

**SECTION FOUR**

**SERVICE DELIVERY**



## **General Principles**

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### **General Principles**

- A county shall provide the basic health care services established by TDSHS in this handbook or less restrictive health care services.
    - The basic health care services are:
      - ◆ Physician services
      - ◆ Annual physical examinations
      - ◆ Immunizations
      - ◆ Medical screening services
        - Blood pressure
        - Blood sugar
        - Cholesterol screening
      - ◆ Laboratory and x-ray services
      - ◆ Family planning services
      - ◆ Skilled nursing facility services
      - ◆ Prescription drugs
      - ◆ Rural health clinic services
      - ◆ Inpatient hospital services
      - ◆ Outpatient hospital services
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**General Principles** (continued)

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**General Principles**  
(continued)

- In addition to providing basic health care services, a county may provide other department-established optional health care services that the county determines to be cost-effective.
  - o The department-established optional health care services are:
    - ◆ Advanced practice nurse services provided by
      - o Nurse practitioner services
      - o Clinical nurse specialist
      - o Certified nurse midwife (CNM)
      - o Certified registered nurse anesthetist
    - ◆ Ambulatory surgical center (freestanding) services
    - ◆ Colostomy medical supplies and equipment
    - ◆ Counseling services provided by
      - o Licensed clinical social worker (LCSW)
      - o Licensed marriage family therapist (LMFT)
      - o Licensed professional counselor (LPC)
      - o Ph.D. psychologist
    - ◆ Dental Care
    - ◆ Diabetic medical supplies and equipment
    - ◆ Durable medical equipment (DME)
    - ◆ Emergency medical services
    - ◆ Home and community health care services
    - ◆ Physician assistant services
    - ◆ Vision care, including eyeglasses
    - ◆ Federally qualified health center services
    - ◆ Occupational therapy services
    - ◆ Physical therapy services
    - ◆ Other medically necessary services or supplies that the local governmental municipality/entity determines to be cost effective.

**General Principles** (continued)

**General Principles**  
(continued)

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- Services or supplies must be reasonable and medically necessary for diagnosis and treatment.
  - For a listing of services, supplies and expenses that may not be CIHCP benefits, refer to the Texas Provider Procedures Medicaid Manual at [http://www.tmhp.com/Pages/Medicaid/Medicaid\\_Publications\\_Provider\\_manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx). Section 1 Provider Enrollment and Responsibilities “Texas Medicaid Limitations and Exclusions.”
  - Chapter 61, Health and Safety Code, Section 61.035, states, “The maximum county liability for each state fiscal year for health care services provided by all assistance providers, including hospital and skilled nursing facility, to each eligible county resident is:
    - 1) \$30,000; or
    - 2) the payment of 30 days of hospitalization or treatment in a skilled nursing facility, or both, or \$30,000, whichever occurs first, if the county provides hospital or skilled nursing facility services to the resident.”
      - ◆ 30 days of hospitalization refers to inpatient hospitalization.
  - Use the client’s actual dates-of-service when determining which fiscal year to apply the maximum county liability.
  - For claim payment to be considered, a claim should be received:
    - 1.) Within 95 days from the approval date for services provided before the household was approved
    - 2.) Within 95 days from the date of service for services provided after the approval date, or
    - 3.) Within the agreed upon timeframe in a legal contract between the providers and the local indigent program.
  - The payment standard is determined by the date the claim is paid.
  - For additional information on claim payment, the User’s Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.
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**Basic Health Care Services**

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TDSHS-established Basic Health Care Services

	<b>Payment Method</b>
• <b>Physician Services</b> .....	Physician Fee Schedule
• <b>Annual Physical Examinations</b> .....	Physician Fee Schedule
• <b>Immunizations</b> .....	Physician Fee Schedule
• <b>Medical Screening Services</b> .....	Physician Fee Schedule
• <b>Laboratory and X-Ray Services</b> .....	Physician Fee Schedule
• <b>Family Planning Services</b> .....	Physician Fee Schedule
• <b>Skilled Nursing Facility Services</b> .....	Daily Rate
• <b>Prescription Drugs</b> .....	Formula
• <b>Rural Health Clinic Services</b> .....	Rate per Visit
• <b>Inpatient Hospital Services</b> .....	DRG or Inpatient Percent Rate
• <b>Outpatient Hospital Services</b> .....	Outpatient Percent Rate or ASC Rate

**Negotiate rates with providers for basic service procedure codes not listed in the Fee Schedules.** For additional information on claim payment, the User’s Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

**Physician Services**

Physician services include services ordered and performed by a physician that are within the scope of practice of their profession as defined by state law. Physician services must be provided in the doctor's office, the patient’s home, a hospital, a skilled nursing facility, or elsewhere.

