Texas Medicaid Fee Schedule Information
Rehabilitative Services – Mental Health

This fee schedule is intended to be used by a variety of provider types and provider specialties. Some procedure codes might not apply to every provider type and provider specialty designated to use the fee schedule. For detailed benefits and limitations, providers should refer to the current year's Texas Medicaid Provider Procedures Manual and relevant issues of the Texas Medicaid Bulletin.

Field Descriptions

TOS: One-character type-of-service (TOS) code .

TOS Desc: Description of the TOS.

Proc code: Procedure code.

Mod 1: 1st Modifier, if required for pricing determination.

Mod 2: 2nd Modifier, if required for pricing determination.

Client Age From: From age, if required for pricing determination. *This is* not *the age restriction of the procedure.* For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 21-999, the age range for the first row 0-999 is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 0-20, the age range for the first row 0-999 is actually for clients 21-999. *See the 2008* Texas Medicaid Provider Procedures Manual *(TMPPM) for exact age limitations.* Correct age ranges will be available in Medicaid fee schedules at a later date.

Client Age Through: Through age, if required for pricing determination. *This is* not *the age restriction of the procedure.* For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 21-999, the age range for the first row 0-999 is actually for clients 0-20. For procedure codes that contain more than one pricing row, if the first row is defined by 0-999 age range and the second row is defined by age range 0-20, the age range for the first row 0-999 is actually for clients 21-999. *See the 2008 TMPPM for exact age limitations.* Correct age ranges will be available in Medicaid fee schedules at a later date.

Resource-Based Fee: Texas Medicaid reimbursement methodology (TMRM) payable amount per Title 1 Texas Administrative Code (TAC) §355.8085. The payable amount for resource-based fees (RBFs) is calculated by multiplying the total relative value units (RVUs) by the applicable Texas Medicaid conversion factor. For anesthesia services, there is no TMRM payable since the payment amount is based on the "Total RVUs" (or base units) plus actual face-to-face time units (in 15-minute increments), with that total multiplied by the appropriate conversion factor. Since CRNAs are reimbursed at 92% of the fee payable to a physician anesthesiologist, the 92% is applied after the payment amount is calculated and before the payment is processed.

Total RVUs/Base Units: The current RVUs for the procedure code, if the fee is a resource-based fee (RBF). For Anesthesia services, RVUs are actually base units.

Conv Factor: The Texas Medicaid conversion factor applicable for determining the TMRM payable for RBFs or for determining payment for anesthesia services.

PPS Fee: Prospective Payment System (PPS) fee.

Access-Based or Max Fee: Per 1 TAC §355.8085, fees are either RBFs or access-based fees (ABFs) for physician services or the maximum fee for nonphysician services.

Effective Date: 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: Note code indicator. Providers should review each note code to identify specific payment explanation or limitation.

1 In an outpatient setting, this procedure is subject to a 60-percent payable if the diagnosis is nonemergency.
2 Clinical Laboratory fee schedule procedure.
3 The calculated payable amount for anesthesia could be reduced based on the modifier used.
4 There must be documentation that supports the medical necessity for an inpatient setting.
5 This procedure is manually reviewed to determine pricing.
6 This procedure is payable only through the Comprehensive Care Program (CCP).
7 Also available as a Home Health/Durable Medical Equipment (DME) service.

Change Ind Change Indicator Indicator denoting that the Fee Schedule row has been updated since the last run. 'C' for change; blank for no changes.

TOS	TOS Desc	Proc Code	Mod 1	Mod 2	Client Age From	Client Age Through	Resource-Based Fee	Total RVUs/Base Units	Conv Factor	PPS Fee	Access-Based or Max Fee	Effective Date	Note Codes	Change Ind
1	MEDICAL SERVICES	H0034			0	999					$13.53	4/1/2017		
1	MEDICAL SERVICES	H0034	HQ		0	20					$3.38	4/1/2017		
1	MEDICAL SERVICES	H0034	HQ		21	999					$2.71	4/1/2017		
1	MEDICAL SERVICES	H2011			0	999					$36.89	4/1/2017		
1	MEDICAL SERVICES	H2012			18	999					$24.32	4/1/2017		
1	MEDICAL SERVICES	H2014			0	999					$25.02	4/1/2017		
1	MEDICAL SERVICES	H2014	HQ		0	20					$6.26	4/1/2017		
1	MEDICAL SERVICES	H2014	HQ		21	999					$5.00	4/1/2017		
1	MEDICAL SERVICES	H2017			18	999					$26.93	9/1/2011		
1	MEDICAL SERVICES	H2017	ET		18	999					$26.93	12/1/2014		
1	MEDICAL SERVICES	H2017	ET		18	999					$26.93	12/1/2014		
1	MEDICAL SERVICES	H2017	HQ		18	999					$5.39	9/1/2011		
1	MEDICAL SERVICES	H2017	HQ	TD	18	999					$5.39	12/1/2014		
1	MEDICAL SERVICES	H2017	TD		18	999					$26.93	12/1/2014		