STATE	Texas
DATE REC'D	6-6-12
DATE APPV'D	8-30-12
DATE EFF	4-1-12
HCFA 179	12-25

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1. Physicians and Other Practitioners

(a) Subject to the qualifications, limitations, and exclusions in the amount, duration and scope of benefits as provided elsewhere in the State Plan, payment to eligible providers of laboratory services, including x-ray services, radiation therapy services, physical and occupational therapists' services, physician services (including anesthesia and physician-administered drugs), podiatry services, chiropractic services, optometric services, dentists' services, psychologists' services, certified respiratory care practitioners' services, maternity clinics' services, tuberculosis clinic services and certified nurse midwife services are reimbursed based on an uniform, statewide, prospective payment system.

(b) The fees for covered services provided by physicians and other practitioners are based upon the determination of adequacy of access to health care services by the Texas Health and Human Services Commission (HHSC), as described in this section.

(1) There shall be no geographical or specialty reimbursement differential for individual services.

(2) The fees for individual services will be reviewed at least every two years and include:

(A) resource-based fees (RBFs) and
(B) access-based fees (ABFs).

The fee schedule is published quarterly.

(3) Measures of adequacy of access to health care services include, but are not limited to, the following determinations:

(A) adequate participation in the Medicaid program by physicians and other practitioners; and/or
(B) the ability of Medicaid recipients to receive adequate health care services in an appropriate setting.

(c) Resource-based fees (RBFs) are based on actual resources required by an economically efficient provider to deliver each individual service and are calculated by multiplying the applicable relative value unit (RVU) times a conversion factor.

SUPERSEDES: TN- 11-47

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1. Physicians and Other Practitioners (continued)

(1) A relative value unit (RVU) is the relative value assigned to each of the three individual components that comprise the cost of providing individual Medicaid services. The three cost components are intended to reflect the work, overhead and the professional liability expense required to provide each individual service. HHSC will review any changes to or revisions of the various Medicare RVUs and, if applicable, adopt the changes as part of the RBF fee schedule.

(2) The conversion factor is the dollar amount by which the sum of the three cost component RVUs is multiplied in order to obtain an RBF for each individual service. HHSC may develop and apply multiple conversion factors for various classes of service, such as obstetrics, pediatrics, general surgeons, and/or primary care services. The following conversion factors are applied and are reflected on the fee schedule for services provided by physicians and other practitioners on the agency's website:

A. $26.7305 – Effective April 1, 2012, for RBFs for physicians and other practitioners primarily applied to adult procedure codes.

B. $28.0672 – Effective April 1, 2012, for RBFs for physicians and other practitioners applied to children's procedure codes.

C. $27.276 – Effective September 1, 1999, for RBFs for physicians and other practitioners.

D. $28.640 – Effective September 1, 2007, for increases to certain RBFs for services provided by physicians and other practitioners. Implemented with respect to recipients under age 21 pursuant to the order of the court in Frew v. Hawkins, Civil Action #3:93/CV65 (Eastern District – Paris Division) on April 27, 2007 (Corrective Action Order: Adequate Supply of Healthcare Providers).

E. $30.000 – Effective April 1, 2010, for increases to certain RBFs for services provided by physicians and other practitioners. Implemented with respect to maintaining access to care for Medicaid clients for certain necessary medical services.

F. Conversion factor equal to the current Medicare conversion factor – Effective April 1, 2010, for increases to certain RBFs for services provided by physicians and other practitioners. Implemented with respect to maintaining access to care for Medicaid clients for certain necessary medical services.

1. Physicians and Other Practitioners (continued)

G. $19.830 – Effective September 1, 2007, for nonobstetrical anesthesia services to clients under age 21. Implemented with respect to recipients under age 21 pursuant to the order of the court in Frew v. Hawkins, Civil Action #3:93/CV65 (Eastern District – Paris Division) on April 27, 2007 (Corrective Action Order: Adequate Supply of Healthcare Providers).

H. $18.420 – Effective January 1, 2010, for nonobsterical anesthesia services to clients 21 years of age and older.

I. $23.220 - Effective September 1, 2007 for obstetrical anesthesia services to clients under 21 years of age. Implemented with respect to recipients under age 21 pursuant to the order of the court in *Frew v. Hawkins*, Civil Action #3:93/CV65 (Eastern District – Paris Division) on April 27, 2007 (Corrective Action Order: Adequate Supply of Healthcare Providers).

J. $19.580 - Effective September 1, 2007 for obstetrical anesthesia services to clients 21 years of age and older.

(d) Access-based fees (ABFs) are developed to account for deficiencies in RBFs relating to adequacy of access to health care services for Medicaid clients and are based upon: (1) historical charges; (2) current total Medicare fee (i.e., RVU times Conversion Factor) for the individual service; (3) review of Medicaid fees paid by other states; (4) survey of providers' costs to provide the individual service; (5) Medicaid fees for similar services; and/or (6) some combination or percentage thereof.

(e) General guidelines used when updating Medicaid fees for services provided by physicians and other practitioners, include, but not limited to the following: updating the Medicaid relative value units (RVUs) to those currently in effect for Medicare and multiplying the updated RVUs by the current Medicaid conversion factor to result in an updated resource-based fee (RBF); increasing the Medicaid conversion factor to increase RBFs for which no RVU update is required in order to increase access to services; changing an existing RBF to an access-based fee (ABF) when the RBF methodology does not provide sufficient access to care; and changing an existing ABF to a RBF as appropriate.

(f) When a procedure code is nationally discontinued, a replacement procedure code is nationally assigned for the discontinued procedure code, and Medicaid implements the replacement procedure code, a state plan amendment will not be submitted since the fee for the service has not changed.

1. Physicians and Other Practitioners (continued)

(g) All fee schedules are available through the agency's website, as outlined on Attachment 4.19-B, page 1.

(h) The agency's fee schedule was revised with new fees for services provided by physicians and other practitioners affiliated with or employed by tuberculosis clinics effective October 1, 2011, and this fee schedule was posted on the agency's website on October 7, 2011.

(i) The agency's fee schedule was revised with new fees for physicians effective April 1, 2012, and this fee schedule was posted on the agency's website on April 6, 2012.

SUPERSEDES: TN- 12-14

STATE Texas
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