Payment Standard for Physicians. Use the Fee Schedule for Texas Medicaid Physician at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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(Physician Services Payment Standard continued on next page)

**Basic Health Care Services** (continued)

**Physician  
Services**  
(continued)

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Payment Standard for Anesthesia Services. Using the Fee Schedule for Texas Medicaid Physician at [www.tmhp.com](http://www.tmhp.com), use the number of Relative Value Units (RVUs) listed in the Total RVUs column, the conversion factor listed in the Conversion Factor column, and the calculation instructions below.

1. Calculate the anesthesia units of time by using the following formula.

$$\frac{\text{total anesthesia time in minutes}}{15} = \text{anesthesia units of time}$$

2. Calculate the reimbursement for anesthesia services by using the following formula.

$$(\text{anesthesia units of time} + \text{RVUs}) \times \text{Conversion Factor} = \text{reimbursement amount}$$

Reduce the reimbursement amount by 2% for dates of services rendered on or after February 1, 2011.

Payment Standard for Podiatrists. Use the Fee Schedule for Texas Medicaid Podiatrist at [www.tmhp.com](http://www.tmhp.com) and proceed using the instructions for Payment Standard for Physicians.

Payment Standard for Injections. Use the Fee Schedule for Texas Medicaid Physician at [www.tmph.com](http://www.tmph.com).

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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**Basic Health Care Services** (continued)

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**Annual  
Physical  
Examinations**

These are examinations provided once per calendar year by a physician, a physician assistant (PA), or an Advance Practice Nurse (APN).

Associated testing, such as mammograms, can be covered with a physician's referral.

These services may be provided by an Advanced Practice Nurse (APN) if they are within the scope of practice of the APN in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13.

Payment Standard for a Physician. Use the Fee Schedule for Texas Medicaid Physician at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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**Basic Health Care Services** (continued)

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**Immunizations** These are given when appropriate.

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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**Medical Screenings**

These health care services include blood pressure, blood sugar, and cholesterol screening.

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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**Basic Health Care Services (continued)**

**Laboratory  
and X-ray  
Services**

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These are professional and technical services ordered by a physician and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient).

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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**Basic Health Care Services (continued)**

**Family  
Planning  
Services**

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These are preventive health care services that assist an individual in controlling fertility and achieving optimal reproductive and general health.

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician Fee Schedule at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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**Skilled  
Nursing  
Facility  
Services**

Services must be

- Medically necessary,
- Ordered by a physician, and
- Provided in a skilled nursing facility that provides daily services on an inpatient basis.

Payment Standard. The skilled nursing facility rate is \$118.00 per day.

This \$118.00 daily rate does not include physician services or three prescription drugs per month. These additional services must be billed separately.

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**Basic Health Care Services (continued)**

**Prescription  
Drugs**

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This service includes up to three prescription drugs per month. New and refilled prescriptions count equally toward this three prescription drugs per month total. Drugs must be prescribed by a physician or other practitioner within the scope of practice under law.

The quantity of each prescription depends on the prescribing practice of the physician and the needs of the patient.

Payment Standard. Use the following information and formula.

- Utilizing any pharmaceutical company's database that provides average wholesale pricing, look-up the drug's 11-digit NDC number and the quantity dispensed to determine the average wholesale price (AWP).
- Net Cost for:
  - **Generic** prescription drugs is **AWP minus 50%**
  - **Brand** name prescription drugs is **AWP minus 15%**
- **The drug dispensing fee is \$3.00.**
- The formula for computing the TDSHS Payable is:

Net Cost + drug dispensing fee = TDSHS Payable

Example: Prescription is written for 34 generic tablets

AWP for 25 tablets is \$100.00.

