

CHAPTER 1141. PHYSICIANS' SERVICES

GENERAL PROVISIONS

- Sec.
- 1141.1. Policy.
- 1141.2. Definitions.

SCOPE OF BENEFITS

- 1141.21. Scope of benefits for the categorically needy.
- 1141.22. Scope of benefits for the medically needy.
- 1141.23. Scope of benefits for State Blind Pension recipients.
- 1141.24. Scope of benefits for General Assistance recipients.

PROVIDER PARTICIPATION

- 1141.41. Participation requirements.
- 1141.42. Ongoing responsibilities of providers.

PAYMENT FOR PHYSICIANS' SERVICES

- 1141.51. General payment policy.
- 1141.52. Payment conditions for various services.
- 1141.53. Payment conditions for outpatient services.
- 1141.53a. Clinic and emergency room services personal performance—Statement of policy.
- 1141.54. Payment conditions for inpatient services.
- 1141.54a. Acute care hospitals and their short procedure unit services personal performance—Statement of policy.
- 1141.55. Payment conditions for sterilizations.
- 1141.56. Payment conditions for hysterectomies.
- 1141.57. Payment conditions for necessary abortions.
- 1141.58. [Reserved].
- 1141.59. Noncompensable services.
- 1141.60. Payment for medications dispensed or ordered in the course of an office visit.

UTILIZATION REVIEW

- 1141.71. Scope of claims review procedures.

ADMINISTRATIVE SANCTIONS

- 1141.81. Provider misutilization.

Authority

The provisions of this Chapter 1141 issued under sections 403 and 443.3(2)(ii) of the Public Welfare Code (62 P.S. §§ 403 and 443.3(2)(ii)), unless otherwise noted.

Source

The provisions of this Chapter 1141 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 1101.31 (relating to scope); 55 Pa. Code § 1101.95 (relating to conflicts between general and specific provisions); 55 Pa. Code § 1150.56b (relating to payment policy for observation services—statement of policy); 55 Pa. Code § 1163.51 (relating to general payment policy); and 55 Pa. Code § 1221.58 (relating to limitations on payment).

GENERAL PROVISIONS**§ 1141.1. Policy.**

The MA Program provides payment for specific medically necessary physician's services rendered to eligible recipients by physicians enrolled as providers under the program. Payment for physicians' services is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.

Authority

The provisions of this § 1141.1 amended under sections 403(a) and (b), 443.2(1) and (2), 443.3(1), (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).

Source

The provisions of this § 1141.1 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; 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 page (117364).

§ 1141.2. Definitions.

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

Abortion—The deliberate termination of a pregnancy before the fetus is viable.

Chronic condition—An illness which frequently recurs or persists for a period in excess of 3 months.

Consultation—A medical evaluation conducted by a specialist at the request of the attending practitioner. For the purposes of the Medical Assistance Program a consultation shall include taking a medical history, examining the patient and preparing a written report that is incorporated into the record of the patient.

Cosmetic surgery—A surgical procedure the primary purpose of which is to improve the appearance of the patient. The procedures include, but are not limited to, otoplasty for protruding ears or lop ears, rhinoplasty, except to correct internal nasal deformity, nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathism or both, dermabrasion, skin grafts and lipectomy.

Covered services—A benefit to which a Medical Assistance recipient is entitled under the Medical Assistance program.

Emergency situation—A condition in which immediate medical care is necessary to prevent the death or serious impairment of health of the individual.

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.

Family planning services—Those diagnostic services, treatments, drugs, supplies, devices and counseling services furnished to individuals to enable them to control the number and spacing of their children.

General medical examination—A medical evaluation conducted by the attending physician of the patient, whether a general practitioner or specialist, at the request of the patient. The evaluation shall consist of a physical examination, the evaluation of diagnostic studies, if warranted, and the recording of the findings in the medical file of the patient.

Institutionalized individual—A person who is one of the following:

(i) Involuntarily detained under a civil or criminal statute in a correctional, rehabilitative or mental retardation facility including a psychiatric hospital or other facility for the care and treatment of mental illness or mental retardation.

(ii) Confined under voluntary commitment in a psychiatric hospital, mental retardation facility or other facility for the care and treatment of mental illness or mental retardation.

