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1. GENERAL INFORMATION

The information in this handbook is intended for Texas chiropractors, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), podiatrists, geneticists, maternity service clinics, physicians, and physician assistants. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures.

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1617(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers may also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

**Refer to:** Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information).


Section 5, “THSteps Medical” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

For information on Advanced Practice Registered Nurses (APRNs), refer to the following subsections in this handbook:

**Section 3, “Certified Nurse Midwife (CNM)”**
- Subsection 3.1, “Provider Enrollment”

**Section 4, “Certified Registered Nurse Anesthetist (CRNA)”**
- Subsection 4.1, “Enrollment”

**Section 5, “Genetic Services”**
- Subsection 5.2, “Services, Benefits, Limitations, and Prior Authorization”

**Section 7, “Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)”**
- Subsection 7.1, “Enrollment”

**Section 8, “Physician”**
1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

Refer to: Subsection 3.6.3.8, “Payment Window Reimbursement Guidelines,” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2. CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)

2.1 Enrollment

To enroll in Texas Medicaid, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

2.2 Services, Benefits, Limitations, and Prior Authorization

CMT performed by a chiropractor licensed by the Texas State Board of Chiropractic Examiners is a benefit of Texas Medicaid.

CMT is limited to an acute condition or an acute exacerbation of a chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day. The 12-month period consists of 12 consecutive months, beginning with the date the client receives the first treatment.

If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute.

CMT is not a benefit of Texas Medicaid for maintenance therapy when:

- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- The chiropractic treatment becomes supportive rather than corrective in nature.

CMT may be reimbursed when billed using procedure codes 98940, 98941, or 98942.

Procedure codes 98940, 98941, and 98942 must be submitted with the AT modifier. The AT modifier is used to identify treatment provided for an acute condition or an exacerbation of a chronic condition that persists for 180 days or less from the start date of treatment. Providers may file an appeal for a claim denied beyond the 180 days of treatment with documentation supporting that further clinical improvement can be reasonably expected, maximal improvement has not been reached, and further improvement has not ceased.

Procedure code 98940 will be denied as part of another service when billed for the same date of service as 98941 or 98942 by any provider.

Procedure code 98941 will be denied as part of another service when billed for the same date of service as 98942 by any provider.
Texas Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by themselves or by others under their orders or directions. Additionally, braces or supports, even though ordered by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) and supplied by a chiropractor are not reimbursable items.

CMT is reimbursed only for a diagnosis of subluxation of the spine. The level of subluxation must be indicated by the appropriate diagnosis codes listed below:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7390</td>
</tr>
</tbody>
</table>

2.2.1 Prior Authorization
Prior authorization is not required for CMT services.

2.3 Documentation Requirements
Manipulations must be provided in accordance with an ongoing, written treatment plan that supports medical necessity of an acute condition or an acute exacerbation of a chronic condition.

Documentation that supports medical necessity for the treatment plan includes all of the following:

- Diagnosis
- Region(s) treated
- Degree of severity
- Impairment characteristics
- Physical examination findings, X-ray, or other pertinent findings
- Specific statements of short- and long-term goals
- A reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and/or the techniques utilized

The treatment plan must be updated as the client’s condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information
Chiropractic services must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.
Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement
The Medicaid rates for chiropractic manipulative treatment (CMT) are reimbursed in accordance with 1 TAC §355.8081 and 355.8085. See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

3. CERTIFIED NURSE MIDWIFE (CNM)

3.1 Provider Enrollment
To enroll in Texas Medicaid, a CNM must be licensed as a registered nurse and as an advanced practice registered nurse (APRN) by the Texas Board of Nursing (BON), and be authorized to practice as a nurse-midwife. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Refer to: The Texas Department of State Health Services (DSHS) website at www.dshs.state.tx.us/famplan for information about family planning and the locations of family planning clinics that receive funding from the DSHS Family Planning Program.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. The collaborating physician does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1252 (3), if the collaborating physician or group is not a participating provider in Texas Medicaid, the CNM must inform clients of
their potential financial responsibility. If the arrangement is changed or canceled, the CNM must notify Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment in writing within two weeks after the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment in Texas Medicaid.

