TEXAS HEALTH AND HUMAN SERVICES COMMISSION
RATE ANALYSIS DEPARTMENT

Proposed Medicaid Payment Rates for Medical Policy Review of Radiology Services (77013, 77022, 78608)

Payment rates are proposed to be effective July 1, 2016

SUMMARY OF PROPOSED MEDICAID PAYMENT RATES

Effective July 1, 2016

Included in this document is information relating to the proposed Medicaid payment rates for Medical Policy Review of Radiology Services (77013, 77022, and 78608). The rates are proposed to be effective July 1, 2016.

Hearing

The Health and Human Services Commission (HHSC) will conduct a public hearing to receive comments regarding the proposed Medicaid rates detailed in this document on May 11, 2016, at 1:30 p.m. in the Public Hearing Room in the Brown-Heatly Building at 4900 North Lamar Boulevard, Austin, Texas 78751, with entrance through Security at the front of the building facing Lamar Boulevard. HHSC will consider concerns expressed at the hearing prior to final rate approval. This public hearing is held in compliance with the provisions of Human Resources Code §32.0282 and the Texas Administrative Code, Title 1 (1 TAC), §355.201, which require a public hearing on proposed payment rates. Should you have any questions regarding the information in this document, please contact:

Ross Keenon, Acute Care Rate Analysis
Texas Health and Human Services Commission
(512) 707-6073 FAX: (512) 730-7475
E-mail: Ross.Keenon@hhsc.state.tx.us

HHSC also will broadcast the public hearing; the broadcast can be accessed at http://www.hhsc.state.tx.us/news/meetings.asp. The broadcast will be archived and can be accessed on demand at the same website.

Background

HHSC is responsible for the reimbursement determination functions for the Texas Medicaid Program. Proposed rates are calculated utilizing established methodologies that conform to the Social Security Act and related federal regulations, the federally approved Texas Medicaid State Plan, all applicable state statutes and rules, and other requirements. HHSC reviews the Medicaid reimbursement rates for all acute care services every two years. These biennial reviews result in rates that are increased, decreased, or remain the same. The reviews are conducted to ensure that rates continue to be based on established rate methodologies.

Methodology

The specific administrative rules that govern the establishment of the fees in this proposal include these rules in 1 TAC:

- §355.8085, which addresses the reimbursement methodology for physicians and other practitioners;

- §355.8061, which addresses outpatient hospital reimbursement.

Proposed Rates

The methodologies used to determine the proposed fee-for-service Medicaid rates are summarized below:

- Procedure codes and descriptions used in the Texas Medicaid Program are national standard code sets as required by federal laws; Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT).
- Resource-based fee (RBF) methodology uses relative value units (RVUs) established by Medicare times a conversion factor. Current conversion factors include $28.0672 for most services provided to children 20 years of age and younger and $26.7305 for services provided to adults 21 years of age and older. Fees for services provided to children and identified as having access-to-care issues may be assigned a higher conversion factor, currently $30.00.
- Access-based fees (ABFs) allow the state to reimburse for procedure codes not covered by Medicare or for which the Medicare fee is inadequate, or account for particularly difficult procedures, or encourage provider participation to ensure access to care.
- ABFs may also be established based on the Medicare fee for a service that is not priced using RVUs. Physician-administered drug pricing methodologies are outlined in §355.8085.
- For services and items that are not covered by Medicare or for which the Medicare rate is insufficient, different approaches are used to develop fees based on available information. These alternate methods include, as applicable:
  - The median or mean of the Medicaid fees from 14 states (the 10 most populous and the 4 bordering Texas) or the median or mean of the states that cover the service
  - Regional Medicare pricing from Novitas
  - The current Medicaid fee for a similar service (comparable code)
  - The most recent *HCPCS Fee Analyzer* or the (CPT) *Customized Fee Analyzer*, customized listings of the 25th, 50th, 75th, and 85th percentiles of reimbursement rates charged for each of the procedures in the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT) respectively, in the Dallas area
  - 82 percent of the manufacturer suggested retail price (MSRP) supplied by provider associations or manufacturers

- 89.5 percent of the average wholesale price for enteral and parenteral products
- Cost shown on a manufacturer's invoice submitted by the provider to HHSC

- Rate determination methodologies related to hospital outpatient imaging is addressed in §355.8061.

