

CHAPTER 1221. CLINIC AND EMERGENCY ROOM SERVICES**GENERAL PROVISIONS**

Sec.

- 1221.1. Policy.
- 1221.2. Definitions.

SCOPE OF BENEFITS

- 1221.21. Scope of benefits for the categorically needy.
- 1221.22. Scope of benefits for the medically needy.
- 1221.23. Scope of benefits for State Blind Pension recipients.
- 1221.24. Scope of benefits for General Assistance recipients.

PROVIDER PARTICIPATION

- 1221.41. Participation requirements.
- 1221.42. Additional participation requirements for hospital clinics and emergency rooms.
- 1221.43. Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate.
- 1221.44. Additional participation requirements for independent clinics.
- 1221.45. Additional participation requirements for medical school clinics.
- 1221.46. Ongoing responsibilities of providers.

PAYMENT FOR CLINIC AND EMERGENCY ROOM SERVICES

- 1221.51. General payment policy.
- 1221.52. Payment conditions for various services.
- 1221.55. Payment conditions for sterilizations.
- 1221.57. Payment conditions for necessary abortions.
- 1221.58. Limitations on payment.
- 1221.59. Noncompensable services and items.

UTILIZATION CONTROL

- 1221.71. Scope of claims review procedures.

ADMINISTRATIVE SANCTIONS

- 1221.81. Provider misutilization.

Authority

The provisions of this Chapter 1221 issued under sections 403, 443.3(1) and 443.3(2)(ii) of the Public Welfare Code (62 P. S. §§ 403, 443.3(1), and 443.3(2)(ii)), unless otherwise noted.

1221-1

(313027) No. 371 Oct. 05

Source

The provisions of this Chapter 1221 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599, 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 § 1150.56 (relating to medical services); and 55 Pa. Code § 1151.41 (relating to general payment policy).

GENERAL PROVISIONS**§ 1221.1. Policy.**

The MA Program provides payment for clinic and emergency room services rendered to eligible recipients by hospital clinics and emergency rooms, medical school clinics and independent clinics that are enrolled as providers under the program. Payment is subject to this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule.

Source

The provisions of this § 1221.1 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117476).

§ 1221.2. 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.

Acute illness—A brief illness marked by the sudden onset of severe symptoms.

Clinic—A hospital clinic, medical school clinic, or independent clinic that provides preventative, diagnostic, therapeutic, rehabilitative or palliative services on an outpatient basis. The clinic is distinct from a group practice in that it has a director, an organized structure, a written program designed to implement the objectives of the clinic, and a professional and administrative quality review program that evaluates the effectiveness of the outpatient service in relation to the stated objectives.

Contract physician—A physician who is paid for professional services by salary or other arrangement such as hourly wage or per diem, by an employer such as a hospital, clinic, or governmental agency. An individual physician may be both an independent and contract physician. The fact that a physician is under contract does not preclude the physician from providing services on a fee for service basis to the private patients of the physician.

Emergency accident care—The initial examination and treatment performed in connection with and within 72 hours following an injury. Examples of emergency accident care include but is not limited to the following: removal of foreign body in the eye, treatment of abrasions, contusions, acute sprains or strains, nose bleeds—caused by trauma, insect bites or stings, choking on food, drink, or foreign body, resuscitation of drowning or smoke inhalation victims, or treatment of concussion, or poisoning—chemical or drug.

Emergency medical care—medical care rendered in response to the sudden onset of a medical condition requiring medical, not surgical, intervention to sustain the life of the person or to prevent damage to the person's health and 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 and, therefore, whether benefits for outpatient services in connection with the treatment of the condition are payable on an emergency basis, 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 A.

(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 intervention would qualify.

Hospital emergency room—An entity within a hospital, organizationally distinct from other outpatient facilities, the primary function of which is to provide emergency accident and emergency medical or surgical care.

Hospital outpatient clinic—A hospital operated facility that provides primary nonemergency health care on an outpatient basis. The hospital may contract out this function but the hospital shall be recognized as the provider.