Subsection 5.2, “Enrollment,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about enrollment in the THSteps Program.


3.1.1 Enrollment in Texas Health Steps (THSteps)

CNMs may enroll as providers of THSteps medical checkups for newborns and adolescent females.

3.2 Services, Benefits, Limitations, and Prior Authorization

CNM providers may be reimbursed for family planning, obstetrical, neonatal, and primary care services.

3.2.1 Deliveries

CNM providers may be reimbursed for procedure code 59409, 59410, 59612, or 59614 for delivery services.

Refer to: Subsection 8.2.46, “Obstetrics and Prenatal Care,” in this handbook for billing requirements.

3.2.2 Newborn Services

Routine newborn care, attendance at delivery, and newborn resuscitation services may be reimbursed to CNM providers.

Refer to: Subsection 5.3.7, “Newborn Examination,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for a list of required components for an initial THSteps examination.

Subsection 8.2.45, “Newborn Services,” in this handbook for additional guidelines and limitations.

3.2.3 * Prenatal and Postpartum Services

CNM and physician providers are limited to a combined total of 20 outpatient prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation should reflect the need for increased visits and is subject to retrospective review.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity.

Postpartum care provided after discharge must be billed using procedure code 59430. Only one postpartum visit is allowed per pregnancy.

Refer to: Subsection 8.2.46, “Obstetrics and Prenatal Care,” in this handbook for additional information about postpartum care.

3.2.4 Laboratory and Radiology Services

Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.
3.2.5 Prior Authorization

Prior authorization is not required for any of these services except delivery in the home. For prior authorization of a home delivery, the CNM must submit a written request for prior authorization during the client’s third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Documentation must also include a plan for access to emergency transport for mother and neonate, if needed. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: (512) 514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization will be denied.

3.2.6 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including CNM services.

CNM services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.2.7 Claims Filing and Reimbursement

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

CNM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

According to 1 TAC §355.8161, the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.
Refer to: Subsection 4.1, “General Medicaid Eligibility,” in Section 4, Client Eligibility (Vol. 1, General Information) for information about crossover payments.

Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.


Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

4. CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

4.1 Enrollment
To enroll in Texas Medicaid, a CRNA must be licensed as a registered nurse (RN) and as an APRN by the Texas BON and must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An RN under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as acceptable documentation of appropriate licensure and certification for enrollment.

Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider’s Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Services, Benefits, Limitations, and Prior Authorization
Medically necessary services that are performed by a CRNA are benefits if the services are within the scope of the CRNA’s practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice and to the extent allowed by state law; and are provided under one of the following conditions:

- There is no physician anesthesiologist on the medical staff of the facility where the services are provided (e.g., rural settings).
- There is no physician anesthesiologist available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician, dentist, or podiatrist who performs the procedure that requires the services specifically requests the services of a CRNA.
- The eligible client who requires the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to the policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

Texas Medicaid does not reimburse the CRNA for equipment, drugs, or supplies.

4.2.1 Prior Authorization
Services performed by a CRNA are subject to the same prior authorization guidelines as services performed by other provider types.

4.3 Documentation Requirements
All services require documentation to support the medical necessity of the services rendered, including CRNA services. CRNA services are subject to retrospective review and recoupment if documentation does not support the service billed.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information
All CRNA services must be billed with a CRNA individual provider identifier or a CRNA group provider identifier. No payment for CRNA services will be made under a hospital or physician provider identifier.

CRNA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 8.2.6.9.3, “CRNA Services,” in this handbook for more information on billing for CRNA services.

4.4.1.1 Interpreting the R&S Report
The Billed Qty field on the Remittance and Status (R&S) Report reflects only the number of time units TMHP processes. The Relative Value Units (RVUs) assigned for the procedure code are not shown in the Billed Qty field.

