

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

PROGRAM	STATE OF MARYLAND LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	A. Services which are not covered are: 1. Services not medically necessary; 2. Physician services (other than those for pregnant women and children) denied by Medicare as not medically necessary. For pregnant women and children, the state will review for medical necessity even if Medicare has denied the coverage; 3. Nonemergency dialysis services related to chronic kidney disorders unless they are provided in a Medicare-certified facility; 4. Services which are investigational or experimental; 5. Autopsies; 6. Physician services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinic; 7. Payment to physicians for specimen collection, except by venipuncture and capillary or arterial puncture; 8. Audiometric tests for adults for the sole purpose of prescribing hearing aids since hearing aids are not covered for adults; 9. Immunizations required for travel outside the continental United States.

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PROGRAM	STATE OF MARYLAND LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	10. Services which are provided outside of the United States; 11. Acupuncture; 12. Radial keratomy; 13. Sterilization reversals and gender changes (sex reassignment). This includes evaluations, procedures, and treatment related in any way to sex reassignment; 14. Injections, and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical records; 15. Visits solely to accomplish one or more of the following: a. Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures; b. Recording of an electrocardiogram; c. Ascertaining the patient's weight; d. Interpretation of laboratory tests or panels which are considered to be part of the office visit and may not be billed separately; and 16. Drugs and supplies dispensed by the physician which are acquired by the physician at no cost.

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STATE PLAN FOR MEDICAL ASSISTANCE
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PROGRAM	STATE OF MARYLAND LIMITATIONS
5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.	<p>B. Preauthorization: The Program will preauthorize services when the provider submits adequate documentation demonstrating that the service is medically necessary.</p> <p>Authorizations for cross-over claims for dual-eligibles, which are normally required by the Program, are waived when the service is covered and approved by Medicare since the State's responsibility in this case is only to pay the co-payment for the service covered by Medicare. However, if the entire or any part of a claim is rejected by Medicare, and the claim is referred to the Program for payment, payment will be made for services covered by the Program only if authorization for those services has been obtained before billing the service.</p> <p>C. The following procedures or services require preauthorization by the Program:</p> <ol style="list-style-type: none">1. Services rendered to an inpatient before one pre-operative inpatient day;2. Cosmetic surgery - Preauthorization will determine whether there is medical documentation that the physical anomaly being addressed by the surgery represents a significant deviation from the normal state and affects the patient's health to a degree that it impairs his or her ability to function in society;

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5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

3. Consultations provided by physicians specializing in radiology or pathology;

4. Lipectomy and panniculectomy - Preauthorization will determine whether there is an abnormal amount of redundant skin and subcutaneous tissue which is causing significant health problems for the patient;

5. Transplantation of vital organs;

6. Surgical procedures for the treatment of morbid obesity; and

7. Elective services from a non-contiguous state.

D. Certain surgical procedures identified under "Inpatient Services" (Attachment 3.1A page 12B number 11) must be preauthorized when performed on a hospital inpatient basis unless:

1. The patient is already a hospital inpatient for a medically necessary condition unrelated to the surgical procedure requiring preauthorization, or

2. An unrelated procedure which requires hospitalization is being performed simultaneously.

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UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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PROGRAM	LIMITATIONS
<p>6e. Nurse Practitioner Services</p> <p>This section includes nurse practitioners other than certified pediatric and certified family.</p>	<p>The Program reimburses certified nurse practitioners directly for medically necessary services rendered to recipients in accordance with the functions allowed under the Maryland Nurse Practice Act or COMAR 10.27.07 and the certified nurse practitioner's written agreement with a physician, or if out of State, those functions authorized in the state in which the services are provided. These services shall be clearly related to the recipient's medical needs and described in the recipient's medical record in sufficient detail to support the invoice submitted for those services. A certified nurse practitioner may practice in Maryland only in the area of specialization in which the nurse practitioner is certified by the Nursing Board; or if out of State, only in the area of specialization allowed by the licensing authority in the state in which services are provided.</p> <p>A. Services which are not covered are:</p> <ol style="list-style-type: none">1. Services not encompassed by the certified nurse practitioner's written agreement with the physician, if required by the state in which services are provided;2. Services not medically necessary;3. Services prohibited by the Maryland Nurse Practice Act or by COMAR 10.27.07;4. Services prohibited in the state in which services are provided;