1. \$100.00 divided by 25 = \$4.00 per tablet

2. \$4.00 per tablet x 34 tablets (prescribed quantity) = \$136.00

3. \$136.00 - \$68.00 (50% for generic) = \$68.00

4. \$68.00 + \$3.00 (dispensing fee) = \$71.00 TDSHS Payable

- A payment amount may be negotiated with the provider for:
  - Prescription compound drugs,
  - Prescription drugs not found in any pharmaceutical database, or
  - Prescription drugs that do not have an NDC number.

**Rural Health  
Clinic (RHC)  
Services**

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RHC services must be provided in a freestanding or hospital-based rural health clinic and provided by a physician, a physician assistant, an advanced practice nurse (including a nurse practitioner, a clinical nurse specialist, and a certified nurse midwife), or a visiting nurse.

Payment Standard: Use the Rate per Visit in the "Medicare-Approved Rural Health Clinic Rates" included in Appendix A.

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**Basic Health Care Services** (continued)

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**Inpatient  
Hospital  
Services**

Inpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital,
- Provided to hospital inpatients,
- Provided by or under the direction of a physician, and
- Provided for the care and treatment of patients.

Payment Standard. For the hospital in which the inpatient services were provided, use the **Hospital Inpatient Payment** lists that are located on the Health and Human Services Commission website at <http://www.hhsc.state.tx.us/rad/hospital-svcs/inpatient.shtml>. These lists will be used to calculate the payment rate using either the Percent Standard or the Diagnosis-Related Group (DRG) Standard.

**Note:** If you are unable to locate payment information for a facility, complete Form 111 Facility Payment Rate Request.

- Inpatient RCC Rates List - Hospitals on this list are paid using the Percent Standard. The percent listed in the Inpatient Rate column reflects all applicable rate reductions.
- Hospital Prospective Standard Dollar Amount (SDA) List - Hospitals on this list are paid using the DRG Standard. The SDA listed in the Final Add-on SDA column reflects all applicable rate reductions.
- Texas APR-DRG Grouper List - This list provides the DRG Code, APR-DRG Title, Relative Weights, Mean Length of Stay (LOS), and Day Threshold needed when using the DRG Standard.

**Percent Standard.** This standard reimburses hospitals based on a percent of the hospital's total billed amount.

1. From the total billed amount, subtract the cost of services that are not a CIHCP benefit; and
2. Use the Inpatient Rate listed on the Inpatient RCC Rates List, then
3. Multiply the remaining billed amount by the Inpatient Rate listed.

**DRG Standard.** This standard reimburses hospitals at a predetermined rate for services based on the patient's diagnosis. In some cases, the reimbursement will be more than the actual cost of providing services for that stay; in other cases, the reimbursement will be less than the hospital's actual cost. In either case, use the calculated DRG payment.

The DRG Standard incorporates the DRG code that is assigned to the hospital stay, the Relative Weight (Rel. Wt.) and the Mean Length Of Stay that are assigned to the DRG code, and the Standard Dollar Amount (SDA), which is the blended average dollar amount a hospital recovers for any given patient account.

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**Basic Health Care Services** (continued)

**Inpatient  
Hospital  
Services**  
(continued)

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To calculate a full or partial DRG payment use the [APR-DRG Version 29](#) of the Core Grouping Software™ along with the DRG Code, Relative Weight, Mean Length of Stay, and the SDA which are located at <http://www.hhsc.state.tx.us/rad/hospital-svcs/inpatient.shtml>.

Determine the type of DRG Payment based on the following information:

- When one hospital provided the patient care or one hospital provided the majority of the days of care, calculate a full DRG payment.
- When one hospital provided the lesser days of care or when two hospitals provided equal days of care, calculate a partial DRG payment.
- If the patient was CIHCP-eligible for any part of the hospital stay, calculate the full DRG payment.
- If the patient was Medicaid-eligible for any part of the hospital stay, there is no CIHCP payment.

Full DRG Payment. To calculate, proceed as follows:

1. Assign the DRG code using Core Grouping Software™,
2. Refer to the assigned DRG code's Relative Weight,
3. Refer to the hospital's SDA, and
4. Multiply the SDA by the Relative Weight.

Partial DRG Payment. To calculate, proceed as follows:

1. Calculate the full DRG payment,
2. Refer to the assigned DRG code's Mean Length of Stay,
3. Divide the full DRG payment by the Mean Length of Stay, and
4. Multiply the result by the CIHCP-allowed number of days of care.