4.4.2 Reimbursement
A CRNA is reimbursed the lesser of either the CRNA’s billed charges or 92 percent of the reimbursement for the same service paid to a physician (MD or DO) anesthesiologist in accordance with 1 TAC §355.8221.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.
Refer to: Subsection 8.2.6.8, “Reimbursement Methodology,” in this handbook for more information about flat fees and time based fees.

5. GENETICISTS

5.1 Enrollment

5.1.1 Geneticists
Geneticists may enroll in Texas Medicaid as both a physician or physician group and as a geneticist. Enrollment as a geneticist allows enhanced reimbursement for specific procedure codes when a claim is submitted using the geneticist provider identifier.

A provider of genetic services that wishes to enroll in Texas Medicaid as a geneticist must complete the required Medicaid provider enrollment application forms and enter into a written agreement with HHSC. Texas Medicaid provider enrollment forms are available from TMHP, and may be downloaded on the TMHP website at www.tmhp.com. Completed applications are submitted to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720

Prior to enrollment, applicant qualifications for the provision of genetic services are verified and approved by DSHS. Verification and approval are administered through the Health Screening and Case Management Unit. Basic contract requirements are as follows:

- The provider must be a clinical geneticist (MD or DO) who is board certified by the American Board of Medical Geneticists (ABMG) or an active candidate of ABMG.
- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including the clinical geneticist and at least one of the following: nurse, social worker, medical geneticist, or genetic counselor.
- Upon DSHS approval, TMHP issues a provider identifier and a performing provider identifier for the provision of genetic services.
- Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

5.2 Services, Benefits, Limitations, and Prior Authorization
Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response. Genetic services may be provided by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and typically include one or more of the following:

- Comprehensive physical exams
- Diagnosis, management, and treatment for clients with genetically-related health problems
- Evaluation of family histories for the client and the client’s family members
- Genetic risk assessment
- Genetic laboratory tests
- Interpretation and evaluation of laboratory test results
• Education and counseling of clients, their families, and other medical professionals on the causes of genetic disorders

• Consultation with other medical professionals to provide treatment

Pharmacogenetics encompasses the use of information encoded in DNA to help predict responses to medicines and thereby enhance the effectiveness and safety of medicines for individual clients. Testing for drug efficacy is not a benefit of Texas Medicaid, except as outlined in other sections of the Texas Medicaid Provider Procedures Manual.

5.2.1 Family History

It is important for primary care providers to recognize potential genetic risk factors in a client so that they can make appropriate referrals to a genetic specialist.

Obtaining an accurate family history is an important part of clinical evaluations, even when genetic abnormalities are not suspected. Knowing the family history may help health-care providers identify single-gene disorders or chromosomal abnormalities that occur in multiple family members or through multiple generations. Some genetic disorders that can be traced through an accurate family history include diabetes, hypertension, certain forms of cancer, and cystic fibrosis. Early identification of the client’s risk for one of these diseases can lead to early intervention and preventive measures that can delay onset or improve health conditions.

Using a genetics-specific questionnaire helps to obtain the information needed to identify possible genetic patterns or disorders. The most commonly used questionnaires are provided by the American Medical Association and include the Prenatal Screening Questionnaire, the Pediatric Clinical Genetics Questionnaire, and the Adult History Form.

5.2.2 Genetic Tests

Diagnostic tests to check for genetic abnormalities must be performed only if the test results will affect treatment decisions or provide prognostic information. Tests for conditions that are treated symptomatically are not appropriate since the treatment would not change. Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to discuss the client’s needs.

Any genetic testing and screening procedure must be accompanied by appropriate non-directive counseling, both before and after the procedure. Information must be provided to the client and family (if appropriate) about the possible risks and purpose and nature of the tests being performed.

The interpretation of certain tests, such as nuchal translucency, requires additional education and experience. Texas Medicaid supports national certification standards when available.

5.2.3 Laboratory Practices

For many heritable diseases and conditions, test performance and interpretation of test results require information about client race/ethnicity, family history, and other pertinent clinical and laboratory information. To facilitate test requests and ensure prompt initiation of appropriate testing procedures and accurate interpretation of test results, the requesting provider must be aware of the specific client information needed by the laboratory before tests are ordered.

