Texas Medicaid Reimbursement

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Section 2

2.1 Payment Information
Refer to: “Payment Information” on page 1-8.

2.2 Reimbursement Methodology
Texas Medicaid reimburses providers using several different reimbursement methodologies, including fee schedules, reasonable cost with interim rates, hospital reimbursement methodology, provider-specific encounter rates, reasonable charge payment methodology, and manual pricing. Each Texas Medicaid service describes the appropriate reimbursement for each service area.

Note: Medicaid reimbursement through the STAR, STAR+PLUS, and NorthSTAR Program health plans may differ according to the provider’s contract with the health plan.

2.2.1 Fee Schedules
Texas Medicaid reimburses certain providers based on rates published in fee schedules. These rates are uniform statewide and by provider type. According to this type of reimbursement methodology, the provider is paid the lower of the billed charges or the Medicaid rate published in the applicable fee schedule.

Providers can obtain the fee schedules as Microsoft Excel® spreadsheets or portable document format (PDF) files from the TMHP website at www.tmhp.com. To determine type of service (TOS) payable for each procedure code, providers may refer to these fee schedules.

The following provider types are reimbursed based on rates published in fee schedules, with the rates calculated in accordance with the referenced reimbursement methodology as published in the Texas Administrative Code (TAC), Part 1 Administration, Part 15 Texas Health and Human Services Commission (HHSC), and Chapter 355 Reimbursement Rates.

- Ambulance. The Medicaid rates for ambulance services are calculated in accordance with 1 TAC §355.8600.
- Ambulatory Surgical Center (ASC). The Medicaid rates for ASCs are calculated in accordance with 1 TAC §355.8121.
- Birthing Center. The Medicaid rates for birthing centers are calculated in accordance with 1 TAC §355.8181.
- Blind Children’s Vocational Discovery and Development Program. The Medicaid rate for this service is calculated in accordance with 1 TAC §355.8381.
- Case Management for Children and Pregnant Women (CPW). The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401.
- Targeted Case Management for Early Childhood Intervention (ECI). The Medicaid rate for this service is calculated in accordance with 1 TAC §355.8421 and 355.8423.

- Certified Nurse-Midwife (CNM). The Medicaid rates for CNMs are calculated in accordance with 1 TAC §355.8161.
- Certified Registered Nurse Anesthetist (CRNA). According to 1 TAC §355.8221, the Medicaid rate for CRNAs is 92 percent of the rate reimbursed to a physician anesthesiologist for the same service.
- Certified Respiratory Care Practitioner (CRCP) Services. The Medicaid rate per daily visit for 1-99503 is calculated in accordance with 1 TAC §355.8089.
- Chemical Dependency Treatment Facility (CDTF). The Medicaid rates for CDTF services are calculated in accordance with 1 TAC §355.8241.
- Chiropractic Services. The Medicaid rates for chiropractic services are calculated in accordance with 1 TAC §355.8081 and 1 TAC §355.8085.
- Dental. The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8085, 1 TAC §355.8441(11), and 1 TAC §355.455(b).
- Durable Medical Equipment (DME). Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355-8021(b)(c). Texas Health Steps-Comprehensive Care Program (THSteps-CCP) is reimbursed for DME and expendable supplies in accordance with 1 TAC §355-8441(4)-(5).
- Family Planning Services. The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8584.
- Genetic Services. The procedure codes and Medicaid rates for genetic services are listed in the Physician - Genetics fee schedule on the TMHP website at www.tmhp.com.
- Hearing Aid and Audiometric Evaluations. Newborn hearing screenings are provided at the birthing facility before hospital discharge and, as such, are reimbursed in accordance with the reimbursement methodology for the specific type of birthing facility. Outpatient hearing screening and diagnostic testing services for children are provided by physicians and are reimbursed in accordance with the reimbursement methodology for physician services at 1 TAC §355.8081 and §355.8085, 1 TAC §355.8141, and 1 TAC §355.8441.
- Texas Medicaid (Title XIX) Home Health Services. The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).
- Independent Laboratory. The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8081 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for a clinical laboratory service cannot exceed the Medicare payment for that service. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/THSteps medical and newborn screening laboratory services provided by the Department of State.
Health Services (DSHS) Laboratory are reimbursed based on actual costs in accordance with 1 TAC §355.8610.