Proposed payment rates are listed in the attachments outlined below:

Med Pol Radiology Att 1.docx
Med Pol Radiology Att 2 – Hospital Outpatient Imaging.docx

This public rate hearing briefing packet presents proposed payment rates and is distributed at HHSC public rate hearings and posted by the proposed effective date on the HHSC website at http://www.hhsc.state.tx.us/rad/rate-packets.shtml. Proposed rates may or may not be adopted, depending on HHSC management decisions after review of public comments and additional information. Provider and public notification about adoption decisions are published on the Texas Medicaid and Healthcare Partnership (TMHP) website at http://www.tmhp.com in banner messages, bulletins, notices, and updates to the Texas Medicaid fee schedules. The fees schedules are available in static files or online lookup at http://public.tmhp.com/FeeSchedules.

MEDICAL POLICY ATTACHMENT 1 - RADIOLOGY SERVICES (77013, 77022 and 78608) (proposed to be effective July 1, 201

							CURRENT		PROPOSED	
TOS *	Procedure Code	Modifier	Long Description **	Age Range	Non-Facility (N)/ Facility (F)	Provider Type (PT) / Provider Specialty (PS)	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee
4	77013		**	0-20	F/N		Not A Benefit	Not A Benefit	$478.25	$478.25
4	77013		**	21-999	F/N		Not A Benefit	Not A Benefit	$455.48	$455.48
I	77013		**	0-20	F/N		$160.54	$160.54	$156.05	$156.05
I	77013		**	21-999	F/N		$152.90	$152.90	$148.62	$148.62
T	77013		**	0-20	F/N		Not A Benefit	Not A Benefit	$322.20	$322.20
T	77013		**	21-999	F/N		Not A Benefit	Not A Benefit	$306.86	$306.86
4	77022		**	0-20	F/N		Not A Benefit	Not A Benefit	$589.87	$589.87
4	77022		**	21-999	F/N		Not A Benefit	Not A Benefit	$561.77	$561.77
I	77022		**	0-20	F/N		$174.86	$174.86	$169.53	$169.53
I	77022		**	21-999	F/N		$166.53	$166.53	$161.45	$161.45
T	77022		**	0-20	F/N		Not A Benefit	Not A Benefit	$420.34	$420.34
T	77022		**	21-999	F/N		Not A Benefit	Not A Benefit	$400.32	$400.32
4	78608		**	0-20	F/N		Not A Benefit	Not A Benefit	$1,114.65	$1,114.65
4	78608		**	21-999	F/N		Not A Benefit	Not A Benefit	$1,061.56	$1,061.56
I	78608		**	0-20	F/N		$58.66	$58.66	$57.26	$57.26
I	78608		**	21-999	F/N		$55.87	$55.87	$54.53	$54.53
T	78608		**	0-20	F/N		Not A Benefit	Not A Benefit	$1,057.39	$1,057.39
T	78608		**	21-999	F/N		Not A Benefit	Not A Benefit	$1,007.03	$1,007.03

*Type of Service (TOS)	
4	Radiology
I	Professional Component
T	Technical Component

** Required Notice: The five-character code included in this notice is obtained from the Current Procedural Terminology (CPT®), copyright 2016 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of this notice is with HHSC and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this notice. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical

Medical Policy - Radiology Attachment 2 - HOSPITAL OUTPATIENT IMAGING (proposed to be effective July 1, 2016)

TOS*	Procedure Code	Modifier**	Long Description **	Age Range	Current Medicaid Fee	*** Proposed Medicaid Fee
4	78608		**	0-999		$1,285.17

*Type of Service (TOS)	
4	Radiology

** Required Notice: The five-character code included in this notice is obtained from the Current Procedural Terminology (CPT®), copyright 2016 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of this notice is with HHSC and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this notice. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained.

***Based on TAC §355.8061: **Reimbursement for imaging services in rural hospitals** – Outpatient rural hospital imaging services will be reimbursed according to the outpatient hospital imaging service fee schedule with an add-on. The add-on fee will be in addition to the fees in the Medicaid fee schedule proportionate to the total Medicaid fee (see table below). Fees will not exceed 100 percent of Medicare fees.

Recommended Urban Hospitals Fee Range	Add on Fee for Rural Hospitals
Less than or equal to $80.00	$3.00
Greater than$ 80.00 but less than or equal to $150.00	$8.00
Greater than $150.00 but less than or equal to $300.00	$15.00
Greater than $300.00	$32.00