**DRG Software.** 3M Health Information Systems Division is the supplier of the [APR-DRG Version 29 Core Grouping Software™](#), which is used to assign a three-digit group or "code" based on the diagnosis code(s). For more information, contact: [www.3mhis.com](http://www.3mhis.com)

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Basic Health Care Services (continued)

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**Outpatient  
Hospital  
Services**

Outpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital or hospital-based ambulatory surgical center (HASC),
- Provided to hospital outpatients,
- Provided by or under the direction of a physician, and
- Diagnostic, therapeutic, or rehabilitative.

Payment Standard. For the hospital in which the outpatient services were provided, use the **Outpatient RCC Rates** list that is located on the Health and Human Services Commission website at <http://www.hhsc.state.tx.us/rad/hospital-svcs/outpatient.shtml>. This list will be used to calculate the payment rate using the Percent Standard.

Outpatient RCC Rates List - Hospitals on this list are paid using the Percent Standard. The percent listed in the Outpatient Rate column reflects all applicable rate reductions.

1. Use the Outpatient Rate listed on the Outpatient RCC Rates List, and
2. Multiply the billed amount by the Outpatient Rate listed.

Exception: If the outpatient service is for a scheduled surgery, the county may use the Fee Schedule for Texas Medicaid Hospital Ambulatory Surgical Center (HASC) Group Rate Amounts and HASC Group # at [www.tmhp.com](http://www.tmhp.com).

A hospital-based ASC service should be billed as one inclusive charge on a UB-04.

**Optional Health Care Services**

**TDSHS-established Optional Health Care Services**

	<u>Payment Method</u>
• <b>Advanced Practice Nurse Services</b> .....	NP/CNS/
• <b>Ambulatory Surgical Center (Freestanding) Services</b> ...	ASC Fee Schedule
• <b>Colostomy Medical Supplies and Equipment</b> .....	DME Fee Schedule
• <b>Counseling Services</b> .....	Psychologist Fee Schedule
• <b>Dental Care</b> .....	Dentist-Orthodontist Fee Schedules
• <b>Diabetic Medical Supplies and Equipment</b> .....	DME Fee Schedule
• <b>Durable Medical Equipment</b> .....	DME Fee Schedule
• <b>Emergency Medical Services</b> .....	Ambulance Fee Schedule
• <b>Home and Community Health Care Services</b> .....	Rate Per Visit
• <b>Physician Assistant Services</b> .....	Physician Assistant Fee Schedule
• <b>Vision Care, including Eyeglasses</b> .....	Optometrist & Optician Fee Schedules
• <b>FQHC (Federally Qualified Health Center) Services</b> ..	Rate Per Visit
• <b>Occupational Therapy Services</b> .....	Occupational Therapist Fee Schedule
• <b>Physical Therapy Services</b> .....	Physical Therapist Fee Schedule
• <b>Other medically necessary services or supplies</b> .....	Fee Schedule or negotiable rate

**Negotiate rates with providers for optional service procedure codes not listed in the Fee Schedules.** For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

**Advanced Practice Nurse (APN) Services**

An APN must be licensed as a registered nurse (RN) within the categories of practice, specifically, a nurse practitioner, a clinical nurse specialist, a certified nurse midwife (CNM), and a certified registered nurse anesthetist (CRNA), as determined by the Board of Nurse Examiners. APN services must be medically necessary and provided within the scope of practice of the APN.

The Medicaid rate for NPs and CNSs reflect 92% of the rate paid to a physician for the same service and 100 % of the rate paid to physicians for laboratory, X-ray, and injections.

Payment Standard for a Nurse Practitioner, a Clinical Nurse Specialist, and a CNM. Use the Fee Schedule for Texas Medicaid Nurse Practitioner and Clinical Nurse Specialist at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

(APN Payment Standard continued on next page)

Optional HealthCare Services

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**APN Services**  
(continued)

Payment Standard for a CRNA. Use the Fee Schedule for Texas Medicaid Certified Registered Nurse Anesthetist at [www.tmhp.com](http://www.tmhp.com).

For Anesthesia, use the number of Relative Value Units (RVUs) listed in the Total RVUs column, the conversion factor listed in the Conversion Factor column, and the calculation instructions below.

