**Professional Services Fee Schedule – January 2020 updated 11/1/20**

**Introduction**
This Fee Schedule includes the current CPT and Level-II HCPCS codes and their maximum reimbursement that the Physicians' Services Program pays for each procedure. To clarify and assist providers in using and navigating this Fee Schedule, it also contains information on the limitations on its use, abbreviations in the schedule, and

**Limitations of the Fee Schedule**
All reimbursement rates and additional documentation requirements **only** apply to professional services when recipients have coverage under fee-for-service Medicaid. Recipients with Managed Care Organization (MCO)

This fee schedule **does not** contain reimbursement rates for all of the HCPCS Level-II codes (beginning with Alpha characters A through W), with the exception of the drugs and injectables that pertain to professional services.

J- codes are now published in this fee schedule. **All** providers must bill J-codes at their **exact acquisition costs**, **NOT** usual and customary charges or average wholesale price (AWP).

There are separate fee schedules for Durable Medical Equipment (DME), Durable Medical Supplies (DMS), and Oxygen providers, as well as laboratory and pathology codes in the 80000 series. These schedules are available
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

This fee schedule does not contain any CPT Category II (Performance Measurement) or CPT Category III (Emerging Technology & Procedures) codes. The Program does not reimburse providers for these procedures.

**Abbreviations Used in the Fee Schedule**
The following abbreviations are used in the fee schedule:
**NFAC: Non-Facility Fee.** The Non-Facility Fee is the Medicaid reimbursement amount for services rendered in an office, home, or school setting. For many procedures, the Non-Facility and Facility rates are identical. Certain procedures may have higher non-facility rates compared to facility rates to accommodate overhead and indirect
**FAC: Facility Fee.** The Facility Fee is the Medicaid reimbursement amount for services rendered in a hospital (inpatient or outpatient), psychiatric hospital (inpatient or outpatient), nursing facility or skilled nursing facility.
**26: Modifier 26.** The Modifier -26 Fee is the Medicaid reimbursement amount for only the **professional**
**TC: Modifier TC.** The Modifier -TC Fee is the Medicaid reimbursement amount for only the **technical component**

**NOTE:** The **NOTE** column is used to designate whether a code requires additional documentation, and may contain one of four abbreviations, listed below. The documentation for each of these forms may be found at:
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

**A: Abortion Form Required**. Certain services require the **Certification for Abortion Form (DHMH 521)** to be
**H: Hysterectomy Form Required**. Certain services require the **Document for Hysterectomy Form (DHMH 2990)**
**S: Sterilization Form Required**. Certain services require the **Sterilization Consent Form (DHMH 2989)** to be
**P: Prior Authorization Required.** Certain services require authorization prior to services being rendered; retro-authorizations are not permitted. All preauthorization requests must document that the services are medically necessary. Requests must be made in writing and faxed to 410-767-6034, using the appropriate forms (see
**INVOICE/REPORT:** Rates with **INVOICE / REPORT** require additional documentation in order to be priced.
limited to) medical notes, surgery notes, or invoices from a manufacturer or wholesaler.
**N.C.:** Rates with **N.C.** are considered non-covered services by the Program.
**N/A:** Rates with **N/A** are not considered an appropriate service for the designated Place of Service.

**Electronic Formats**

To conveniently locate a specific code, please use the “Find” search functions on your computer (On Windows:

**Special Note**

Please use G0453 in place of 95941, and G0455 in place of 44705. The rates for both of these replacement codes

Unlisted/Unclassified procedure codes are listed in this Fee Schedule; however, these codes must be manually priced. Therefore, all claims using an unlisted/unclassified code must include legible surgical notes or other medical record documentation to enable a medical reviewer to arrive at a price value for the procedure and to When billing for unlisted procedures, please include:

- A description of the service provided as well the reason the procedure was medically necessary;
- A comparable CPT code;
- If there is a third party payor (Medicare, CareFirst, etc.), the explanation of Benefits (EOB) from Medicare or
- Additional information (if required for justification).

Failure to provide the aforementioned information **WILL** result in a denial of the claim.

**For information on the Preauthorization process please visit the Professional Services Preauthorization**
**https://mmcp.health.maryland.gov/Pages/Preauthorization-Information.aspx**