



MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE

July 27, 2006

EFFECTIVE DATE

July 31, 2006

NUMBER

*See Below

SUBJECT

Medical Assistance Program Fee Schedule Revisions for Medical and Radiological Procedure Codes

BY


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Office of Medical Assistance Programs

PURPOSE:

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

SCOPE:

This bulletin applies to all Physicians, Podiatrists, Extended Care Facilities, Clinics, X-Ray Clinics, and Inpatient Facilities enrolled in the Pennsylvania MA Program and providing service in the fee-for-service delivery system. 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 has determined that MA payment rates for 16 medical and radiological procedure codes are above the Medicare-approved amount for the same procedure codes. The Department is adjusting the MA Program Fee Schedule payment rates for these 16 procedure codes to equal the Medicare-approved amount. Revision of these fees is necessary to comply with the State Plan and to avoid a federal disallowance.

***01-06-08 ; 03-06-09 ; 08-06-12 ; 14-06-09 ; 29-06-01 ; 31-06-17**

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

PROCEDURE:

The Department will revise the total fee (billed with no modifier) and the professional component fee (billed with modifier 26) for all of the following medical and radiological procedure codes. In addition and as set forth below, the Department will revise the technical component fee (billed with modifier TC) for procedure codes 73564 and 73610. These revisions are effective July 31, 2006.

Procedure Codes with Fees Exceeding 100% Medicare				
Code	Description	Professional Component Fee Revision (Billing with Modifier 26)	Technical Component Fee Revision (Billing with Modifier TC)	Total Fee Revision (Billing with No Modifier)
70450	COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL(S)	\$43.01	No Change	\$120.51
70544	MAGNETIC RESONANCE ANGIOGRAPHY, HEAD; WITHOUT CONTRAST MATERIAL(S)	\$60.68	No Change	\$328.09
71020	RADIOLOGIC EXAMINATION, CHEST, TWO VIEWS, FRONTAL AND LATERAL;	\$11.04	No Change	\$26.04
71275	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, CHEST, WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS, INCLUDING IMAGE POST-PROCESSING	\$97.05	No Change	\$313.85
72146	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, THORACIC; WITHOUT CONTRAST MATERIAL	\$80.89	No Change	\$268.09
72148	MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITHOUT CONTRAST MATERIAL	\$74.98	No Change	\$262.18
73564	RADIOLOGIC EXAMINATION, KNEE; COMPLETE, FOUR OR MORE VIEWS	\$11.04	\$22.42	\$33.45
73610	RADIOLOGIC EXAMINATION, ANKLE; COMPLETE, MINIMUM OF THREE VIEWS	\$8.80	\$18.73	\$27.53
74183	MAGNETIC RESONANCE (EG, PROTON) IMAGING, ABDOMEN; WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY WITH CONTRAST MATERIAL(S) AND FURTHER SEQUENCES	\$114.00	No Change	\$673.01
78465	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), MULTIPLE STUDIES (INCLUDING ATTENUATION CORRECTION WHEN PERFORMED), AT REST AND/OR STRESS (EXERCISE AND/OR PHARMACOLOGIC) AND REDISTRIBUTION AND/OR REST INJECTION, WITH OR WITHOUT QUANTIFICATION	\$74.63	No Change	\$337.43
93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; COMPLETE	\$47.75	No Change	\$142.75

Code	Description	Professional Component Fee Revision (Billing with Modifier 26)	Technical Component Fee Revision (Billing with Modifier TC)	Total Fee Revision (Billing with No Modifier)
93320	DOPPLER ECHOCARDIOGRAPHY, PULSED WAVE AND/OR CONTINUOUS WAVE WITH SPECTRAL DISPLAY (LIST SEPARATELY IN ADDITION TO CODES FOR ECHOCARDIOGRAPHIC IMAGING); COMPLETE	\$19.84	No Change	\$66.34
93923	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, MULTIPLE LEVELS OR WITH PROVOCATIVE FUNCTIONAL MANEUVERS, COMPLETE BILATERAL STUDY (EG, SEGMENTAL BLOOD PRESSURE MEASUREMENTS, SEGMENTAL DOPPLER WAVEFORM ANALYSIS, SEGMENTAL VOLUME PLETHYSMOGRAPHY, SEGMENTAL TRANSCUTANEOUS OXYGEN TENSION MEASUREMENTS, MEASUREMENTS WITH POSTURAL PROVOCATIVE TESTS, MEASUREMENTS WITH REACTIVE HYPEREMIA)	\$23.40	No Change	\$93.45
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY	\$35.46	No Change	\$149.66
93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; UNILATERAL OR LIMITED STUDY	\$23.10	No Change	\$101.70
95903	NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE; MOTOR, WITH F-WAVE STUDY	\$32.54	No Change	\$41.52