code § 5221.42 (relating to payment).

§ 1150.63. Waivers.

(a) The Department may waive the requirements of § 1150.51(6) (relating to general payment policies) upon written request by a provider.

(b) The Department, under extraordinary circumstances, will pay for a medical service or item that is not one for which the MA Program has an established fee. If a practitioner concludes that lack of the service or item would impair the recipient's health, the practitioner may either give the recipient the prescription or order to take to the CAO, or send the prescription or order to the CAO by mail.

(c) The CAO shall forward the prescription and a completed Form MA 325 (Request for Waiver) to the Office of MA Programs where it will be reviewed by the Department's medical consultants. The Office of MA Programs will notify the requestor of its decision. Section 1101.67 (relating to prior authorization) which requires a decision on requests for prior authorization within 21 days does not apply to requests for waivers.

(d) The Department will review each request using the following guidelines:

(1) Payment for the procedure is not allowable according to the fee schedule, is a type of service covered by the program and is generally accepted by the medical community.

(2) The procedure is not experimental.

(3) The therapeutic effectiveness of the procedure has been scientifically documented.

Source

The provisions of this § 1150.63 adopted September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418.

Notes of Decisions

Waiver provision applies even if the provider is not involved in the MA Program. *Walizer v. Department of Public Welfare*, 611 A.2d 1359 (Pa. Cmwlth. 1992); appeal denied 619 A.2d 701 (Pa. Cmwlth. 1993).

Cross References

This section cited in 55 Pa. Code § 41.92 (relating to expedited disposition procedure for certain appeals); and 55 Pa. Code § 1150.51 (relating to general payment policies).

APPENDIX A. [Reserved]

Source

The provisions of this Appendix A adopted January 7, 1988, effective January 1, 1988, 18 Pa.B. 305; amended March 11, 1983, effective March 12, 1983, 13 Pa.B. 986; amended October 28, 1983, effective January 1, 1984, 13 Pa.B. 3303; corrected November 18, 1983, effective January 1, 1984, 13 Pa.B. 3665; amended August 10, 1984, effective September 1, 1984, 14 Pa.B. 2926; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252; amended January 25, 1985, effective January 15, 1985, 15 Pa.B. 255; amended January 25, 1985, effective January 26, 1985, 15 Pa.B. 256; reserved September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (93512) to (93638), (96139) to (96146) and (114415) to (114416).

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