1. Calculate the anesthesia units of time by using the following formula.

$$\frac{\text{total anesthesia time in minutes}}{15} = \text{anesthesia units of time}$$

2. Calculate the reimbursement for anesthesia services by using the following formula.

$$(\text{anesthesia units of time} + \text{RVUs}) \times \text{Conversion Factor} = \text{reimbursement amount}$$

3. Use 92% of this physician amount to reimburse CRNA services.

Reduce the CRNA reimbursement by 2% for services rendered on or after February 1, 2011.

For Medical, Surgery, and Laboratory Services proceed as follows:

1. Use the amount listed in the age appropriate Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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## Optional Health Care Services

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### **Ambulatory Surgical Center (ASC) Services**

These services must be provided in a freestanding ASC and are limited to items and services provided in reference to an ambulatory surgical procedure. A freestanding ASC service should be billed as one inclusive charge on a CMS-1500. If more than one procedure code is listed, only the code with the highest DSHS Payable amount should be paid.

Payment Standard. Use the Fee Schedule for Texas Medicaid ASC Group Rate Amounts and ASC Group # at [www.tmhp.com](http://www.tmhp.com).

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### **Colostomy Medical Supplies and Equipment**

These supplies and equipment must be medically necessary and prescribed by a physician or an APN within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13. The county may require the supplier to receive prior authorization.

Items covered are: cleansing irrigation kits, colostomy bags/pouches, paste or powder, and skin barriers with flange (wafers).

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid Durable Medical Equipment/Medical Supplies at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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## Optional Health Care Services

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### Counseling Services

Behavioral health services must be medically necessary; based on a physician referral; and provided by a licensed clinical social worker (LCSW, previously known as LMSW-ACP), a licensed marriage family therapist (LMFT), licensed professional counselor (LPC), or a Ph.D. psychologist. These services may also be provided based on an APN referral if the referral is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13.

Payment Standard for LCSW, LMFT, and LPC. The following procedure codes are covered for TOS 1 counseling services provided by these providers: 90806, 90847, and 90853 (CPT codes only copyright 2004 American Medical Association. All Rights Reserved). The DSHS Payable amounts may be accessed in the Texas Medicaid Physician Fee Schedule.

Payment Standard for Ph.D. Psychologist. Use the appropriate Texas Medicaid Outpatient Behavioral Health Fee Schedule at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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## Optional HealthCare Services

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### Dental Care

These services must be medically necessary and provided by a Doctor of Dental Surgery (DDS), a Doctor of Dental Medicine (DMD), or a Doctor of Dental Medicine (DDM). The county may require prior authorization.

Items covered are: an annual routine dental exam, annual routine cleaning, one set of annual x-rays, and the least-costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection or extreme pain.

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid Dentist-Orthodontist at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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**Optional Health Care Services**

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**Diabetic  
Medical  
Supplies and  
Equipment**

These supplies and equipment must be medically necessary and prescribed by a physician. These supplies and equipment may also be prescribed by an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13. The county may require the supplier to receive prior authorization.

Items covered are: test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and needles required for the humulin pens.

Insulin syringes, humulin pens, and the needles required for humulin pens are dispensed with a National Dispensing Code (NDC) number and are paid as prescription drugs; they do not count toward the three prescription drugs per month limitation. Insulin and humulin pen refills are prescription drugs (not optional services) and count toward the three prescription drugs per month limitation.

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid Durable Medical Equipment/Medical Supplies at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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Optional Health Care Services

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**Durable  
Medical  
Equipment  
(DME)**

This equipment must be medically necessary; meet the Medicare/Texas Title XIX Medicaid requirements; and be provided under a physician's prescription. These supplies and equipment may also be prescribed by an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13. Items can be rented or purchased, whichever is the least costly. The county may require the supplier to receive prior authorization.

Items covered are: appliances for measuring blood pressure that are reasonable and appropriate, canes, crutches, home oxygen equipment (including masks, oxygen hose, and nebulizers), hospital beds, standard wheelchairs, walkers.

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid DME at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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## Optional Health Care Services

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### Emergency Medical Services

Emergency Medical Services (EMS) services are ground ambulance transport services. When the person's condition is life-threatening and requires the use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, ground transport is an emergency service.

Payment Standard. Use the Fee Schedule for Texas Medicaid Ambulance at [www.tmph.com](http://www.tmph.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
  2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.
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**Optional Health Care Services**

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**Home and  
Community  
Health Care  
Services**

These services must be medically necessary; meet the Medicare/Medicaid requirements; and are provided by a certified home health agency.