Hospital outpatient department—An organizational division of a hospital composed of hospital outpatient clinics designed to provide comprehensive or specialized medical care on an outpatient basis. For the purpose of reimbursement under this chapter, a hospital outpatient department shall not include the hospital emergency room, outpatient psychiatric clinic, or outpatient drug and alcohol clinic when the hospital operates such facilities directly or through contract agreements. Reimbursement for outpatient psychiatric services are subject to Chapter 1153 (relating to outpatient psychiatric services). Reimbursement for outpatient drug and alcohol services are subject to Chapter 1223 (relating to outpatient drug and alcohol clinic services).

Independent medical clinic—A free-standing facility which provides comprehensive primary health care and which is neither located in a hospital owned nor under the management and control of the hospital. An independent medical

clinic shall be operated by a public or private nonprofit corporation other than a hospital or corporation that owns or operates a hospital.

Independent physician—A physician who is paid for professional services on a fee-for-service basis. The physician may be in private practice alone or in a group with other physicians. An independent physician or group may be incorporated.

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 school clinic—A primary health care facility operated by a medical college located in the Commonwealth of Pennsylvania which has been fully accredited by the Association of American Medical Colleges or the American Medical Association and which has an agreement with a hospital to serve as its outpatient department.

Medical school outpatient department—A term used to describe collectively all medical school clinics operated by a medical college. For the purpose of reimbursement under this chapter, a medical school outpatient department shall not include the outpatient psychiatric clinic or outpatient drug and alcohol clinic regardless of whether the medical school operates such facilities directly or through contract agreements. Reimbursement for outpatient psychiatric services are subject to Chapter 1153. Reimbursement for outpatient drug and alcohol services are subject to Chapter 1223.

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 item—A service a provider furnishes for which there is no provision for payment under MA regulations.

Nonemergency medical services—A compensable physicians' services provided for conditions not requiring immediate medical intervention in order to sustain the life of the person or to prevent damage to his health.

Nonprofit—A term which describes a private agency, institution or organization which is a corporation or association, or is owned or operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure to the benefit of a private shareholder or individual.

Physician—An individual licensed under the laws of the Commonwealth to practice medicine and surgery within the scope of the Medical Practice Act 1974 (63 P. S. § 421.11) or the Osteopathic Medical Practice Act (63 P. S. §§ 271.1—271.18).

Primary health care—Preventive, diagnostic, therapeutic, rehabilitative or palliative services provided by or under the supervision of a physician.

Rural health clinic—A clinic that is located in a rural area designated by the Department of Health and Human Services as a shortage area with respect to primary health care. Rural health clinics so designated participate in the Medical Assistance program subject to the regulations set forth in Chapter 1229 (relating to health maintenance organization services).

Support services—The basic facilities, supplies and ancillary services necessary to deliver health care on an outpatient basis.

Surgical services—Those procedures listed in the Medical Assistance program fee schedule.

Visit—A face-to-face encounter between a patient and a member of the independent clinic, hospital outpatient department or hospital emergency room staff for the purpose of receiving medical services provided by or under the direction of a physician. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day constitute a single visit.

Source

The provisions of this § 1221.2 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (117476) and (86849) to (86852).

Cross References

This section cited in 55 Pa. Code § 1221.55 (relating to payment conditions for sterilizations).

SCOPE OF BENEFITS

§ 1221.21. Scope of benefits for the categorically needy.

Categorically needy recipients are eligible for medically necessary services prescribed by a physician and provided in a clinic or emergency room subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1221.21 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.22. Scope of benefits for the medically needy.

Medically needy recipients are eligible for medically necessary services prescribed by a physician and provided in a clinic or emergency room subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1221.22 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for clinic and emergency room services. Blind and visually impaired individuals, however, are eligible for services if they qualify as categorically needy or medically needy recipients.