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PROGRAM	LIMITATIONS
<p>6e. Nurse Practitioner Services</p> <p>This section includes nurse practitioners other than certified pediatric and certified family.</p>	<p>5. Nurse practitioner services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinic;</p> <p>6. Visits solely to accomplish one or more of the following:</p> <ul style="list-style-type: none">a. Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures;b. Recording of an electrocardiogram;c. Ascertaining the patient's weight;d. Interpretation of laboratory tests or panels which are considered to be part of the office visit and may not be billed separately; and <p>7. Drugs and supplies dispensed by the nurse practitioner which are acquired at no cost;</p> <p>8. Payment to nurse practitioners for specimen collection, except by venipuncture and capillary or arterial puncture;</p> <p>9. Services (other than those for pregnant women and children) denied by Medicare as not medically necessary. For pregnant women and children, the state will review for medical necessity even if Medicare has denied the coverage;</p>

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PROGRAM	LIMITATIONS
<p>6e. Nurse Practitioner Services</p> <p>This section includes nurse practitioners other than certified pediatric and certified family.</p>	<ol style="list-style-type: none">10. Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical record;11. More than one visit per day unless adequately documented as an emergency situation;12. Services paid under COMAR 10.09.22, Free-Standing Dialysis Facility Services;13. Audiometric tests for adults for the sole purpose of prescribing hearing aids since hearing aids are not covered for adults;14. Immunizations required for travel outside the continental United States;15. Services which are investigational or experimental;16. Services which are provided outside of the United States;

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PROGRAM	LIMITATIONS
<p>6. Medical care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.</p> <p>f. Nurse Anesthetists This section includes services by independently practicing nurse anesthetists.</p>	<p>The Program reimburses nurse anesthetists directly for medically necessary services, performed in collaboration with an anesthesiologist, other licensed physician, licensed dentist. These services require substantial specialized knowledge, judgment, and skill related to the administration of anesthesia, including the assessment of patients before and after operations; administration of anesthetics; monitoring of patients during anesthesia; management of fluid in intravenous therapy; and provision of respiratory care. These functions must be rendered to recipients in accordance with the functions allowed under the Maryland Nurse Practice Act or COMAR 10.27.06 and the nurse anesthetist's written agreement with a physician or dentist, or if out of State, those functions authorized in the state in which the services are provided.</p> <p>A. Services which are not covered are:</p> <ol style="list-style-type: none">1. Services not encompassed by the definition of the practice of nurse anesthesia;2. Services not medically necessary;3. Services prohibited by the Maryland Nurse Practice Act or by COMAR 10.27.06;4. Services prohibited in the state in which services are provided;

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PROGRAM	STATE OF MARYLAND LIMITATIONS
10. Dental Services	A. The Program provides a comprehensive package of medically necessary dental services for individuals younger than 21 years old, including but not limited to the following: (1) Emergency, preventive, diagnostic, and treatment services; (2) Semiannual cleaning, fluoride treatment and examination; (3) Pit and fissure sealants for the occlusal surfaces of posterior permanent teeth that are without decay; (4) Orthodontic care for conditions which: (a) Have adjusted case scores of at least 15 points on the Handicapping Labio-Lingual Deviations Index (HLD) Table No. 4; and (b) Cause dysfunction due to a handicapping malocclusion that is supported by comprehensive pretreatment orthodontic records, which include at a minimum: (i) Upper and lower study models; (ii) Cephalometric head film with analysis; (iii) Panoramic or full series periapical radiographs; (iv) Extra-oral and intra-oral photographs; (v) Clinical summary with diagnosis; (vi) HLD score sheets from attending orthodontist; and