A plan of care must be recommended, signed, and dated by the recipient's attending physician prior to care being provided.

The county may require prior authorization.

Items covered are: Registered Nurse (RN) visits for skilled nursing observation, assessment, evaluation, and treatment provided a physician specifically requests the RN visit for this purpose. A home health aide to assist with administering medication is also covered.

Visits made for performing household services are not covered.

The skilled nurse visit is also called an SNV, RN, or LVN visit. The CPT code G0154 in the chart below includes \$10 maximum for incidental supplies used during the visit.

The home health aide visit is also called an HHA visit. The CPT code G0156 in the chart below includes incidental supplies used during the visit.

Payment Standard. Use the TDSHS Payable in the chart below.

TOS	Procedure Code
C	G0154 / Visit
C	G0156 / Visit

**Physician  
Assistant (PA)  
Services**

These services must be medically necessary and provided by a PA under the supervision of a physician and billed by and paid to the supervising physician.

Payment Standard. Use the Fee Schedules for Texas Medicaid Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant at [www.tmhp.com](http://www.tmhp.com).

The Medicaid rate for PAs reflects 92% of the rate paid to a physician for the same service and 100 % of the rate paid to physicians for laboratory, X-ray, and injections.

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## Optional Health Care Services

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### **Vision Care, Including Eyeglasses**

Every 24 months one examination of the eyes by refraction and one pair of prescribed eyeglasses may be covered. The county may require prior authorization.

Payment Standard for Examination of the Eyes by Refraction. Use the Fee Schedule for Texas Medicaid Optometrist at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

Payment Standard for Prescribed Eyeglasses. Use the Fee Schedule for Texas Medicaid Optician at [www.tmhp.com](http://www.tmhp.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, DSHS does not have a payable amount; however, a payment amount may be negotiated with the provider.

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For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

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## Optional Health Care Services

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### Federally Qualified Health Center (FQHC) Services

These services must be provided in an approved FQHC by a physician, a physician assistant, an advanced practice nurse, a clinical psychologist, or a clinical social worker.

Payment Standard. Use the Rate Per Visit in the “FQHC Rates” included in Appendix B.

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### Occupational Therapy Services

These services must be medically necessary and may be covered if provided in a physician’s office, a therapist’s office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider’s scope of practice, as defined by Occupations Code, Chapter 454.

Payment Standard. Use the Fee Schedule for Texas Medicaid Occupational Therapist at [www.tmph.com](http://www.tmph.com) and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
- 

### Physical Therapy Services

These services must be medically necessary and may be covered if provided in a physician’s office, a therapist’s office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider’s scope of practice, as defined by Occupations Code, Chapter 453.

1. Payment Standard. Use the Fee Schedule for Texas Medicaid Physical Therapist at [www.tmph.com](http://www.tmph.com) and proceed as follows:
2. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.

**Fee Schedules**

**ALL TEXAS MEDICAID FEE SCHEDULES ARE AVAILABLE AT THE FOLLOWING LINK: [www.tmhp.com](http://www.tmhp.com)**

- The Texas Medicaid Fee Schedule is categorized by field descriptions. TOS (Types of Service) codes are listed in the first field. The TOS identifies the specific field or specialty of services provided. The TOS descriptions are listed below:

<b>0</b> Blood Products	<b>5</b> Laboratory	<b>9</b> DME – Other
<b>1</b> Medical Services	<b>6</b> Radiation Therapy	<b>E</b> Eyeglasses
<b>2</b> Surgery	<b>7</b> Anesthesia	<b>I</b> Interpretation
<b>3</b> Consultation	<b>8</b> Assistant Surgery	<b>T</b> Technical
<b>4</b> Radiology	<b>F</b> ASC / HASC	

Procedure Code. The third field lists the current procedure codes. The Texas Medicaid Physician, APN, and CRNA Fee Schedules each contain a list of payment rates for Current Procedural Terminology (CPT) codes, including the (TOS 7) American Society of Anesthesiologists (ASA) procedure codes. The five-character alphanumeric procedure codes follow the numeric procedure codes.

