

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

Limitations:

Include:

- Any services identified by the Department as not medically necessary or not covered;
- investigational and experimental drugs and procedures;
- visits solely for the purpose of one or more of the following
 - prescription, drug or supply pick-up, or collection of laboratory specimens;
 - ascertaining the patient's weight; and
 - measurement of blood pressure
- injections and visits solely for the administration of injections;
- immunizations required for travel outside the Continental U.S.;
- visits solely for group or individual health education;
- separate billing for services which are included as part of another service; and
- separate reimbursement to a physician for services provided in a clinic in addition to the clinic reimbursement

For Outpatient Methadone Treatment Centers:

In addition to limitations listed above, the Department will not pay for:

- Intensive Outpatient (IOP), individual and group substance abuse counseling services provided in the same week during the time an individual is receiving methadone services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland**Physician and Osteopath Rates**

- 5.a The Agency's rates for professional services rendered by a physician or osteopath were set as of 7/1/10 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 3.1A 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 5.a, 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. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 will be set at 100% using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates. The average Maryland Medicaid payment rate is approximately 85% of Medicare fees. In addition, the State will pay the federally calculated VFC vaccine administration charge. All rates are published on the Agency's website accessed by the following link and selecting the most recent year:
<http://mmcp.dhmdh.maryland.gov/SitePages/Provider%20Information.aspx>
- 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 3.1A 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/>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland**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 7/1/10 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. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 will be set at 100% using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates. The average Maryland Medicaid payment rate is approximately 85% of Medicare fees. In addition, the State will pay the federally calculated VFC vaccine administration charge. All rates are published on the Agency's website accessed by the following link and selecting the most recent year:
<http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>
- 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.
 - 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland**Certified Nurse Mid-wife Rates**

- 7.a The Agency's rates for professional services rendered by a certified mid-wife were set as of 7/1/10 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. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 will be set at 100% using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates. The average Maryland Medicaid payment rate is approximately 85% of Medicare fees. In addition, the State will pay the federally calculated VFC vaccine administration charge. All rates are published on the Agency's website accessed by the following link and selecting the most recent year:
<http://mmcp.dhmdh.maryland.gov/SitePages/Provider%20Information.aspx>
- 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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State of Maryland**Podiatrist Rates**

- 8.a The Agency's rates for professional services rendered by a podiatrist were set as of 7/1/10 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 3.1A 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. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 will be set at 100% using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates. The average Maryland Medicaid payment rate is approximately 85% of Medicare fees. In addition, the State will pay the federally calculated VFC vaccine administration charge. All rates are published on the Agency's website accessed by the following link and selecting the most recent year:
<http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>
- 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.
 - 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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❖ Local Health Departments and General Clinics

Physicians are reimbursed based on the current fee schedule which is effective for Local Health Department as of January 1, 2012 and for the General Clinics the effective date is January 1, 1993. A unit of service is a visit or procedure as defined in the American Medical Association Current Procedural Terminology (AMA CPT). For dates of service between January 1, 2013 and December 30, 2014, provider rates for Evaluation and Management (E&M) procedure codes will be set at 100% of the Medicare mean. In addition, the State will pay the federally calculated VFC vaccine administration charge. The State-developed fee schedule rates are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided:

<http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>

The current fee schedule is located by selecting the link for the Physicians Fee Schedule for the most recent year posted.

The Department does not pay for:

- (1) Any services identified by the Department as not medically necessary or not covered;
- (2) Investigational and experimental drugs and procedures;
- (3) Visits solely for the purpose of one or more of the following:
 - a. prescription, drug or supply pick-up, or collection of laboratory specimens;
 - b. ascertaining the patient's weight; or
 - c. measurement of blood pressure
- (4) Injections and visits solely for the administration of injections;
- (5) Immunizations required for travel outside the Continental U.S.;
- (6) Visits solely for group or individual health education;
- (7) Separate billing for services which are included as part of another service; or
- (8) Separate reimbursement to a physician for services provided in a clinic in addition to the clinic reimbursement.

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❖ Family Planning Clinics

State-developed fee schedule rates are the same for both governmental and private individual practitioners and are published on the DHMH website using the link provided below:

<http://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx>

Physicians are reimbursed based on the current fee schedule which is effective as of January 1, 2012. A unit of service is a visit or procedure as defined in the American Medical Association Current Procedural Terminology (AMA CPT). For dates of service between January 1, 2013 and December 30, 2014, provider rates for Evaluation and Management (E&M) procedure codes will be set at 100% of the Medicare mean. In addition, the State will pay the federally calculated VFC vaccine administration charge. The fee schedule is located by selecting the link for the Physicians Fee Schedule for the most recent year posted.

The Department does not pay for:

- (1) Any services identified by the Department as not medically necessary or not covered;
- (2) Investigational and experimental drugs and procedures;
- (3) Visits solely for the purpose of one or more of the following:
 - a. prescription, drug or supply pick-up, or collection of laboratory specimens;
 - b. ascertaining the patient's weight; and
 - c. measurement of blood pressure;
- (4) Injections and visits solely for the administration of injections;
- (5) Immunizations required for travel outside the Continental U.S.;
- (6) Visits solely for group or individual health education;
- (7) Separate billing for services which are included as part of another service; or
- (8) Separate reimbursement to a physician for services provided in a clinic in addition to the clinic reimbursement.

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