Medical emergency care—Care rendered in response to the sudden and unexpected onset of a medical, not surgical condition, requiring medical, not surgical, intervention which the recipient secures immediately after the onset or as soon thereafter as the care can be made available, but in no case later than 72 hours after the onset. In order to determine whether a medical emergency existed the following criteria shall be applied:

(i) Severe symptoms have to occur. The symptoms must be sufficiently severe to cause a person to seek immediate medical aid. Some symptoms or conditions indicating medical emergency care are listed in Appendix C.

(ii) Severe symptoms must occur suddenly and unexpectedly. Subacute symptoms of a chronic condition would not qualify as a medical emergency. However, chronic symptoms that suddenly become severe enough to require immediate medical attention would qualify.

(iii) Immediate care was secured. A medical emergency would not be considered to exist if medical care were not rendered immediately after the patient reported his symptoms to the physician. A telephone call to a doctor would not fulfill this requirement if examination and treatment by the physician were deferred until the next day.

Medical examination requested by the Department—A medical evaluation conducted by the attending physician of the patient whether a general practitioner or specialist at the request of the Department. The evaluation shall consist of a physical examination, the evaluation of diagnostic studies, the recording of findings in the file of the patient and the completion of medical evaluation forms supplied by the Department.

Medical justification—Written documentation in the medical record of the patient indicating the specific health condition or risk that made the particular service the physician rendered, ordered or prescribed necessary.

Medically necessary—A service, item, procedure or level of care that is:

- (i) Compensable under the Medical Assistance program.
- (ii) Necessary to the proper treatment or management of an illness, injury or disability.
- (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.

Mentally incompetent individual—A person who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction for any purpose unless he has been declared competent for the purposes which include the ability to consent to sterilization.

Noncompensable—A service a provider furnishes for which there is no provision for payment under Medical Assistance regulations.

Nonemergency medical services—A compensable physicians' services other than those provided for condition urgently requiring medical intervention in order to sustain the life of the person to prevent damage to his health.

Physician—An individual licensed under the laws of this Commonwealth to practice medicine and surgery within the scope of the Medical Practice Act of July 20, 1974 (P. L. 551, No. 190) (63 P. S. § 421.10) or the Osteopathic Medical Practice Act (63 P. S. §§ 271.1—271.18).

Short procedure unit—A unit of a hospital organized for the delivery of non-emergency surgical services to patients who do not remain in the hospital overnight.

Specialist—A physician who limits his practice to the study and treatment of one class of diseases or to treatment of specific organs or systems within the body, recognized by the American Medical Association or the American Osteopathic Association for his particular specialty.

Sterilization—A recognized medical procedure the primary purpose of which is to render the patient incapable of reproduction.

Source

The provisions of this § 1141.2 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended April 27, 1984, effective April 28, 1984, 14 Pa.B. 1454; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (117364), (93481) to (93482) and (96099).

Cross References

This section cited in 55 Pa. Code § 1141.55 (relating to payment conditions for sterilizations); and 55 Pa. Code § 1141.59 (relating to noncompensable services).

SCOPE OF BENEFITS**§ 1141.21. Scope of benefits for the categorically needy.**

Categorically needy recipients are eligible for medically necessary physicians' services covered by the MA Program subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1141.21 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

§ 1141.22. Scope of benefits for the medically needy.

Medically needy recipients are eligible for medically necessary physicians' services covered by the MA Program subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to the general provisions).

Source

The provisions of this § 1141.22 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

§ 1141.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are only eligible for physicians' services provided in the home of the recipient or the office of the physician.

Source

The provisions of this § 1141.23 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

§ 1141.24. Scope of benefits for General Assistance recipients.

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

Source

The provisions of this § 1141.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

PROVIDER PARTICIPATION**§ 1141.41. Participation requirements.**

Participation requirements are established in §§ 1101.41—1101.43 (relating to participation).

Source

The provisions of this § 1141.41 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

§ 1141.42. Ongoing responsibilities of providers.