Modifier. It is placed after the five-digit procedure code, if applicable. A modifier describes and qualifies services that are provided however not all procedures require a modifier. Modifiers may affect the CIHCP payment amount. A list of frequently used modifiers is located in the Texas Medicaid Providers Procedures Manual in Section 6 “Claims Filing” at [http://www.tmhp.com/TMHP\\_File\\_Library/Provider\\_Manuals/TMPPM/2011\\_Texas\\_Medicaid\\_Provider\\_Procedures\\_Manual.pdf](http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2011_Texas_Medicaid_Provider_Procedures_Manual.pdf)

Child Age. The sixth and seventh fields list the age range for pricing determination.

Resource-Based Units. Texas Medicaid Reimbursement Methodology. The eighth field lists the payable amount for the TOS and procedure code.

Total RVUs. The ninth field lists the relative value units for the procedure code.

Conv Factor. The tenth field lists the conversion factor used in the calculation formula for anesthesia services in determining the TMRM payable amount.

PPS Fee. The eleventh field lists the prospective payment system (PPS) fee. **Not applicable for CIHCP.**

**Fee Schedules**  
(continued)

Access-Based or Max Fee. The twelfth field lists the access-based fee amount or maximum fee.

Effective Date. The thirteenth field lists the effective date for total RVUs for RBFs. For fees other than RBFs, the effective date for the PPS, access-based, or max fee.

Note Code. The fourteenth field lists the note code indicator. For CIHCP, a payment amount may be negotiated with the provider when the Note Code is 5.

- TOS. The CPT codes are divided into sections based on the type of service (TOS) codes. The 1-digit TOS code identifies the specific field or specialty of services provided.

TOS 0 and TOS 9 are not basic health care services.

***Use the following TOS definitions and payment information.***

**TOS**

**DEFINITION and PAYMENT INFORMATION**

- 1 Medical Services** – includes office, inpatient hospital, and emergency room visits; allergy treatment; chemotherapy; injections; physical therapy; dialysis; psychotherapy; ophthalmology; dermatology; ventilation; etc. Excludes anesthesia, radiological interpretations, and laboratory interpretations.

**Fee Schedules**  
(continued)

**2 Surgery** – includes invasive diagnostic procedures.

**Single Surgical Procedure.** Unless the description for a surgical procedure clearly states otherwise, a single surgical procedure code represents the full scope of activities performed to complete the surgical procedure.

**Multiple Surgical Procedures.** Some surgical services involve multiple surgical procedures that may be payable as separate procedures **but only** if they are not a component of a more comprehensive procedure.

Determine if the multiple surgical procedure codes are:

- o components of one comprehensive procedure, or
- o a primary procedure and secondary procedure(s).

If you are unable to make this determination, contact the provider for further clarification.

The payment standard for paying multiple surgical procedures that are not components of one comprehensive procedure is to allow the full TDSHS physician payment standard for the primary procedure and half of the TDSHS physician payment standard for the other procedure(s).

**3 Consultations** – used when the attending physician consults with another physician concerning some non-surgical aspect of the patient's treatment.

**Fee Schedules**  
Types of Service  
(continued)

**TOS**

**DEFINITION and PAYMENT INFORMATION**

- 4 Radiology** (total component, i. e., technical and interpretation) – includes radiological exams (x-rays), computerized axial tomography (CAT scans), magnetic resonance imaging (MRI), mammography, echography (ultrasound), and other types of internal organ and vascular x-rays.

Procedure codes with a TOS 4 include radiology services that are both the technical component and the interpretation (professional) component of x-ray services.

Use the following information for processing bills for TOS 4 (Radiology), TOS T (Technical), and TOS I (Interpretation).

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 4).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 4 = total component (Technical + Interpretation)

TOS 4 = TOS T + TOS I

In summary,

- o If a TOS 4 is paid first, then the total component has been met.
- o If a TOS T is paid first, then a TOS I may be payable.
- o If a TOS I is paid first, then a TOS T may be payable.

**Fee Schedules**  
Types of Service  
(continued)

**TOS**

**DEFINITION and PAYMENT INFORMATION**

- 5 Laboratory** (total component, i. e., technical and interpretation) – includes most types of blood, urine, feces, and sputum tests and tests on other bodily fluids or by-products; tissue studies and analysis; various hearing and speech tests; electrocardiograms (EKGs) and cardiovascular stress tests; respiratory (pulmonary) function tests; electroencephalograms (EEGs) and other brain activity tests.

