Section 2: Texas Medicaid Fee-for-Service Reimbursement

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SECTION 2: TEXAS MEDICAID FEE-FOR-SERVICE REIMBURSEMENT

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2.1 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT).

Refer to: Subsection 1.2, "Payment Information" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2 Fee-for-Service 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: *If a client is covered by a Medicaid managed care organizations (MCO) or dental plan, providers must contact the client's MCO or dental plan for reimbursement information. The MCOs and dental plans are not required to follow the Texas Medicaid fee schedules, so there may be some differences in reimbursement based on decisions made by the individual health and dental plans.*

2.2.1 Online Fee Lookup (OFL) and Static Fee Schedules

Texas Medicaid reimburses certain providers based on rates published in the OFL and static 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 static fee schedule or OFL.

Providers can obtain fee information using the OFL functionality on the TMHP website at www.tmhp.com.

The online OFL can be used to:

- Retrieve real-time fee information.
- Search for procedure code reimbursement rates individually, in a list, or in a range.
- Search and review contracted rates for a specific provider (provider must login).
- Retrieve up to 24 months of history for a procedure code by searching for specific dates of service within that 2-year period.
- Search for benefit limitations for dental and durable medical equipment (DME) procedure codes.

Providers can obtain the static fee schedules as *Microsoft Excel*® spreadsheets or portable document format (PDF) files from the TMHP website at www.tmhp.com.

Type of service (TOS) codes payable for each procedure code are available on the OFL and the static fee schedules.

The following provider types and services are reimbursed based on rates published 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.
- *Case Management for Children and Pregnant Women*. The Medicaid rates for this service are calculated in accordance with 1 TAC §355.8401.

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- *Targeted Case Management for Early Childhood Intervention (ECI)*. The Medicaid rate for this service is reimbursed in accordance with 1 TAC §§355.8421.
- *Specialized Skills Training for ECI*. The Medicaid rate for this service is reimbursed in accordance with 1 TAC § 355.8422
- *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 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 §355.8085.
- *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, Prostheses, Orthoses and Supplies (DMEPOS)*. DMEPOS items provided by home health agencies and providers/suppliers of DMEPOS are reimbursed in accordance with 1 TAC §355.8023. DMEPOS items provided by the Comprehensive Care Program (CCP) are reimbursed in the same manner, in accordance with 1 TAC §355.8441.
- *Family Planning Services*. The Medicaid rates for family planning services are calculated in accordance with 1 TAC §355.8581.
- *Genetic Services*. The procedure codes and Medicaid rates for genetic services are listed in the OFL or the Physician - Genetics fee schedule on the TMHP website at www.tmhp.com.
- *Hearing Aid and Audiometric Evaluations*. Hearing screening services for newborns are provided at the birthing facility before discharge and 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 §355.8085, 1 TAC §355.8141, and 1 TAC §355.8441.
- *Texas Medicaid (Title XIX) Home Health Services*. The reimbursement methodology for home health nursing and aide services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021.
- *Independent Laboratory*. The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §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)/Texas Health Steps medical and newborn screening laboratory services provided by the Department of State Health Services (DSHS) Laboratory are reimbursed based on the Medicare payment for that service.
- *Indian Health Services*. The reimbursement methodology for 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.

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- *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 Midwife (LM).* According to 1 TAC §355.8161, covered professional services provided by an LM and billed under the LM's own provider number are reimbursed the lesser of the LM's billed charges or 70 percent of the reimbursement for the same professional service paid to a physician (M.D. or D.O.).
- *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 §355.8085.
- *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 (PT), Occupational (OT), and Speech (ST) Therapy Services*. Covered therapy services provided by home health agencies, comprehensive outpatient rehabilitation facilities or outpatient rehabilitation facilities, independent therapists (including Early Childhood Intervention) and physicians and other practitioners are reimbursed according to 1 TAC §355.8097.
- *Physical Therapists/Independent Practitioners*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8085.
- *Physician*. The Medicaid rates for physicians and 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 §355.8085.
- *Radiological and Physiological Laboratory and Portable X-Ray Supplier*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §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.
- Texas Health Steps 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(2).
- Telemedicine, telehealth, and home telemonitoring services are reimbursed in accordance with 1 TAC 355.7001.