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PROGRAM	LIMITATIONS
10. Dental Services	<p>(vii) Treatment plan;</p> <p>(5) Consultations for individuals receiving services described in A (1), (2), (3), and (4) above;</p> <p>(6) Drugs dispensed or injectable drugs administered by the dentist who meets the requirements of the Program;</p> <p>(7) Oral Health assessment by a certified EPSDT provider, and if determined medically necessary, the certified EPSDT provider may apply fluoride varnish for children 9 months through 3 years of age and if necessary, make a referral to a dentist;</p> <p>(8) General anesthesia during dental procedures when it is medically necessary; and</p> <p>(9) Fluoride varnish.</p> <p>Under EPSDT, service limitations may be exceeded based on medical necessity.</p> <p>B. The Program covers certain medically necessary dental services in the following broad categories for pregnant recipients at or above 21 years of age:</p> <p>(1) Preventive;</p> <p>(2) Restorative;</p> <p>(3) Diagnostic;</p> <p>(4) Endodontics;</p> <p>(5) Periodontics;</p> <p>(6) Oral surgery;</p> <p>(7) Prosthodontics; and</p> <p>(8) Emergency services.</p>

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PROGRAM	STATE OF MARYLAND LIMITATIONS
10. Dental Services	<p>Coverage descriptions for these services are described in Maryland Medicaid Regulations: COMAR 10.09.05.04(b).</p> <p>C. The Program will reimburse for covered services in A and B above under the following conditions:</p> <p>(1) The services are rendered in the dentist's office, the recipient's home, a general acute hospital, a skilled or intermediate care nursing facility, a free-standing clinic or in an EPSDT provider's office; and</p> <p>(2) The services are provided by or under the supervision of a dentist or by or under the supervision of a certified EPSDT primary care provider for the purpose of applying fluoride varnish.</p> <p>D. The Program limitations are included in Maryland Medicaid regulations: COMAR 10.09.05.05.</p> <p>E. Certain dental services require preauthorization. Preauthorization requirements can be found in Maryland Medicaid regulations: COMAR 10.09.05.06.</p> <p>F. Preauthorization normally required by the Program is waived when the services are covered and approved by Medicare.</p>

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PROGRAM	STATE OF MARYLAND LIMITATIONS
11. Physical therapy and related services A. Physical Therapy	<p>The Physical Therapy Program covers medically necessary physical therapy services prescribed in writing by a physician, dentist, or podiatrist when the services are provided by appropriately qualified staff as described below. Services must be diagnostic, rehabilitative or therapeutic in addition to being directly related to the written treatment order.</p> <p>Physical therapy services and physical therapists shall meet requirements listed in 42 CFR 440.110. In addition, a physical therapist shall be licensed by the State Board of Physical Therapy Examiners of Maryland to practice physical therapy, as defined in Health Occupations Article, Title 13, Annotated Code of Maryland, or by the appropriate licensing body in the jurisdiction where the physical therapy services are performed.</p> <p>A. The Physical Therapy Services Program does not cover:</p> <ol style="list-style-type: none">1. Services provided in a facility or by a group where reimbursement for physical therapy is covered by another segment of the Program;2. Services performed by physical therapy assistants when not under the direct supervision of a physical therapist;3. Services performed by physical therapy aides; or4. Experimental treatment.

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PROGRAM	STATE OF MARYLAND LIMITATIONS
17. Nurse-Midwife	<p>The Program reimburses nurse-midwives directly for medically necessary services related to the management and complete care of normal women during the antepartum, intrapartum and postpartum periods (including family planning), and normal newborn children.</p>
	<p>Nurse midwives shall:</p> <ol style="list-style-type: none">1. Hold a current license to practice registered nursing in Maryland;2. Have a written agreement with a licensed physician which describes the functions and scope of practice of the nurse midwife;3. Be certified as a nurse midwife by the American College of Nurse-Midwives; and4. Be in compliance with requirements to practice nurse midwifery established by the State Board of Nursing.
	<p>The following are not covered under the Nurse-Midwife Regulations:</p> <ol style="list-style-type: none">1. Services not medically necessary;2. Services prohibited by the Maryland Nurse Practice Act or by the State Board of Examiners of Nurses;3. Services for inpatient recipients in State-operated psychiatric, mental retardation facilities, or State chronic hospitals;4. Visits to the nurse-midwife solely for the purpose of obtaining prescriptions, drugs, food