- Indian Health Services. The reimbursement methodology for outpatient services provided in Indian Health Services Facilities operating under the authority of Public Law 93-638 is located at 1 TAC §355.8620.
- In-Home Total Parenteral Nutrition (TPN) Supplier. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8087.
- Licensed Clinical Social Worker (LCSW). According to 1 TAC §355.8091, the Medicaid rate for LCSWs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- Licensed Marriage and Family Therapist (LMFT). According to 1 TAC §355.8091, the Medicaid rate for LMFTs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- Licensed Professional Counselor (LPC). According to 1 TAC §355.8091, the Medicaid rate for LPCs is 70 percent of the rate paid to a psychiatrist or psychologist for a similar service per 1 TAC §355.8085.
- Maternity Service Clinic (MSC). The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8201.
- Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS). According to Title 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.
- Physical Therapists/Independent Practitioners. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and 355.8085.
- Physician. The Medicaid rates for physicians and certain other practitioners are calculated in accordance with 1 TAC §355.8085.
- Physician Assistant (PA). According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.
- Psychologist. The Medicaid rates for psychologists are calculated in accordance with 1 TAC §355.8081 and §355.8085.
- Radiological and Physiological Laboratory and Portable X-Ray Supplier. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085.
- Renal Dialysis Facility. The Medicaid rates for these providers are composite rates based on calculations specified by the Centers for Medicare & Medicaid Services (CMS).

- School Health and Related Services (SHARS). The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8443.
- THSteps reimburses by provider type in accordance with 1 TAC §355.8441. Approved providers enrolled in Texas Medicaid are reimbursed for THSteps services in the same manner as they are reimbursed for other Medicaid services. THSteps-CCP reimburses for DME and expendable supplies in accordance with 1 TAC §355.8441(4)(5).
- Tuberculosis (TB) Clinics. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8341.
- Vision Care (Optometrists, Opticians). The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8081 and §355.8085.

2.2.1.1 Physician Services in Outpatient Hospital Setting

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices. The limit is 60 percent of the Medicaid rate for the nonemergency service furnished in physician offices. The following table identifies the services applicable to the 60 percent limitation when furnished in outpatient hospital settings:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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These procedures are designated with note code “1” in the current fee schedule, which is available on the TMHP website at www.tmhp.com. The following services are excluded from the 60 percent limitation:

- Services furnished in rural health clinics (RHCs)
- Surgical services that are covered ASC/hospital-based ambulatory surgical center (HASC) services
- Anesthesiology and radiology services
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client’s health
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

Exception: Because of TEFRA, Medicaid reimbursement for a payable nonemergency office service performed in
the outpatient department of a hospital is limited to 60 percent of the Medicaid rate for that service. If the condition qualifies as an emergency, the 60 percent professional service reimbursement limit does not apply.

2.2.1.2 Drugs/ Biologicals
Physician-administered drugs/biologicals are reimbursed under Texas Medicaid as access-based fees under the physician fee schedule in accordance with 1 TAC § 355.8085. Physicians and certain other practitioners are reimbursed for physician-administered drugs/biologicals at the lesser of their usual and customary or billed charges and the Medicaid fee established by the HHSC. The Medicaid fee is an estimate of the provider’s acquisition cost for the specific drug/biological. An invoice must be submitted when it is in the provider’s possession. Submission of an invoice will document that the provider is billing the lesser of the usual and customary charge or the access-based fee.

The following guidelines should be used with respect to fee decisions for physician-administered drugs/biologicals:

- Vaccines and infusion drugs furnished through an item of implanted DME are based on the lesser of documented provider acquisition/invoice cost (if available) or 89.5 percent of the average wholesale price (AWP).
- The remaining drugs/biologicals not listed in two previous bullets above that are covered by Medicare are based on the lesser of documented provider acquisition/invoice cost (if available) or 106 percent of average sales price (ASP).
- Those remaining drugs/biologicals not listed in the first two bullets above that are not covered by Medicare are based on the lesser of documented provider acquisition/invoice cost or one of the following:
  - 89.5 percent of AWP if the drug/biological is considered a new drug/biological (i.e., approved for marketing by the Food and Drug Administration within 12 months of implementation as a benefit of Texas Medicaid)
  - 85.0 percent of AWP if the drug/biological does not meet the definition of a new drug (above)

HHSC reserves the option to use other data sources to determine Medicaid fees for drugs/biologicals when AWP or ASP calculations are determined to be unreasonable or insufficient.

Prescriptions are covered under the Texas Medicaid Vendor Drug Program (VDP). The reimbursement methodology for pharmacy services is located at 1 TAC §§ 355.8541–355.8551.

2.2.2 Cost Reimbursement
Medicaid providers who are cost reimbursed are subject to cost report, cost reconciliation, and cost settlement processes, including time study requirements.