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- *Tuberculosis (TB) Clinics*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355.8085.
- *Vision Care (Optometrists, Opticians)*. The Medicaid rates for these providers are calculated in accordance with 1 TAC §355. 8001 and §355.8085.

2.2.1.1 Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare and 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 non-emergency service furnished in physician offices.

Reimbursement for non-emergent and non-urgent services that are rendered by the facility during the emergency room visit will be limited to 125 percent of the adult, physician office visit fee for procedure code 99202. Reimbursement will not be reduced for those services that were rendered to address conditions that meet any of the following criteria:

- Problems of high-severity
- Problems that require urgent evaluation by a physician
- Problems that pose immediate and significant threats to physical or mental function
- Critically ill or critically injured

Non-emergent and non-urgent services that are rendered by rural hospitals will be reimbursed at 55 percent of the allowed rates.

Non-rural hospitals will receive a flat rate which is limited to 125 percent of the adult, physician office visit fee for procedure code 99202.

Diagnostic services, such as laboratory and radiology, will not be reduced by 40 percent.

Refer to: Subsection 9.2.60.4.5, "Physician Services Provided in the Emergency Department" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about non-emergent and non-urgent services rendered in the emergency department.

Subsection 4.2.2.1, "Emergency Department Payment Reductions" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about non-emergent and non-urgent services rendered in the emergency department.

These procedures are designated with note code "1" in the current fee schedule or OFL 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
- Prenatal services when billed with modifier TH and the appropriate E/M procedure code to the highest level of specificity
- 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

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- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

2.2.1.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2.2.1.3 Drugs and Biologicals

Physician-administered drugs and biologicals are reimbursed under Texas Medicaid as access-based fees under the physician fee schedule in accordance with 1 TAC §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and 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 and 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.

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

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

Important: *Outpatient prescription medications are covered through the Medicaid Vendor Drug Program. Refer to Subsection 1.1, "About the Vendor Drug Program" in the Outpatient Drug Services Handbook (Vol. 2, Provider Handbooks) for more information.*

2.2.2 Cost Reimbursement

Medicaid providers who are cost reimbursed are subject to cost reporting, cost reconciliation, and cost settlement processes, including time study requirements.

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

- 1 TAC §355.743—Mental health (MH) case management
- 1 TAC §355.746—Mental retardation (MR) service coordination
- 1 TAC §355.781—MH rehabilitative services
- 1 TAC §355.8443—School Health and Related Services (SHARS)
- 1 TAC §355.8061—Outpatient Hospital Reimbursement
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology

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2.2.3 Reasonable Cost and 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. To determine the provider's payable amount, the interim rate is applied to the claim details allowed amount.

2.2.4 Hospitals

Inpatient and outpatient hospital services are reimbursed as follows:

- 1 TAC §355.8052—Inpatient Hospital Reimbursement
- 1 TAC §355.8056—State-Owned Teaching Hospital Reimbursement Methodology
- 1 TAC §355.8058—Inpatient Direct Graduate Medical Education (GME) Reimbursement
- 1 TAC §355.8060—Reimbursement Methodology for Freestanding Psychiatric Facilities
- 1 TAC §355.8061—Outpatient Hospital Reimbursement
- 1 TAC §355.8065—Disproportionate Share Hospital (DSH) Reimbursement Methodology
- 1 TAC §355.8066—Hospital-Specific Limit Methodology

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 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*)

Section 8, "Rural Health Clinic" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

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. DME and medical supplies, other than nutritional products, that have no established fee are subject to manual pricing at the documented MSRP less 18 percent or the provider's documented invoice cost.