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17. Nurse-Midwife	supplements, laboratory specimens, or the interpretation of laboratory findings; 5. Drugs and supplies which are acquired at no cost; 6. Injections and visits solely for injections unless medical necessity and patient's inability to take appropriate oral medications are adequately documented; 7. More than one visit per day unless adequately documented as an emergency situation; 8. Separate visit charge on date of delivery; 9. Laboratory or radiology services performed by another facility. The facility must bill directly; 10. Specimen collections as a separate service, except venipuncture; 11. Services paid under COMAR 10.09.22, Free-Standing Dialysis Facility Services; 12. Immunizations required for travel outside the continental United States; 13. Services which are investigational or experimental; 14. Services which are provided outside of the United States;
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PROGRAM	STATE OF MARYLAND LIMITATIONS
<p>23.h. Nurse Practitioner Services</p> <p>This section includes certified pediatric and certified family nurse practitioners. Both groups must meet requirements listed under 440.166 of the Code of Federal Regulations.</p> <p>See section 6e of this plan for limitations for other licensed nurse practitioners.</p>	<p>The Program reimburses pediatric and family nurse practitioners directly for medically necessary services rendered to recipients in accordance with the functions allowed under the Maryland Nurse Practice Act or COMAR 10.27.07 and the certified nurse practitioner's written agreement with a physician, or if out of State, those functions authorized in the state in which the services are provided. These services shall be clearly related to the recipient's medical needs and described in the recipient's medical record in sufficient detail to support the invoice submitted for those services. A certified pediatric or family nurse practitioner may practice in Maryland only in the area of specialization in which the nurse practitioner is certified by the Nursing Board; or if out of State, only in the area of specialization allowed by the licensing authority in the state in which services are provided.</p> <p>A. Services which are not covered are:</p> <ol style="list-style-type: none">1. Services not encompassed by the certified nurse practitioner's written agreement with the physician, if required by the state in which services are provided;2. Services not medically necessary;3. Services prohibited by the Maryland Nurse Practice Act or by COMAR 10.27.07;4. Services prohibited in the state in which services are provided;

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23.h. Nurse Practitioner Services

This section includes certified pediatric and certified family nurse practitioners. Both groups must meet requirements listed under 440.166 of the Code of Federal Regulations.

See section 6e of this plan for limitations for other licensed nurse practitioners.

5. Nurse practitioner services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinic;
6. Visits solely to accomplish one or more of the following:
 - a. Prescription, drug or food supplement pick-up, collection of specimens for laboratory procedures;
 - b. Recording of an electrocardiogram;
 - c. Ascertaining the patient's weight;
 - d. Interpretation of laboratory tests or panels which are considered to be part of the office visit and may not be billed separately; and
7. Drugs and supplies dispensed by the nurse practitioner which are acquired at no cost;
8. Payment to nurse practitioners for specimen collection, except by venipuncture and capillary or arterial puncture;
9. Services (other than those for pregnant women and children) denied by Medicare as not medically necessary. For pregnant women and children, the state will review for medical necessity even if Medicare has denied the coverage;

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<p>23.h. Nurse Practitioner Services</p> <p>This section includes certified pediatric and certified family nurse practitioners. Both groups must meet requirements listed under 440.166 of the Code of Federal Regulations.</p> <p>See section 6e of this plan for limitations for other licensed nurse practitioners.</p>	<p>10. Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical record;</p> <p>11. Services paid under COMAR 10.09.22, Free-Standing Dialysis Facility Services;</p> <p>12. More than one visit per day unless adequately documented as an emergency situation;</p> <p>13. Audiometric tests for adults for the sole purpose of prescribing hearing aids since hearing aids are not covered for adults;</p> <p>14. Immunizations required for travel outside the continental United States;</p> <p>17. Services which are investigational or experimental;</p> <p>18. Services which are provided outside of the United States;</p>
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State of Maryland