Source

The provisions of this § 1221.23 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.24. 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 § 1221.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

PROVIDER PARTICIPATION**§ 1221.41. Participation requirements.**

(a) In addition to the participation requirements established in Chapter 1101 (relating to general provisions) clinics and hospital emergency rooms shall:

- (1) Have an established fee schedule for billing third parties and private payors.
- (2) Have a patient referral process that ensures follow up treatment by other physicians or appropriate specialists.
- (3) Abide by applicable Federal and State statutes and regulations, including but not limited to Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396p), the Public Welfare Code (62 P.S. § 443.1 et seq.) and applicable licensing statutes.

(b) In addition to the participation requirements set forth in subsection (a) hospital clinics, medical school clinics and independent medical clinics shall:

- (1) Not be enrolled in the MA Program as a Rural Health Clinic.
- (2) Be licensed/approved by the Department of Health if abortions are performed in the facility.

Source

The provisions of this § 1221.41 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial pages (58131) and (79327).

Cross References

This section cited in 55 Pa. Code § 1221.42 (relating to additional participation requirements for hospital clinics and emergency rooms); 55 Pa. Code § 1221.44 (relating to additional participation requirements for independent clinics); and 55 Pa. Code § 1221.45 (relating to additional participation requirements for medical school clinics).

§ 1221.42. Additional participation requirements for hospital clinics and emergency rooms.

In addition to the participation requirements listed in § 1221.41 (relating to participation requirements) hospital outpatient clinics and hospital emergency rooms shall:

- (1) Be operated by the hospital directly or under written contract with private physicians or physician group practice.
- (2) Be part of an institution that is licensed/approved as a hospital by the Department of Health and that meets the requirements for participation in Medicare.
- (3) Be organizationally integrated with the inpatient services of the hospital and have the authority to admit patients to the hospital.

Source

The provisions of this § 1221.42 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.43. Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate.

To be eligible to bill for the higher MA fee identified in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule outpatient hospital clinics and emergency rooms shall:

- (1) Provide comprehensive medical services for a minimum of 40 hours per week. Outpatient hospital clinics meet this requirement if the outpatient department of the hospital is open and provides some clinic service 40 hours per week.
- (2) Have a licensed physician present in the clinic or emergency room at all times during scheduled hours of operation to perform medical services. A physician shall be responsible for the overall management of patient care.
- (3) Be approved by the Department for higher reimbursement rate.

Authority

The provisions of this § 1221.43 issued under section 443.3(1) of the Public Welfare Code (62 P. S. § 443.3(1)).

Source

The provisions of this § 1221.43 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended through December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (86853) to (86854).

Cross References

This section cited in 55 Pa. Code § 1221.45 (relating to additional participation requirements for medical school clinics).

§ 1221.44. Additional participation requirements for independent clinics.

In addition to the participation requirements listed in § 1221.41 (relating to participation requirements), independent medical clinics shall:

- (1) Be currently receiving funds or have received initial start-up funds through Federal public health service programs such as the Community Health Center Program (42 U.S.C.A. § 254c), Migrant Health Program (42 U.S.C.A. § 254b), National Health Service Corps (42 U.S.C.A. § 254d) or the Appalachian Regional Development Program (40 U.S.C.A. §§ 202 and 214) or through the Department of Health's Division of Primary Health Care Development.
- (2) Provide services either directly by a physician or under the supervision of a physician. This means that one or more physicians shall be on staff to either provide directly or supervise the provision of services. If a physician does not provide services directly, then the services shall be provided by a certified registered nurse practitioner within the scope of the Medical Practice Act of 1974 (63 P. S. §§ 421.1—421.18) and the Professional Nursing Law (63 P. S. §§ 211—225) or by a physician assistant within the scope of the Medical Practice Act of 1974 (63 P. S. §§ 421.1—421.18) or the Osteopathic Medical Practice Act (63 P. S. §§ 271.1—271.18).
- (3) Provide medical services for a minimum of 40 hours per week.
- (4) Not limit the number of patients it serves by virtue of the payment source.
- (5) Provide direct emergency medical care and, through formal agreements, provide for access to health care for medical emergencies during and after the regularly scheduled hours of the clinic.