2.3 Reimbursement Reductions

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

2.4 Using Payouts to Satisfy Accounts Receivables Across Programs and Alternate Legacy Identifiers (IDs)

The TMHP accounts receivable process identifies funds that a provider owes to TMHP and subtracts these funds from payments to the provider. TMHP satisfies outstanding accounts receivables using all available funds from the providers' Medicaid payouts, as well as managed care payouts, until the accounts receivables have been recovered. Outstanding balances are recovered as follows:

- For outstanding fee-for-service accounts receivables, TMHP first recovers funds from any available *fee-for-service* payments. If there is still an accounts receivable balance for that week's financial cycle, TMHP recovers funds from any available *managed care* payments.

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- For outstanding managed care accounts receivables, TMHP first recovers funds from any available *managed care* payments. If there is still an accounts receivable balance for that week's financial cycle, TMHP will recover funds from any available *fee-for-service* payments

1099 Reports

Providers receive one 1099 report for each legacy ID. The 1099 report has combined information for both fee-for-service and managed care programs.

Paper Remittance and Status (R&S) Report

The summary page of the R&S report has combined information from the fee-for-service and managed care programs.

The Financial Transactions Sub-Owner Recoupment page has accounts receivable for both programs. A column on the page identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Financial Transactions Accounts Receivable page has the accounts receivable for both programs. A column identifies the program (Medicaid [fee-for-service] or Managed Care) from which the funds were recouped.

The Original Date in the Accounts Receivable section of the R&S Report reflects the date on which the accounts receivable first appeared on the R&S Report.

ER&S Report

The Pending and Non-Pending ER&S Reports have combined information for both programs.

2.4.1 HHSC Recoupment of Accounts Receivables from Legacy Identifiers (IDs)

HHSC recoups the outstanding accounts receivable balances of all existing Medicaid and managed care legacy IDs from alternate legacy IDs that use the same Tax ID or National Provider Identifier (NPI).

If a Medicaid or managed care provider has a legacy ID that is no longer active or has been terminated and that legacy ID has an outstanding accounts receivable balance, the balance is recouped from future payments made to any and all legacy IDs that have the same Tax ID or NPI. Recoupments are reflected on future R&S Reports.

Note: *This process affects only managed care claims that are submitted to TMHP.*

Refer to: Subsection 2.2.5, "Accounts Receivable" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care claims and outstanding accounts receivables.

Subsection 2.2.5, "Accounts Receivable" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for additional information about managed care claims and outstanding accounts receivables.

2.4.2 Medicaid Funds May Be Used to Satisfy Children with Special Health Care Needs (CSHCN) Services Program Accounts Receivables

A service that is rendered to a CSHCN Services Program client who receives retroactive Medicaid eligibility may be reimbursed by the CSHCN Services Program or by Medicaid, but not by both.

The CSHCN Services Program is the payer of last resort. The CSHCN Services Program does not supplement a client's Medicaid benefits. However, services that are not a benefit of Medicaid may be covered by the CSHCN Services Program. If dual Medicaid and CSHCN Services Program eligibility is determined, claims that have already been paid by the CSHCN Services Program will be reprocessed under the appropriate program.

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An accounts receivable is created for each CSHCN Services Program claim that is reprocessed and subsequently reimbursed under Medicaid so that the amount the CSHCN Services Program originally reimbursed can be returned to the CSHCN Services Program.

If the CSHCN Services Program payout during the week's financial cycle in which the claim was reprocessed is not sufficient to satisfy the accounts receivable, the provider's Medicaid claim payouts are used to satisfy the CSHCN Services Program accounts receivable.

Note: *The deduction from Medicaid claim payouts does not exceed the amount Medicaid reimbursed the provider when the CSHCN Services Program claim was reprocessed.*

2.5 Additional Payments to High-Volume Providers

High volume provider payments are made to outpatient hospitals per1 TAC §355.8061 and ASCs/HASCs per 1 TAC §355.8121.

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.