5. Physician and Osteopath Rates

- 5.a The Agency's rates for professional services rendered by a physician or osteopath were set as of 7/1/09 and are effective for services on or after that date. All providers must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1.A of the Maryland State Plan. Providers will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule.
- 5.b All providers described in 5a, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers are paid by CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 81 percent of Medicare 2009 fees beginning as of 7/1/09. All rates are published on the Agency's website at: <http://www.dhmh.state.md.us/mma/providerinfo/doc/010109revphysfeeschedrev2.xls>.
- 5.c For professional services rendered by physicians to a trauma patient on the State Trauma Registry, who is receiving emergency room or inpatient services in a state designated trauma center, reimbursement will be 100% of the Baltimore City and surrounding area Title XVIII Medicare physician fee schedule facility fee rate. All providers must be licensed in the jurisdiction in which they provide services and must be providing services within a state designated trauma center. Services are limited to those outlined in 3.1.A of the Maryland State Plan. The provider will be paid the lower of the provider's customary fee schedule to the general public or the fee methodology described above.
- 5.d All providers described in 5.c., are paid by CPT codes and both government and non-government providers are reimbursed pursuant to the same fee schedule which is published on the CMS website at: <http://www.cms.hhs.gov/FeeScheduleGenInfo/>

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5.e. Payment limitations:

- Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultants.
- Referrals from one physician to another for treatment of specific patient problems may not be billed as consultations.
- The operating surgeon may not bill for the administration of anesthesia or for an assistant surgeon who is not in his employ.
- Payment for consultations provided in a multi-specialty setting is limited by criteria established by the Department.
- The Department will not pay a provider for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
- The Department will not pay physicians under their physician's provider number for services rendered by an employed non-physician extender, such as, a physical therapist, an occupational therapist, a speech language pathologist, an audiologist or a nutritionist.
- The Department will not pay for physician-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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6. Nurse Practitioner Rates (for all nurse practitioners and nurse anesthetists)

- 6.a. The Agency's rates for professional services rendered by nurse practitioners and nurse anesthetists were set as of 7/1/09 and are effective for services on or after that date. All practitioners must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The practitioner will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule.
- 6.b. Both government and non-government practitioners are reimbursed pursuant to the same fee schedule. All practitioners are paid by CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 81 percent of Medicare 2009 fees beginning as of 7/1/09. All rates are published on the Agency's website at:
<http://www.dhmh.state.md.us/mma/providerinfo/doc/010109revphysfeeschedrev2.xls>.
- 6.c. Payment limitations:
- The Department will not pay for practitioner-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
 - The Department will not pay for disposable medical supplies usually included with the office visit.
 - The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The Department will not pay a provider for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
 - In addition, for nurse anesthetists, preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the nurse anesthetist may not bill them as consultants.

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6.c. Continued

- The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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7. Certified Nurse Mid-wife Rates

- 7.a. The Agency's rates for professional services rendered by a certified mid-wife were set as of 7/1/09 and are effective for services on or after that date. All nurse midwives must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The certified nurse midwife will be paid the lower of the certified nurse midwife's customary fee schedule to the general public or the published fee schedule.
- 7.b. All certified nurse midwives, both government and non-government, are reimbursed pursuant to the same fee schedule. Certified nurse midwives are paid by CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 81 percent of Medicare 2009 fees beginning as of 7/1/09. All rates are published on the Agency's website at:
http://www.dhmh.state.md.us/maa/providerinfo/doc/010109revphysfee_schedrev2.xls.
- 7.c. Payment limitations:
- The Department will not pay for practitioner-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
 - The Department will not pay for disposable medical supplies usually included with the office visit.
 - The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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8. Podiatrist Rates