Procedure codes with a TOS 5 include laboratory services that are both the technical component and the interpretation (professional) component of laboratory services.

Use the following information for processing bills for TOS 5 (Laboratory), TOS T (Technical), and TOS I (Interpretation).

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 5).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 5 = total component (Technical + Interpretation)

TOS 5 = TOS T + TOS I

In summary,

- o If a TOS 5 is paid first, then the total component has been met.
  - o If a TOS T is paid first, then a TOS I may be payable.
  - o If a TOS I is paid first, then a TOS T may be payable.
-

**Fee Schedules**  
Types of Service  
(continued)

**TOS**

**DEFINITION and PAYMENT INFORMATION**

- 6 Radiation Therapy** (total component, i. e., technical and interpretation) – includes radiology treatment planning, radiological dosimetry, teletherapy, megavoltage treatment, and radioelement application.

Procedure codes with a TOS 6 include radiation therapy services that are both the technical component and the interpretation (professional) component of radiology treatment planning, radiological dosimetry, teletherapy, megavoltage treatment, and radioelement application services.

Use the following information for processing bills for TOS 6 (Radiation Therapy), TOS T (Technical), and TOS I (Interpretation).

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 6).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 6 = total component (Technical + Interpretation)

TOS 6 = TOS T + TOS I

In summary,

- o If a TOS 6 is paid first, then the total component has been met.
- o If a TOS T is paid first, then a TOS I may be payable.
- o If a TOS I is paid first, then a TOS T may be payable.

**Fee Schedules**  
Types of Service  
(continued)

**TOS**

**DEFINITION and PAYMENT INFORMATION**

- 7 Anesthesia** – usually provided by or under the supervision of a physician in a hospital setting.

**Fee Schedules**  
Types of Service  
(continued)

**TOS**

**DEFINITION and PAYMENT INFORMATION**

- 8 Assistant Surgery** – a surgical procedure that requires the assistance of another surgeon.

Procedure codes with a TOS 8 include assistant surgical services. In addition, use of a modifier code of 80, 81, and 82 with a surgical procedure code results in TOS 8 being assigned to the procedure.

Although certain surgical procedures require the service of an assistant surgeon, not all surgical procedures require this service.

**Single Surgical Procedure.** Unless the description for a surgical procedure clearly states otherwise, a single surgical procedure code represents the full scope of activities performed to complete the surgical procedure.

**Multiple Surgical Procedures.** Some surgical services involve multiple surgical procedures that may be payable as separate procedures **but only** if they are not a component of a more comprehensive procedure.

Determine if the multiple surgical procedure codes are:

- o components of one comprehensive procedure, or
- o a primary procedure and secondary procedure(s).

If you are unable to make this determination, contact the provider for further clarification.

The payment standard for paying multiple surgical procedures that are not components of one comprehensive procedure is to allow the full TDSHS physician payment standard for the primary procedure and pay half of the TDSHS physician payment standard for the other procedure(s).

**Fee Schedules**  
Types of Service  
(continued)

**TOS**

**DEFINITION and PAYMENT INFORMATION**

- I Interpretation** – professional component for radiology, laboratory, or radiation therapy services.

Only one provider is entitled to reimbursement for interpreting a radiology, laboratory or radiation therapy procedure.

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 4, 5, or 6).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 4, 5, or 6 = total component (Technical and Interpretation)

TOS 4, 5, or 6 = TOS T + TOS I

In summary,

- o If a TOS 4, 5, or 6 is paid first, then the total component has been met.
- o If a TOS T is paid first, then a TOS I may be payable.
- o If a TOS I is paid first, then a TOS T may be payable.

**Fee Schedules**  
Types of Service  
(continued)

**TOS**

**DEFINITION and PAYMENT INFORMATION**

**T Technical** – technical component for radiology, laboratory, or radiation therapy services.

Only one provider is entitled to reimbursement for performing the technical component of a radiology, laboratory, or radiation therapy procedure.

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 4, 5, or 6).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 4, 5, or 6 = total component (Technical + Interpretation)

TOS 4, 5, or 6 = TOS T + TOS I

In summary,

- o If a TOS 4, 5, or 6 is paid first, then the total component has been met.
- o If a TOS T is paid first, then a TOS I may be payable.
- o If a TOS I is paid first, then a TOS T may be payable.