The following providers are cost reimbursed in accordance with the noted TAC rules:

- DSHS laboratory for THSteps medical and newborn screenings, 1 TAC § 355.8610
- Mental health (MH) case management, 1 TAC § 355.743
- Mental retardation (MR) service coordination, 1 TAC § 355.746
- MH rehabilitative services, 1 TAC § 355.781
- School Health and Related Services (SHARS), 1 TAC § 355.8443

2.2.3 Reasonable Cost/ Interim Rates
Outpatient hospital services are reimbursed in accordance with 1 TAC § 355.8061. The reimbursement methodology is based on reasonable costs, and providers are reimbursed at an interim rate based on the provider’s most recent Medicaid cost report settlement. This interim rate is applied to the provider’s allowed amount (per claim detail) to determine the provider’s payable amount.

2.2.4 Hospitals
Inpatient hospital services are reimbursed in accordance with 1 TAC § 355.8052. Reimbursement for in-state children’s hospitals is made in accordance with 1 TAC § 355.8054. Reimbursement for state-owned teaching hospitals is made in accordance with 1 TAC § 355.8056. Guidelines for additional reimbursement to disproportionate share hospitals are located at 1 TAC § 355.8065, while the reimbursement methodology for disproportionate share hospitals is located at 1 TAC § 355.8067. Supplemental payment guidelines to certain rural public hospitals are located at 1 TAC § 355.8069.

2.2.5 Provider-Specific Visit Rates
Medicaid provider-specific prospective payment system (PPS) visit rates for RHCs are calculated in accordance with 1 TAC § 355.8101, and those for Federally Qualified Health Centers (FQHCs) are calculated in accordance with 1 TAC § 355.8261.

Refer to: Section 21 regarding FQHCs and Section 41 regarding RHCs for more information.

2.2.6 Manual Pricing
When services or products do not have an established reimbursement amount, the detail or claim is manually reviewed to determine an appropriate reimbursement. The manual pricing methodology for DME and expendable supplies is included with the reimbursement methodology for these products.
2.3 Professional Providers and Outpatient Facilities Reimbursement Reduction

Both the standard dollar amount (SDA) and the TEFRA cost reimbursement for inpatient hospitals are reduced by 2.5 percent.

2.4 Additional Payments to High-Volume Providers

High volume provider payments are made to outpatient hospitals and ASCs/HASCs per 1 TAC §355.8061.

Outpatient hospital services are those services provided by outpatient hospitals and ASCs/HASCs. The definition of a high-volume outpatient hospital provider is one that was paid a minimum of $200,000 during the qualifying period. This criterion captured about 95 percent of total outpatient hospital spending. Similar criteria were developed for ASCs/HASCs, such that providers accounting for 95 percent of total payments were designated as high-volume providers. Payments to high-volume outpatient hospitals were increased by 5.2 percent. The new payment amount was implemented by increasing the discount factor for designated high-volume providers of outpatient hospital services from 80.3 percent to 84.48 percent. ASCs/HASCs that qualify as high-volume providers also receive a 5.2 percent increase in payment rates.

2.5 Out-of-State Medicaid Providers

Texas Medicaid covers medical assistance services provided to eligible Texas recipients while absent from Texas, as long as they do not leave Texas to receive out-of-state medical care that can be received in Texas. Services provided outside the state are covered to the same extent medical assistance is furnished and covered in Texas when the service meets one or more of the following requirements of 1 TAC §355.8063:

- The medical services are needed because of a medical emergency documented by the attending physician or other provider.

Note: An out-of-state provider seeking enrollment under this criterion must include with the enrollment application a copy of the claim containing the diagnosis indicating emergency care and/or medical record documentation. The documentation must demonstrate emergency care was provided to a Texas Medicaid client. Providers enrolled under this criterion will be enrolled for a period of 90 days from the enrollment date.

- The services are medically necessary and, in the opinion of the attending physician or other provider, the recipient’s health would be endangered if he or she were required to travel to Texas.

Note: An out-of-state provider seeking enrollment under this criterion must include with the enrollment application an explanation of the circumstances, demonstrating why the Texas Medicaid recipient’s health would have been endangered if the recipient had been required to travel to Texas. Providers enrolled under this criterion will be enrolled for a period of 90 days from the enrollment date.

- HHSC or its designee determines that the medically necessary services are more readily available in the state where the recipient is located.

Note: This criterion may apply when the Texas Medicaid recipient is already out of state and receives services that are not readily available in Texas, or when a Texas Medicaid recipient must leave Texas in order to receive care that is not readily available in Texas. HHSC makes the determination of whether this criterion applies on a case by case basis. An out-of-state provider seeking enrollment under this criterion must include with the enrollment application documentation for why this criterion applies, and must provide any additional information requested by HHSC or its designee. Providers enrolled under this criterion may be enrolled for a time limited period.