Ongoing responsibilities of providers are established in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1141.42 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

PAYMENT FOR PHYSICIANS' SERVICES**§ 1141.51. General payment policy.**

Payment is made for covered services provided by participating physicians subject to the conditions and limitations established in Chapter 1101 (relating to general provisions), §§ 1141.52—1141.57, 1141.59 and Chapter 1150 (relating to MA Program payment policies). Payment will not be made for a covered physicians' service if payment is available from another public agency or another insurance or health program.

Authority

The provisions of this § 1141.51 issued under sections 403(a) and (b), 443.2(1) and (2), 443.3(1) and (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).

Source

The provisions of this § 1141.51 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; 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 page (96100).

Cross References

This section cited in 55 Pa. Code § 1141.52 (relating to payment conditions for various services).

§ 1141.52. Payment conditions for various services.

In order for payment to be made to a physician for covered services, such services shall meet the applicable conditions of §§ 1141.51—1141.57.

Source

The provisions of this § 1141.52 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

Cross References

This section cited in 55 Pa. Code § 1141.51 (relating to general payment policy).

§ 1141.53. Payment conditions for outpatient services.

(a) Payment is made for services performed in an approved Short Procedure Unit (SPU) only if the service could not be appropriately and safely performed in the physician's office, the clinic, or the emergency room of a hospital because of the medical need for inpatient hospital resources such as an operating room and the administration of general anesthesia.

(b) Specialists' examinations and consultations require prior authorization from the Department as described in § 1101.67 (relating to prior authorization).

(c) Physicians' services provided to recipients in skilled and intermediate care facilities by the physician administrator or medical director of the facility are compensable only if the administrator's or medical director's salary does not include payment for patient care.

(d) Payment for sterilizations is subject to the conditions set forth in § 1141.55 (relating to payment conditions for sterilizations).

(e) Payment for abortions is subject to the conditions set forth in § 1141.57 (relating to payment conditions for necessary abortions).

(f) All covered outpatient physicians' services billed to the Department shall be performed by such physician either personally or by a registered nurse, physician's assistant, or a midwife under the physician's direct supervision.

(g) The Department pays a \$10 per month fee only to physicians who are approved by the Department to participate in the restricted recipient program as set forth in § 1101.91 (relating to recipient misutilization and abuse). The physician is paid the \$10 monthly fee for the restricted recipient under the physician's medical supervision. This fee is in addition to fees paid to the physician during the month for necessary and covered medical services furnished to restricted recipient.

Authority

The provisions of this § 1141.53 amended under sections 403(a) and (b), 443.2(1) and (2), 443.3(1) and (2)(i)—(v), 443.4, 443.6 and 509 of the Public Welfare Code, §§ 403(a) and (b), 443.2(1) and (2), 443.3(1), 443.3(2)(i)—(v), 443.4, 443.6 and 509 (62 P. S. §§ 403(a) and (b), 443.2(1) and (2), 443.3(1), 443.3(2)(i)—(v), 443.4, 443.6 and 509).

Source

The provisions of this § 1141.53 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended October 8, 1982, effective October 9, 1982, 12 Pa.B. 3647; amended April 27, 1984, effective April 28, 1984, 14 Pa.B. 1454; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252; amended November 30, 1984, effective December 1, 1984, 14 Pa.B. 4370, and by approval of the court of a joint motion for modification of a consent agreement dated February 11, 1985 in *Turner v. Beal, et al.*, C.A. No. 74-1680 (E.D. Pa. 1975). Immediately preceding text appears at serial pages (96100) to (96101).

Cross References

This section cited in 55 Pa. Code § 1141.51 (relating to general payment policy); and 55 Pa. Code § 1141.52 (relating to payment conditions for various services).

§ 1141.53a. Clinic and emergency room services personal performance—statement of policy.

(a) Consistent with 42 CFR 415.152 (relating to definitions), a teaching physician is a physician (other than another resident) who involves residents in the care of that teaching physician's patients.

(b) Clinic services rendered by a resident are compensable when a teaching physician is readily available for immediate face-to-face consultation and assistance.

(c) Emergency room services rendered by a resident are compensable when a teaching physician is readily available for immediate face-to-face consultation and assistance.

(d) Consistent with 42 CFR 415.180 (relating to teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests), the interpretation of diagnostic radiology and other diagnostic tests is compensable. Documentation must indicate that the teaching physician personally performed the interpretation or reviewed the resident's interpretation with the resident.

