Texas Medicaid Fee Schedule Information
MISCELLANEOUS OTHER PROFESSIONALS - COMPREHENSIVE HEALTH CENTER (CHC)

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 assigned to each procedure code for system administration.

TOS Desc: Description of the TOS.

Proc Code: The five-digit code for services and items defined in Current Procedure Terminology or the Healthcare Common Procedure Coding System.

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

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

Client Age

Frm: The "from age" is the beginning of an age range, if it is required for determining pricing. Some procedure codes have more than one pricing row. If the first row has a 0-999 age range, and the second row has a 21-999 age range, then the client age range for the first row (0-999) is actually 0-20 years of age. If the first row has a 0-999 age range and the second row has a 0-20 age range, then the client age range for the first row (0-999) is actually 21-999 years of age. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for the exact age limitations.

Thru: The "through age" is the end of an age range, if it is required for determining pricing. Some procedure codes have more than one pricing row. If the first row has a 0-999 age range, and the second row has a 21-999 age range, then the client age range for the first row (0-999) is actually 0-20 years of age. If the first row has a 0-999 age range and the second row has a 0-20 age range, then the client age range for the first row (0-999) is actually 21-999 years of age. Refer to the TMPPM for exact age limitations.

Client Age Units: Medicaid rates are based on the client's age in days, months or years.

Non-facility/Facility Non-Facility pricing is for services that are rendered in places of service other than an inpatient hospital or an outpatient hospital. Facility pricing is for services that are rendered in an inpatient hospital (place of service [POS] 3), or an outpatient hospital or ambulatory surgical center (POS 5).

Total RVUs/Base Units: The current relative value units (RVUs) for the procedure code, if the fee is a resource-based fee (RBF). The payable amount for RBFs is calculated by multiplying the total RVUs by the applicable conversion factor. For Anesthesia services only, this column shows the base units instead; and payment is based on the sum of the base units plus actual face-to-face time units multiplied by the applicable conversion factor.

Conversion Factor: The Texas Medicaid conversion factor that is applicable for determining the amount payable when the rate is calculated by base units for anesthesia services or RVUs for other services.

Medicaid Fee: The Medicaid allowed amount.

Fee Effect Date: The effective date of service for which the fee is payable.

Adjust %: A percentage reduction has been applied to the allowed fee for this service. This column shows the percent by which the fee was adjusted. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Adjusted Fee for Report Date: A percentage reduction has been applied to the allowed fee for this service. This column does not show reductions that may have been applied using other criteria that include but are not limited to place of service, client type program, or provider specialty. Additional information about rate changes is available on the TMHP website at www.tmhp.com.

Note Codes: Note code indicator. Providers should review each note code to identify specific payment explanation or limitation. See Note Codes worksheet for applicable payment explanation or limitation.

Last Pricing Review Date: Medicaid rates are reviewed every two years or as necessary. This column shows the date on which the most recent review was conducted.

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

TOS	TOS Desc	Proc Code	Mod 1	Mod 2	Client Age			Non-facility									Facility									Last Pricing Review Date	Change Ind
					Frm	Thru	Units	Total RVUs/ Base Units	Conversion Factor	Medicaid Fee	Fee Effect Date	Adjust %	Adjusted Fee for Report Date	Note Codes 1	2	3	Total RVUs/ Base Units	Conversion Factor	Medicaid Fee	Fee Effect Date	Adjust %	Adjusted Fee for Report Date	Note Codes 1	2	3		
1	MEDICAL SERVICES	90673			19	999	Years	0.00	$0.0000	$57.45	9/1/2021	0.00	$57.45	9			0.00	$0.0000	$57.45	9/1/2021	0.00	$57.45	9			9/1/2021	
1	MEDICAL SERVICES	90682			18	999	Years	0.00	$0.0000	$57.45	9/1/2021	0.00	$57.45	9			0.00	$0.0000	$57.45	9/1/2021	0.00	$57.45	9			9/1/2021	

Note Code(s): 9 - The NP/CNS/PA/CNM Provider Fee Schedule reflects 100 percent of the fee applicable to a physician.