- The customary or general practice for recipients in a particular locality is to use medical resources in the other state.

Note: An out-of-state provider located within 50 miles of the Texas border is automatically considered to meet this criterion. HHSC makes the determination of whether this criterion applies on a case by case basis. An out-of-state provider located more than 50 miles from Texas and seeking enrollment under this criterion must include with the enrollment application documentation for why this criterion applies, and must provide any additional information requested by HHSC or its designee. Such providers, if approved for enrollment, may be enrolled for a time limited period.

- HHSC makes Title IV-E adoption assistance or Title IV-E foster care maintenance payments for a child who is also eligible for Texas medical assistance benefits.

Note: HHSC makes the determination of whether this criterion applies on a case by case basis. An out-of-state provider seeking enrollment under this criterion must include with the enrollment application documentation explaining why this criterion applies, and must provide any additional information requested by HHSC or its designee. Such providers, if approved for enrollment, may be enrolled for a time limited period.

- Other out-of-state medical care may be considered when prior authorized by HHSC or its designee.

Note: Providers seeking enrollment under this criterion are encouraged to contact TMHP to request approval before filing an enrollment application. TMHP will coordinate the request with HHSC. HHSC will make the determination of whether this criterion applies on a case by case basis. The provider must include with the request documentation for why this criterion applies, and must provide any additional information requested by HHSC or its designee. Such providers, if approved for enrollment, may be enrolled for a time limited period.
Providers located out of state seeking reimbursement under one or more of the above criteria must submit an enrollment application and be approved for enrollment. Refer to: “Provider Enrollment” on page 1-3

An out-of-state provider that meets none of the above criteria, but that is eligible to receive reimbursement for Medicare crossover claims involving Texas Medicaid dual eligible recipients, may seek enrollment in order to receive such reimbursement. Such providers, if approved for enrollment, will be restricted to receiving reimbursement only for Medicare crossover claims. Refer to: “Medicare Crossover Reimbursement” on page 2-6.

Payments to out-of-state providers enrolled in Texas Medicaid are made according to the usual, customary, and reasonable charges or the stipulated fee for services as appropriate for the provided care. Reimbursement may not exceed the lesser of:

- The Medicaid reasonable charge or fee determined for the same services in Texas; or
- If agreed to by HHSC, 100 percent of the Medicare reasonable charge determination for the same service in the state where the service was provided.

Inpatient hospital stays are reimbursed according to the Texas prospective payment methodology (diagnosis-related group [DRG]). Payments made on a reasonable cost basis are mutually determined by the state agency and the contractor.

TMHP must receive claims from out-of-state providers within 365 days from the date of service. Refer to: “Procedure Codes Requiring Mandatory Prior Authorization” on page 36-145.

2.6 Medicare Crossover Reimbursement

2.6.1 Part A

The payment of the Medicare Part A coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries is based on the following:

- If the Medicare payment amount equals or exceeds the Medicaid payment rate, Medicaid does not pay the Medicare Part A coinsurance/deductible on a crossover claim.
- If the Medicare payment amount is less than the Medicaid payment rate, Medicaid pays the Medicare Part A coinsurance/deductible, but the amount of the payment is limited to the lesser of the coinsurance/deductible or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

2.6.2 Part B

The payment of the Medicare Part B coinsurance and deductibles for Medicaid clients who are Medicare beneficiaries is based on the following:

- If the Medicaid client is eligible for Medicaid only as a qualified Medicare beneficiary (QMB), Medicaid pays the Medicare Part B coinsurance/deductible on valid Medicare claims.
- If the Medicaid client is not a QMB, Medicaid pays the client’s Part B:
  - Deductible liability on valid, assigned Medicare claims.
  - Coinsurance liability on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program, and would be covered by Medicaid when the services are provided, if Medicare did not exist.

Medicaid payment of a client’s coinsurance/deductible liabilities satisfies the Medicaid obligation to provide coverage for services that Medicaid would have paid in the absence of Medicare coverage.

2.7 Federal Financial Participation (FFP) Rate

The FFP rates for providers who receive the federal matching share portion of Medicaid reimbursement or the enhanced federal matching share portion of Medicaid reimbursement for services provided to Children’s Health Insurance Program (CHIP) clients are effective for dates of service on or after October 1, 2008, at an FFP rate of 59.44 percent and an enhanced FFP rate of 71.61 percent. The FFP is subject to change on October 1 of each year or as otherwise directed by CMS.