Source

The provisions of this § 1221.44 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.45. Additional participation requirements for medical school clinics.

In addition to the participation requirements listed in § 1221.41 (relating to participation requirements) medical school clinics shall:

- (1) Meet requirements set forth in § 1221.43(1) and (2) (relating to participation requirements for hospital clinics and emergency rooms for higher reimbursement rate).
- (2) Have an agreement with a hospital to serve as the outpatient department of the hospital.

Source

The provisions of this § 1221.45 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.46. Ongoing responsibilities of providers.

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

Source

The provisions of this § 1221.46 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

PAYMENT FOR CLINIC AND EMERGENCY ROOM SERVICES**§ 1221.51. General payment policy.**

Payment for clinic and emergency room services is subject to the conditions and limitations in this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program Fee Schedule. The following describes the payment policies applicable to hospital outpatient clinics, medical school clinics, independent medical clinics and hospital emergency rooms.

- (1) Hospital outpatient clinics, medical school clinics and independent medical clinics have the option of billing either the fee for a specific compensable procedure performed in the clinic or, but not in addition to, the flat visit fee except as noted in paragraph (7). Compensable procedures are specified in the MA Program Fee Schedule. The visit fee includes the professional, technical and support components of a clinic visit. The visit fee includes medical services rendered by a physician or under the supervision of a physician, drugs and biologicals administered or provided during the clinic visit and services and supplies commonly rendered without charge and incident to professional services. Visit fees are listed in the MA Program Fee Schedule. Specific vaccines, as determined by the Department, and listed in Chapter 1241, Appendix D (relating to EPSDT immunization guidelines—statement of policy) are

excluded from the established clinic fee and may be billed separately by clinics approved by the Department.

(2) Reimbursement for abortions performed in a clinic meeting the conditions set forth in § 1221.57 (relating to payment conditions for necessary abortions) is made on a component basis as listed in the MA Program Fee Schedule.

(3) The usual and customary charge to the general public for independent clinics with fee schedules based on the ability of the patient to pay shall be the most frequent charge to the self-paying public for the same service in the preceding calendar month.

(4) Hospital emergency rooms are paid a support component and a physicians component as set forth in Chapter 1150. Diagnostic and radiology services are compensable in addition to the physicians component as specified in paragraph (7).

(5) The hospital is considered the provider regardless of whether the hospital clinics are operated directly by the hospital or through contract between the hospital and other organizations or individuals. The hospital is responsible for the delivery of service and for billings.

(6) The medical school is considered the provider for all services provided by medical school clinics and is responsible for the delivery of the service and for billings.

(7) Diagnostic medical services, such as electrocardiograms, electroencephalograms, electromyographies and diagnostic or therapeutic radiology services provided during routine examination and treatment services are compensable in addition to the flat visit fee or fee for a specific compensable procedure. Endoscopic procedures, such as rhinoscopy, otoscopy or indirect laryngoscopy performed in the course of the visit are not compensable in addition to the flat visit fee.

(8) When two or more surgical operations are performed at the same time, or during the same visit, the procedure carrying the highest fee will be paid in full, plus 25% of the fee for the next highest procedure, with no allowance for additional procedures. The total fee allowance may not exceed \$200.

Source

The provisions of this § 1221.51 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended January 24, 1992, effective November 9, 1991, 22 Pa.B. 361. Immediately preceding text appears at serial pages (131082) and (150219).

Cross References

This section cited in 55 Pa. Code § 1147.53 (relating to limitations on payment); 55 Pa. Code § 1221.58 (relating to limitations on payment); and 55 Pa. Code § 1221.59 (relating to noncompensable services and items).

1221-10

§ 1221.52. Payment conditions for various services.