To help providers make appropriate test selections and requests, handle and submit specimens, and provide clinical care, laboratories that perform molecular genetic testing for heritable diseases and conditions must educate providers that request services about the molecular genetic tests the laboratory performs. For each molecular genetic test, the laboratory must provide the following information:

• Indications for testing

• Relevant clinical and laboratory information

• Client race and ethnicity
• Family history
• Pedigree

Testing performed on a client to provide genetic information for a family member, and testing performed on a non-Medicaid client to provide genetic information for a Medicaid client are not benefits of Texas Medicaid.

5.2.4 Genetic Counselors

Genetic counselor services may be billed by a physician when the genetic counselor is under physician supervision and is an employee of the physician. Services provided by independent genetic counselors are not a benefit of Texas Medicaid.

5.2.5 Genetic Evaluation and Counseling by a Geneticist

A provider enrolled in Texas Medicaid as a geneticist may bill the following evaluation and management codes and receive an enhanced reimbursement. All other procedure codes must be billed under the geneticist's individual, group, or laboratory provider identifier.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>96040</td>
<td>None</td>
</tr>
<tr>
<td>99213</td>
<td>None</td>
</tr>
<tr>
<td>99214</td>
<td>None</td>
</tr>
<tr>
<td>99215</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>99244</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99245</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99254</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99255</td>
<td>One every three years, any provider</td>
</tr>
<tr>
<td>99402</td>
<td>One per pregnancy, per provider*</td>
</tr>
<tr>
<td>99404</td>
<td>One every three years, any provider</td>
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</tbody>
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* Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies a claim.

One office consultation, performed by a geneticist, (procedure code 99244 or 99245) may be considered for reimbursement if procedure code 99244, 99245, 99254, or 99255 has not been submitted by and reimbursed to that geneticist in the previous three years.

Inpatient consultations, performed by a geneticist, (procedure codes 99254 and 99255) may be considered for reimbursement once every three years even if an office consultation has been reimbursed in the previous three years.

5.2.6 Prior Authorization

Prior authorization is not required for services billed by a geneticist.

5.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including genetic services. Genetic services are subject to retrospective review and recoupment if documentation does not support the service billed.
5.4 Claims Filing and Reimbursement

5.4.1 Claims Information
Genetic services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5.4.2 Reimbursement
Genetic services providers are reimbursed according to the established allowable maximum fee schedule. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

6. MATERNITY SERVICE CLINICS (MSC)

6.1 Provider Enrollment
To enroll in Texas Medicaid, MSCs must submit a complete application and meet the following requirements:

- Must be a facility that is not an administrative, organizational, or financial part of a hospital.
- Must be organized and operated to provide maternity clinic services to outpatients.
- Must comply with all applicable federal, state, and local laws and regulations.
- Must employ or have a contractual agreement or formal arrangement with a licensed MD or DO who assumes professional responsibility for the services provided to the clinic’s patients.
- Must adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of Health, unless otherwise specified by the department or its designee.
• Must ensure that services provided to each patient are commensurate with the patient’s risk assessment and are documented in the patient’s medical record.

The supervising physician’s license information must be provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days.

Medicare certification is not a prerequisite for MSC enrollment.

6.1.1 Physician Responsibility

To meet the requirement to assume professional responsibility for the services provided to the clinic’s clients, the supervising physician must do the following:

• See the client at least once

• Prescribe the type of care to be provided or approve the client’s plan of care (POC)

• Periodically review the need for continued care (if the services are not limited by the prescription)

The physician must base the POC on a risk assessment completed by the physician or by licensed, professional clinic staff. The assessment must be based on findings obtained through a health history, laboratory or screening services, and a physical examination.

6.1.2 Case Management Services to High-Risk Individuals

An MSC that wants to bill and receive reimbursement for case management services to high-risk individuals including infants, pregnant adolescents, and women must meet the eligibility criteria for case management services. To be considered for reimbursement for case management for these clients, the MSC must enroll as a group in Case Management for Children and Pregnant Women, and each eligible case manager must enroll as a performing provider.