Source

The provisions of this § 1141.53a adopted September 15, 2006, effective September 16, 2006, 36 Pa.B. 5786.

Cross References

This section cited in 55 Pa. Code § 1141.54a (relating to acute care hospitals and their short procedure unit services personal performance—statement of policy).

§ 1141.54. Payment conditions for inpatient services.

(a) A physician is eligible to bill the Department for services he provides to a hospitalized recipient:

(1) If inpatient hospital care is medically necessary as certified by the hospital's utilization review committee or the Department's Bureau of Utilization Review.

(2) For an outpatient (OP) designated procedure, only if the medical condition of the patient is such that to perform the procedure on an outpatient basis could result in undue risk to the life or health of the patient. Detailed documentation supporting 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) If the hospital has not been denied payment by the Department for the day the service was provided.

(b) Payment for sterilizations is subject to the conditions set forth in § 1141.55 (relating to payment conditions for sterilizations).

(c) Payment for hysterectomies is subject to the conditions set forth in § 1141.56 (relating to payment conditions for hysterectomies).

(d) Payment for abortions is subject to the conditions set forth in § 1141.57 (relating to payment conditions for necessary abortions).

(e) [Reserved].

(f) All inpatient physicians' services billed to the Department shall be performed by the physician either personally or by a registered nurse, physician's assistant or midwife under the physician's direct supervision.

Authority

The provisions of this § 1141.54 issued under sections 403(a) and (b), 443.2(1) and (2), 443.3(1) and (2)(i)—(v), 443.4 and 509 of the Public Welfare Code, §§ 403(a) and (b) 443.2(1) and (2), 443.3(1), 443.3(2)(i)—(v), 443.4 and 509 (62 P. S. §§ 403(a) and (b) 443.2(1) and (2), 443.3(1), 443.3(2)(i)—(v), 443.4 and 509).

Source

The provisions of this § 1141.54 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended October 8, 1982, effective October 9, 1982, 12 Pa.B. 3647; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252. Immediately preceding text appears at serial pages (88744) to (86757).

Cross References

This section cited in 55 Pa. Code § 1141.51 (relating to general payment policy); and 55 Pa. Code § 1141.52 (relating to payment conditions for various services).

§ 1141.54a. Acute care hospitals and their short procedure unit services personal performance—statement of policy.

(a) Consistent with 42 CFR 415.152 (relating to definitions), a teaching physician is a physician (other than another resident) who involves residents in the care of that teaching physician's patients.

(b) The Department will reimburse for teaching physician services rendered in acute care hospitals or their short procedure units in accordance with the Medicare standards governing payment for professional services rendered by teaching physicians in 42 CFR 415.170—415.184, including any subsequent

amendments thereto, except as provided in § 1141.53a (relating to clinic and emergency room services personal performance—statement of policy).

Source

The provisions of this § 1141.54a adopted September 15, 2006, effective September 16, 2006, 36 Pa.B. 5786.

§ 1141.55. Payment conditions for sterilizations.

(a) Payment for covered sterilization procedures is made to a physician only if all of the following requirements are met:

- (1) The individual requesting sterilization has voluntarily given informed consent in accordance with all requirements described in subsection (b) of this section.
- (2) The individual is at least 21 years old at the time informed consent is obtained.
- (3) The individual is not a mentally incompetent individual or an institutionalized individual as defined in § 1141.2 (relating to definitions).

(b) An individual requesting sterilization has voluntarily given informed consent only if all of the following requirements are met:

- (1) The Consent Form, MA 31, is completed correctly in accordance with all instructions in the Provider Handbook and within the time frame specified in subsection (c)(1). See Appendix A for a facsimile of the Consent Form and the Provider Handbook for detailed instructions on its completion.
- (2) The person obtaining informed consent has explained orally all elements of informed consent as included in the Consent to Sterilization section of the Consent Form.
- (3) The person obtaining informed consent has advised the individual that a decision not to be sterilized shall not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds and has offered to answer any questions the individual may have concerning the sterilization procedure.

(4) The individual providing informed consent has been permitted to have a witness of his or her choice present when informed consent was given.