In order for payment to be made for a clinic visit or for emergency room services, the following conditions shall be met:

- (1) The services shall be provided at the clinic or emergency room site.
- (2) The services shall be provided by, or under the supervision of a physician.
- (3) Payment for the service shall not be available through another public or private agency.

Source

The provisions of this § 1221.52 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.55. Payment conditions for sterilizations.

(a) Payment for covered sterilization procedures shall be made 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 § 1221.2 (relating to definitions).

(b) For the purposes of this chapter, an individual requesting sterilization has voluntarily given informed consent only if all of the following requirements are met:

- (1) The consent form is completed correctly in accordance with all instructions in the Provider Handbook and within the time frame specified in subsection (c)(1). See Provider Handbook for a facsimile of the consent form and 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 may not result in the withdrawal or withholding of benefits provided by programs or projects receiving Federal funds and has offered to answer questions the individual may have concerning the sterilization procedure.
- (4) The individual providing informed consent has been permitted to have a witness of his choice present when informed consent is 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) Additional State or local laws for obtaining consent have been met.
(c) A consent form 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 a sterilization performed during emergency abdominal surgery, 72 hours shall have passed between the time of informed consent and the time of sterilization. In the case of sterilization performed during premature delivery, informed consent shall 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) Another 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 § 1221.55 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

§ 1221.57. Payment conditions for necessary abortions.

(a) Coverage for abortions funded under the MA 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. Payment will be made only if a "Physician Certification for an Abortion" form, signed by a licensed physician, is submitted with the Medical Services Invoice. A sample of the required "Physician Certification for an Abortion" form appears in the provider handbook with instructions for its completion.

(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 Fed-

eral, 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 if a "Physician Certification for an Abortion" form is submitted 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 must include the following:

(A) 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 shall 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 MA 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 MA Program for abortions performed in a hospital which has been licensed/approved by the Department of Health.

Authority

The provisions of this § 1221.57 issued under the Public Welfare Code (62 P. S. § 453).

Source

The provisions of this § 1221.57 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; 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 (60745) and (60746).

Cross References

This section cited in 55 Pa. Code § 1221.51 (relating to general payment policy).

§ 1221.58. Limitations on payment.

The following limits apply to payment for compensable services:

(1) Prenatal visits shall be limited to 12 per pregnancy. Complications attributable to pregnancy may not be counted as part of the 12 prenatal visits but are classified for invoicing purposes as acute illness.

(2) The physician's component for an emergency room visit may be either an emergency room physician's service fee, emergency or nonemergency or the fee for a specific compensable procedure. No payment may be made for the emergency room physician's service fee if a specific compensable procedure is billed for the same emergency room visit. Only those services noted in § 1221.51(7) (relating to general payment policy) shall be compensable in addition to either the emergency room physician's service fee or the fee for a specific compensable procedure. Two or more specific compensable surgical procedures performed at the same time shall be paid in accordance with § 1221.51(8).

(3) The flat visit fee shall not be paid if a specific compensable procedure is billed for the same hospital, medical school or independent clinic visit. Only those services noted in § 1221.51(7) shall be compensable in addition to either the flat visit fee or fee for specific compensable procedure. Two or more specific compensable surgical procedures performed at the same time shall be paid in accordance with § 1221.51(8).

(4) Payment for physicians' services performed in a hospital clinic, medical school clinic, independent clinic or hospital emergency room shall be subject to the limitations and provisions of Chapter 1141 (relating to physicians' services).

Source

The provisions of this § 1221.58 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial page (58138).

§ 1221.59. Noncompensable services and items.

Payment will not be made to clinics or emergency rooms for the following services or items:

(1) Services rendered in the hospital emergency room to a recipient who is admitted to the hospital the same day.

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

(3) Physicians' services not listed in the MA Program Fee Schedule.

(4) Methadone maintenance.

(5) Prescribed medications and medical supplies. Payment for these services is made only to participating pharmacies and medical suppliers. Section 1221.51(1) (relating to general payment policy) describes an exception for spe-

cific vaccines provided in hospital outpatient clinics, if the hospital does not have a pharmacy enrolled in the MA Program, and independent medical/surgical clinics.