The reimbursement rate for non-high-volume hospitals is as follows with the application of the hospital specific interim rate:

Non-High-Volume Provider	Current Allowable Rate
Children's hospitals	72.27 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	72.27 percent of the allowable charges
Other hospitals	68.44 percent of the allowable charges

The reimbursement rate for high-volume hospitals is as follows with the application of the hospital specific interim rate:

High-Volume Provider	Current Allowable Rate
Children's hospitals	76.03 percent of the allowable charges
Rural hospitals	100 percent of the allowable charges
State-owned teaching hospitals	76.03 percent of the allowable charges
Other hospitals	72 percent of the allowable charges
ASCs/HASCs that qualify as high-volume providers	Additional 5.2 percent increase in payment rates

2.6 Out-of-State Medicaid Providers

Texas Medicaid covers medical assistance services provided to eligible Texas Medicaid clients while in a state other than Texas, as long as the client does 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 requirements of 1 TAC §354.1440 (a). TMHP must receive claims from out-of-state providers within 365 days from the date of service.

Note: *Border state providers (i.e., providers rendering services within 50 miles of the Texas border) are considered in-state providers for Texas Medicaid.*

Refer to: Subsection 1.9, "Enrollment Criteria for Out-of-State Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

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2.7 Medicare Crossover Claim Reimbursement

2.7.1 Medicare-Only Crossover Claims

Per Title 42 Code of Federal Regulations (CFR) 455.410(d), Medicare-only providers can enroll in Texas Medicaid and submit Medicare crossover claims to HHSC for proof of Medicaid nonpayment in a Remittance and Status (R&S) Report. With this proof of nonpayment, Medicare-only providers may pursue Medicare reimbursement for these claims.

2.7.2 Part A

Providers must accept Medicare assignment to receive Medicaid payment for any portion of the coinsurance and deductible amounts for services rendered to Qualified Medicare Beneficiary (QMB) and Medicaid Qualified Medicare Beneficiary (MQMB) clients. If a provider has accepted a Medicare assignment, the provider may receive, on behalf of the QMB or MQMB client, payment for deductible or coinsurance according to current payment guidelines.

Any payments made by Medicare and Medicaid must be considered payment in full. Providers that accept Medicare or Medicaid assignment cannot legally require the client to pay the Medicare coinsurance or deductible amounts or any remaining amount after Medicaid payment has been made.

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 Medicare 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.

2.7.3 Part B

Texas Medicaid reimburses coinsurance liability for MQMB clients on valid, assigned Medicare claims that are within the amount, duration, and scope of the Medicaid program and, if Medicare did not exist, would be covered by Medicaid.

For Medicare crossover claims, Texas Medicaid reimburses the lesser of the following:

- The coinsurance and deductible payment
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service (If this amount is less than the deductible, then the full deductible is reimbursed instead.)

If the Medicare payment is equal to or exceeds the Medicaid allowed amount or encounter payment for the service, Texas Medicaid does not make a payment for coinsurance.

Important: *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. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

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2.7.4 Part C: Medicare Advantage Plans (MAPs)

2.7.4.1 Contracted MAPs

HHSC makes a per-client-per-month payment to MAPs that contract with HHSC. The payment to the MAP includes all costs associated with the Medicare coinsurance and deductible for a client who is dually eligible for Medicare and Medicaid. TMHP does not reimburse the coinsurance or deductible amounts for these claims. These costs must be billed to the MAP and must not be billed to TMHP or the Medicaid client.

Refer to: A list of MAPs that are contracted with HHSC is available on the TMHP website at www.tmhp.com/topics/edi/map-contractors. The list is updated as additional plans receive approved contracts.

2.7.4.2 Noncontracted MAPs

Texas Medicaid reimburses professional and outpatient facility crossover claims the lesser of the following:

- The coinsurance and deductible amounts
- The amount remaining after the Medicare payment amount is subtracted from the allowed Medicaid fee or encounter rate for the service

For Medicare Part B cost sharing obligations, all deductible obligations will be reimbursed at 100 percent of the deductible amount owed, even if the cost sharing comparison results in a lower payment. For all other cost sharing obligations (including Medicare Part A and Part B coinsurance, and C), the cost sharing comparison is performed according to current guidelines.

Exception: *Texas Medicaid will reimburse coinsurance liability for MQMB clients 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.*

If the Medicare payment is equal to or exceeds the allowed Medicaid fee or encounter rate for the service, Texas Medicaid will not make a payment for coinsurance and deductible.