(5) The individual has been offered a language interpreter, if necessary, or an appropriate interpreter if the individual is blind, deaf, or otherwise handicapped.

(6) Any additional State or local laws for obtaining consent have been met.

(c) A Consent Form, MA 31, is considered to be completed correctly only if all of the following requirements are met:

- (1) At least 30 days, but no more than 180 days, have passed between the date the individual has given written informed consent and the date of the sterilization procedure.

Exception: In the case of emergency abdominal surgery, 72 hours must have passed between the time of informed consent and the time of surgery. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery.

(2) The person obtaining informed consent has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given.

(3) Any other witness or interpreter has properly signed the Consent Form in accordance with instructions in the Provider Handbook.

(4) The physician performing the sterilization procedure has certified and signed the Physician's Statement section of the Consent Form after the procedure has been performed.

Source

The provisions of this § 1141.55 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial pages (60740) to (60741).

Cross References

This section cited in 55 Pa. Code § 1141.51 (relating to general payment policy); 55 Pa. Code § 1141.52 (relating to payment conditions for various services); 55 Pa. Code § 1141.53 (relating to payment conditions for outpatient services); and 55 Pa. Code § 1141.54 (relating to payment conditions for inpatient services).

§ 1141.56. Payment conditions for hysterectomies.

(a) Except as specified in subsection (c), if an individual is not sterile prior to the hysterectomy, payment will be made for a hysterectomy only if all of the following requirements are met:

(1) The hysterectomy was medically necessary and performed for a valid medical reason other than sterilization.

(2) The individual and her representative, if any, were advised orally and in writing, before the operation, that the hysterectomy would render the individual permanently incapable of reproducing.

(3) The individual or her representative, if any, has signed a written acknowledgement of receipt of that information. The acknowledgement statement shall be signed and dated before or after the operation. If the statement is signed after surgery, it must clearly reflect that the individual was informed before the operation. See the Provider Handbook for a facsimile of the Patient Acknowledgement Form for Hysterectomy, MA 30, and for instructions on its completion.

(b) Except as specified in subsection (c), if the individual was already sterile, payment is made for hysterectomy only if both of the following conditions are met:

- (1) The physician who performed the hysterectomy certified in writing that the woman was sterile prior to the procedure and stated the cause of the sterility. Such reasons may include, but are not limited to, congenital disorders, a previous sterilization or postmenopausal sterility. A statement certifying the cause of sterility must be noted on the invoice.
- (2) The hysterectomy was medically necessary.
- (c) Payment is also made for a hysterectomy performed, whether or not the patient was already sterile, if:
 - (1) The individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgement was not possible. The physician must include a description of the nature of the emergency, documenting that prior acknowledgement was not possible. A description of the nature of the emergency must be noted on the invoice.
 - (2) The hysterectomy was medically necessary and performed for a valid medical reason other than sterilization.

Authority

The provisions of this § 1141.56 issued under sections 403(a) and (b), 443.2(1) and (2), 443.3(1), 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).

Source

The provisions of this § 1141.56 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended December 2, 1983, effective August 4, 1982, 13 Pa.B. 3758; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252. Immediately preceding text appears at serial pages (86760) to (86761).

Cross References

This section cited in 55 Pa. Code § 1141.51 (relating to general payment policy); 55 Pa. Code § 1141.52 (relating to payment conditions for various services); and 55 Pa. Code § 1141.54 (relating to payment conditions for inpatient services).

§ 1141.57. Payment conditions for necessary abortions.

- (a) Coverage for abortions funded under the Medical Assistance Program will be available only under the following circumstances:
 - (1) Where a physician has certified in writing and documented in the patient's record that the life of the woman would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the woman's life is endangered is a medical judgment to be made by the woman's physician.
 - (i) Payment will be made only if a licensed physician submits a signed "Physician Certification for An Abortion" form, as set forth in Appendix B, with the Medical Services Invoice.
 - (ii) A second physician's opinion regarding endangerment of the woman's life is optional and is not a prerequisite to payment for a covered abor-

tion. However, the person or the attending physician, with the consent of the person, may obtain a second physician's opinion.