(6) Laboratory services. Payment for these services will be made only to participating laboratories.

(7) Surgical procedures and medical care provided in connection with sex reassignment. This includes, hormone therapy and release of vaginal adhesions.

(8) More than one flat visit fee or fee for a specific compensable service provided by an independent medical clinic, hospital outpatient department, medical school outpatient department or hospital emergency room on the same day, regardless of specialty, except as noted in § 1221.51(6) and (7).

(9) Nonemergency use of the emergency room. Services to patients who do not exhibit symptoms or have a diagnosis that is listed in Appendix A are not reimbursable unless the recipient declares that he does not have access to a primary care physician or an outpatient clinic to treat nonemergency situations. The hospital emergency room staff and the emergency room physician shall document in the patient's medical record the declaration of no access to primary care.

Authority

The provisions of this § 1221.59 amended under sections 201(2) and 443.3 of the Public Welfare Code (62 P. S. §§ 201(2) and 443.3).

Source

The provisions of this § 1221.59 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418; amended January 24, 1992, effective November 9, 1991, 22 Pa.B. 361; amended September 22, 1995, effective September 23, 1995, 25 Pa.B. 3983. Immediately preceding text appears at serial pages (166155) to (166156).

UTILIZATION CONTROL

§ 1221.71. Scope of claims review procedures.

Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1221.71 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

ADMINISTRATIVE SANCTIONS**§ 1221.81. Provider misutilization.**

Providers determined to have billed for services inconsistent with MA 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 § 1221.81 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599.

**APPENDIX A
MEDICAL EMERGENCY
CARE SYMPTOMS**

Allergy Reactions, Acute (Except Allergy Tests)	Glaucoma, Severe
Appendicitis, Acute	Headache, Severe
Asthma, Acute	Heart Attack, Suspected
Breathing Difficulties or Shortness of Breath	Hemorrhage
Bronchitis, Severe	Hysteria
Bursitis, Severe Onset	Insulin Shock (Overdose)
Chest Pain, Severe	Kidney Stones
Choking	Maternity Complications, such as Suspected Miscarriage
Colitis	Pain, Sudden or Severe Onset
Coma	Pleurisy
Convulsions and/or Seizures	Pneumonitis
Cystitis	Poisoning (including overdose)
Dermatitis or Hives (Resulting from Internal or Unknown Causes)	Pyelitis
Diabetic Coma	Pyelonephritis (Shock)
Diarrhea, Severe	Spasms, Cerebral or Cardiac
Drug Reaction	Spontaneous Pneumothorax
Earache, Severe	Stomach Pains, Severe
Epistaxis (nosebleed)	Strangulated Hernia
Fainting	Stroke
Fecal Impaction, Severe	Sunstroke
Food Poisoning	Swollen Ring Finger
Frost Bite	Tachycardia
Gall Bladder, Acute Attack	Thrombosis and/or Phlebitis
Gastritis	Unconsciousness
Gastro-intestinal Conditions Acute	Urinary Retention, Acute
	Vision loss, Sudden Onset
	Vomiting, Severe

Source

The provisions of this Appendix A adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial page (79331).

APPENDIX B. [Reserved]

Source

The provisions of this Appendix B adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended August 7, 1981, effective August 8, 1981, 11 Pa.B. 2770; reserved December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial pages (79331) to (79332).

APPENDIX C. [Reserved]

Source

The provisions of this Appendix C adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; reserved December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial pages (79332) and (60960).

APPENDIX D. [Reserved]

Source

The provisions of this Appendix D adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4599; amended February 13, 1981, effective February 15, 1981, 11 Pa.B. 657; reserved December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932. Immediately preceding text appears at serial pages (60960) to (60965).

[Next page is 1223-1.]

1221-18

(251242) No. 291 Feb. 99

Copyright © 1999 Commonwealth of Pennsylvania