Important: *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. The client has no liability for any balance or Medicare coinsurance and deductible related to Medicaid-covered services.*

2.7.5 Exceptions

2.7.5.1 Full Amount of Part B and Part C Coinsurance and Deductible Reimbursed

Texas Medicaid reimburses the full amount of the Medicare Part B and Part C (noncontracted MAPs only) coinsurance and deductible for the following services:

- All ambulance services
- Services rendered by psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, and licensed professional counselors
- Procedure codes R0070 and R0075 for services rendered by physicians

2.7.5.2 Nephrology (Hemodialysis, Renal Dialysis) and Renal Dialysis Facility Providers

Texas Medicaid pays the Medicare coinsurance less 5 percent and full Medicare deductible for Medicare crossover claims that are submitted by nephrology (hemodialysis, renal dialysis) and renal dialysis facility providers.

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2.8 Home Health Agency Reimbursement

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

Home Health Agency providers should note the following:

- The client's primary physician must request professional, SN, and HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a numerical quantity of one-month for medical supplies according to the billing requirements.
- SN, HHA, OT, and PT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency's legacy ID. File these services on a UB-04 CMS-1450 claim form.
- OT and PT are always billed as POS 2 (home) and may be prior authorized to be provided in the home of the client or the home of the caregiver/guardian.

Note: *Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a home health services benefit. These services may be considered a benefit for clients who qualify for CCP.*

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in this section.

2.8.1 Pending Agency Certification

Home health agencies submitting claims before the enrollment process is complete or without prior authorization for services issued by the TMHP Home Health Services Prior Authorization Department will not be reimbursed. The effective date of enrollment is when all Texas Medicaid provider enrollment forms are received and approved by TMHP.

Upon the receipt of notice of Texas Medicaid enrollment, the agency must contact the TMHP Home Health Services Prior Authorization Department before serving a Texas Medicaid client for services that require a prior authorization number. Prior authorization cannot be issued before Texas Medicaid enrollment is complete. Regular prior authorization procedures are followed at that time.

Home health agencies that provide laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers who do not comply with CLIA will not be reimbursed for laboratory services.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

2.8.2 Prohibition of Medicaid Payment to Home Health Agencies Based on Ownership

Medicaid denies Home Health Services claims when TMHP records indicate that the physician ordering treatment has a significant ownership interest in, or a significant financial or contractual relationship with, the nongovernmental home health agency billing for the services. Federal regulation Title 42 CFR §424.22 (d) states that "a physician who has a significant financial or contractual relationship with, or a significant ownership in a nongovernmental home health agency may not certify or recertify the need for Home Health Services care services and may not establish or review a plan of treatment."

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A physician is considered to have a significant ownership interest in a home health agency if either of the following conditions apply:

- The physician has a direct or indirect ownership of five percent or more in the capital, stock, or profits of the home health agency.
- The physician has an ownership of five percent or more of any mortgage, deed of trust, or other obligation that is secured by the agency, if that interest equals five percent or more of the agency's assets.

A physician is considered to have a significant financial or contractual relationship with a home health agency if any of the following conditions apply:

- The physician receives any compensation as an officer or director of the home health agency.
- The physician has indirect business transactions, such as contracts, agreements, purchase orders, or leases to obtain services, medical supplies, DME, space, and salaried employment with the home health agency.
- The physician has direct or indirect business transactions with the home health agency that, in any fiscal year, amount to more than $25,000 or five percent of the agency's total operating expenses, whichever is less.

Providers must submit claims for CCP services and general home health services on two separate UB-04 CMS-1450 paper claim forms with the appropriate prior authorization number. Claims that are denied because of an ownership conflict will continue to be denied until the home health agency submits documentation that indicates that the ordering physician no longer has a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency that is providing the services. Providers should send documentation to TMHP Provider Enrollment at the address indicated in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

2.9 Federal Medical Assistance Percentage (FMAP)

The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services and State medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

The "Federal Medical Assistance Percentages" are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating Federal Medical Assistance Percentages.

"Enhanced Federal Medical Assistance Percentages" are for the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages. The FMAPs are subject to change.

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