(2) Where the recipient was the victim of rape or incest and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and within 72 hours of the time the physician notified the patient that she was pregnant in the case of incest. A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service means an agency of the Federal, State, or local government or a facility certified by the Federal government as a Rural Health Clinic that provides health or medical services except for those agencies whose principal function is the performance of abortions.

(i) Payment will be made only if a licensed physician submits a signed "Physician Certification for an Abortion" form, as set forth in Appendix B, with the Medical Services Invoice along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation shall include the following:

(A) All of the information specified in subparagraph (ii).

(B) A statement that the report was signed by the person making the report.

(ii) The report of the rape or incest need not be made by the victim herself but can be reported by another person. The report need not be made in person but may be made by mail. The report itself must be signed by the person who reports the rape or incest and shall include the following information:

(A) The name and address of the victim.

(B) The name and address of the person who made the report—if different from the victim.

(C) The date of the incident if it was rape.

(D) The date the report was made.

(b) Insofar as required by the Department of Health regulations, during the first 12 weeks of pregnancy payment will only be made under the Medical Assistance Program for an abortion performed in a licensed physician's office, a clinic or a hospital facility, that has been licensed/approved by the Department of Health for that purpose.

(c) Insofar as required by the Department of Health regulations, after the first 12 weeks of pregnancy, payment will only be made under the Medical Assistance Program for abortions performed in a hospital which has been licensed/approved by the Department of Health.

Authority

The provisions of this § 1141.57 issued under the Public Welfare Code (62 P. S. § 453).

Source

The provisions of this § 1141.57 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended February 13, 1981, effective February 15, 1981, 11 Pa.B. 657; amended August 7, 1981, effective August 8, 1981, 11 Pa.B. 2770. Immediately preceding text appears at serial pages (60742) and (60743).

Notes of Decisions

The Department of Public Welfare's regulations which require that a victim of a rape report its occurrence within 72 hours to a law enforcement agency or a public health service or that a victim of incest report to either a public authority or a public health service within 72 hours from the time the victim is advised of her pregnancy in order to qualify for state funding of an abortion were held to be an unconstitutional intrusion upon the right of privacy guaranteed under Article I, Section 1 of the Pennsylvania Constitution. *Fischer v. Dept. of Public Welfare*, 482 A.2d 1148, 1153 (1984); affirmed 502 A.2d 114 (Pa. 1985); motion denied 543 A.2d 177 (Pa. 1988).

Cross References

This section cited in 55 Pa. Code § 1126.51 (relating to general payment policy); 55 Pa. Code § 1141.51 (relating to general payment policy); 55 Pa. Code § 1141.52 (relating to payment conditions for various services); 55 Pa. Code § 1141.53 (relating to payment conditions for outpatient services); and 55 Pa. Code § 1141.54 (relating to payment conditions for inpatient services).

§ 1141.58. [Reserved].**Source**

The provisions of this § 1141.58 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; reserved December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial page (54172).

§ 1141.59. Noncompensable services.

Payment will not be made for the following physicians' services:

- (1) Procedures not listed in the Medical Assistance program fee schedule.
- (2) Medical services or surgical procedures performed on an inpatient basis that could have been performed in the physician's office, the clinic, the emergency room, or a short procedure unit without endangering the life or health of the patient.
- (3) Medical or surgical procedures designated in the Medical Assistance program fee schedule as outpatient procedures, signified by the letters OP which are performed on an inpatient basis unless the requirements specified in Chapter 1150 (relating to noncompensable services) are met.
- (4) Dental rehabilitation and restorative services provided on an inpatient basis.

Exception—Oral restorative services are compensable on an inpatient basis for persons requiring extensive oral rehabilitation or restoration who are unmanageable in a doctor's office because of a severe physical or mental condition and require general anesthesia. Documentation of a secondary diagnosis or the specific physical or mental condition that made the hospital-

ization necessary shall be included in the record of the patient and on the invoice submitted for payment.

(5) Diagnostic tests, for which a patient was admitted, that may be performed on an outpatient basis; tests not related to the diagnosis and treatment of the illness for which the patient was admitted; tests for which there is no medical justification.

(6) Methadone maintenance.

(7) Hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing or if there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual incapable of reproducing.