- 8.a. The Agency's rates for professional services rendered by a podiatrist were set as of 7/1/09 and are effective for services on or after that date. All podiatrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1.A of the Maryland State Plan. The podiatrist will be paid the lower of the podiatrist's customary fee schedule to the general public or the published fee schedule.
- 8.b. All podiatrists, both government and non-government, are reimbursed pursuant to the same fee schedule. Podiatrists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 81 percent of Medicare 2009 fees beginning as of 7/1/09. All rates are published on the Agency's website at: <http://www.dhmh.state.md.us/mma/providerinfo/doc/010109revphysfeeschedrev2.xls>.
- 8.c. Payment limitations:
- Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultants.
 - Referrals from one podiatrist to another for treatment of specific patient problems may not be billed as consultations.
 - The operating podiatrist may not bill for the administration of anesthesia or for an assistant podiatrist who is not in his employ.
 - Payment for consultations provided in a multi-specialty setting is limited by criteria established by the Department.
 - The Department will not pay a podiatrist for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
 - The Department will not pay for provider-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
 - The Department will not pay for disposable medical supplies usually included with the office visit.

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8.c. Continued :

- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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9. Physical Therapist's Rates

- 9.a. The Agency's rates for professional services rendered by a physical therapist were set as of 7/1/09 and are effective for services on or after that date. All physical therapists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1.A of the Maryland State Plan. The physical therapist will be paid the lower of the physical therapist's customary fee schedule to the general public or the published fee schedule.
- 9.b. All physical therapists, both government and non-government, are reimbursed pursuant to the same fee schedule. Physical therapists are paid by CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 81 percent of Medicare 2009 fees beginning as of 7/1/09. All rates are published on the Agency's website at: <http://www.dhmh.state.md.us/mma/providerinfo/doc/010109revphysfeeschedrev2.xls>.
- 9.c. Payment limitations:
- The Department will not pay for disposable medical supplies usually included with the office visit.
 - The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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10. Dentist Rates

- 10.a. The Agency's rates for professional services rendered by a dentist were set as of 7/1/09 and are effective for services on or after that date. All dentists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1.A of the Maryland State Plan. The dentist will be paid the lower of the dentist's customary fee schedule to the general public or the published fee schedule.
- 10.b. All dentists, both government and non-government, are reimbursed pursuant to the same fee schedule. Dentists are paid by CDT codes which are based on a percentage of the 50th percentile of the American Dental Association's (ADA) South Atlantic region charges for all dental procedures. The average Maryland Medicaid payment rate is approximately 61 percent of the ADA's 2009 fees beginning as of 7/1/09. All rates are published on the Agency's website at: <http://www.dhmh.state.md.us/mma/providerinfo/doc/010109revphysfeeschedrev2.xls>.
- 10.c. Payment limitations:
- The Department will not pay for drugs administered by dentists that have been obtained from manufacturers which do not participate in the federal Drug Rebate Program.
 - The Department will not pay for disposable medical supplies usually included with the office visit.
 - The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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11. Optometrist Rates

- 11.a. The Agency's rates for professional services rendered by an optometrist were set as of 7/1/09 and are effective for services on or after that date. All optometrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1.A of the Maryland State Plan. The optometrist will be paid the lower of the optometrist's customary fee schedule to the general public or the published fee schedule.
- 11.b. All optometrists, both government and non-government, are reimbursed pursuant to the same fee schedule. Optometrists are paid based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 81 percent of Medicare 2009 fees beginning as of 7/1/09. All rates are published on the Agency's website at:
<http://www.dhnh.state.md.us/inma/providerinfo/doc/Q10109rcvphysfeeschedrev2.xls>
- 11.c. Payment limitations:
- The Department will not pay for practitioner-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
 - The Department will not pay for disposable medical supplies usually included with the office visit.
 - The Department will not pay for services which do not involve direct, face-to-face, patient contact.
 - The provider may not bill the Program or the recipient for:
 - Completion of forms and reports;
 - Broken or missed appointments;
 - Professional services rendered by mail or telephone;
 - Services which are provided at no charge to the general public;
 - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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