(8) Acupuncture, medically unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileo-jejunal shunt—except when all other types of treatment of morbid obesity have failed—and other procedures which are experimental or are not in accordance with customary standards of medical practice.

(9) Services and procedures that are available through other public agencies or private insurance plans.

(10) Services to inpatients who no longer require acute inpatient care. However, the Department will make payment to the hospital for skilled nursing or intermediate care provided for a patient in a certified bed in a certified and approved hospital based skilled nursing or intermediate care unit.

(11) Surgical procedures and medical care provided in connection with sex reassignment. This includes but is not limited to hormone therapy, penile construction, revision of labia, vaginoplasty, vaginal dilation, vaginal reconstruction, penectomy, orchiectomy, mamoplasty, mastectomy, hysterectomy, and release of vaginal adhesions.

(12) Experimental procedures as defined in § 1141.2 (relating to definitions).

(13) Cosmetic surgery as defined in § 1141.2.

Exception: Cosmetic surgery is a covered service when performed in order to improve the functioning of a malformed body member, to correct a visible disfigurement which would affect the ability of the person to obtain or hold employment, or as postmastectomy breast reconstruction.

(14) Diagnostic pathological examinations of body fluids or tissues, procedure codes 80001 through 89360 and 89900 and 99901. Except for professional components for anatomical pathology, payment for these procedures is made only to hospital and independent laboratories that are approved to participate in the Medical Assistance Program.

(15) Services and procedures related to the delivery within the antepartum period and postpartum period when performed and billed by a midwife.

(16) Medical services or surgical procedures performed in a short procedure unit that could have been appropriately and safely performed in the physician's office, the clinic, or the emergency room without endangering the life or health of the patient.

Authority

The provisions of this § 1141.59 issued under the Public Welfare Code, §§ 403(a) and (b), 443.2(1) and (2), 443.3(1), 443.3(2)(i)—(v), 443.4 and 509 (62 P. S. §§ 403(a) and (b), 443.2(1) and (2), 443.3(1), 443.3(2)(i)—(v), 443.4 and 509).

Source

The provisions of this § 1141.59 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; amended October 8, 1982, effective October 9, 1982, 12 Pa.B. 3647; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 7, 1984, effective July 1, 1984, 14 Pa.B. 3252; amended September 30, 1988, effective November 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (99333) to (99335) and (93493).

Cross References

This section cited in 55 Pa. Code § 1141.51 (relating to general payment policy).

§ 1141.60. Payment for medications dispensed or ordered in the course of an office visit.

Physicians may be reimbursed for the actual cost of medications administered or dispensed to an eligible recipient in the course of an office or home visit providing the physician is certified for dispensing by the Office of Medical Assistance, Bureau of Provider Relations. There is no reimbursement to a physician for medical supplies or equipment dispensed in the course of an office or home visit. Payment for medical supplies and equipment is made only to pharmacies and medical suppliers participating in the Medical Assistance program.

Exception: Physicians may bill the Department for Rho(d) Immune Globulin, intrauterine devices, eyeglasses and for immunizing biologicals and antigens and drugs not provided by the Department of Health.

Source

The provisions of this § 1141.60 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

UTILIZATION REVIEW

§ 1141.71. Scope of claims review procedures.

All claims submitted for payment under the Medical Assistance program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1141.71 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

ADMINISTRATIVE SANCTIONS**§ 1141.81. Provider misutilization.**

Providers determined to have billed for services inconsistent with Medical Assistance program regulations, to have provided services outside the scope of customary standards of medical practice or to have otherwise violated the standards set forth in the provider agreement, are subject to the sanctions described in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1141.81 adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386.

APPENDIX A**Source**

The provisions of this Appendix A adopted August 15, 1980, effective September 1, 1980, 10 Pa.B. 3386; corrected February 13, 1981, effective February 14, 1981, 11 Pa.B. 656; amended February 13, 1981, effective February 15, 1981, 11 Pa.B. 657; amended August 7, 1981, effective August 8, 1981, 11 Pa.B. 2770; amended November 6, 1981, effective November 1, 1981, 11 Pa.B. 3981; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial pages (75078) to (75080), (54178) to (54179), (60748) to (60957), and (65124).

[Next page is 1142-1.]

1141-18

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