6.2 Services, Benefits, Limitations, and Prior Authorization

Services billed by an MSC are those provided by a physician or by licensed, professional clinic staff and are determined to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do not include deliveries.

MSCs are limited to 20 prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation must reflect the need for increased visits and is subject to retrospective review.

Procedure codes in the following table are for prenatal and postpartum care visits:

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<tbody>
<tr>
<td>Procedure Code</td>
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*Procedure code 59430 is not submitted with modifier TH

Note: The prenatal visits must be billed with modifier TH
Providers must bill the most appropriate new or established prenatal visit code or postpartum visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

An MSC may be reimbursed for prenatal and postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for prenatal care and not separately reimbursed. Services other than prenatal and postpartum care visits will be denied. MSCs that are enrolled in Case Management for Children and Pregnant Women as a group may be reimbursed for theses services under the group provider identifier assigned to their facility.

Medical services must be furnished on an outpatient basis by the physician or by licensed, professional clinic staff under the direction of the physician and must be within the staff’s scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic and ensure through approval of the POC that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

Providers submitting charges for high-risk prenatal care must document the high-risk diagnosis on the claim form and document the condition in the client’s medical record.

Refer to: Subsection 8.2.46.13.1, “HIV Testing,” in this handbook for information about required HIV testing for pregnant women.

6.2.1 Initial Prenatal Care Visit Components

The following initial prenatal care visit components should be completed as early as possible in the client’s pregnancy.

6.2.1.1 History

History includes OB-GYN, present pregnancy, medical and surgical, substance use, environmental, nutritional, psychosocial (including violence), and family support system.

6.2.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

6.2.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC provider identifier. These services may be ordered by MSC personnel and provided by a reference laboratory.

MSCs must supply the client’s Medicaid number and the MSC provider identifier to the reference laboratory when laboratory services are requested.

The laboratory services requested by an MSC may include, but are not limited to, the following:

- Hemoglobin, hematocrit, or complete blood count (CBC)
- Urinalysis
- Blood type and Rh
• Antibody screen
• Rubella antibody titer
• Serology for syphilis
• Hepatitis B surface antigen
• Cervical cytology
• Other laboratory tests

The following tests may be performed at the initial prenatal care visit, as indicated:

• Pregnancy test
• Gonorrhea test
• Urine culture
• Sickle cell test
• Tuberculosis (TB) test
• Chlamydia test

As stated in the Health and Safety Code §81.090, screening for Hepatitis B virus infection, HIV, and Syphilis must be performed at the initial prenatal care visit. In addition, HIV testing must be performed in the third trimester. HBV and Syphilis must be performed at labor and delivery.

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

6.2.1.4 Assessment

Assessment includes pregnancy, general health, medical, and psychosocial.

6.2.1.5 Plan

Plan includes pregnancy, preventive health, medical, and referral as indicated.

6.2.1.6 Education and Counseling

Education and counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health. The education and counseling should also include the need for a medical home and information about THSteps medical and dental checkups for the child.

The complete physical examination may be completed at the second visit if the MSC’s routine involves a two-stage initial evaluation.

6.2.2 Subsequent Prenatal Care Visits

The following is a recommended guide for the frequency of subsequent prenatal visits for a regular pregnancy:

• One visit every 4 weeks for the first 28 weeks of pregnancy.
• One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy.
• One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, CNMs, and MSCs are limited to 20 prenatal care visits per pregnancy and 1 postpartum care visit per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.
Each subsequent visit must include the following:

- Interim History
- Problems
- Maternal status
- Fetal status

### 6.2.2.1 Physical Examination

The physical examination must include the following:

- Weight and blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

### 6.2.2.2 Laboratory Tests

Required laboratory tests include the following:

- Urinalysis for protein and glucose every visit
  
  **Note:** The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.

- Hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy

- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy

- Repeated antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)

- Gestational diabetes screen at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load

- Blood sample for HBsAg screening at the first examination and visit followed by a second blood sample for HBsAg screening on admission for delivery

- Other laboratory tests as indicated by the medical condition of the client

### 6.2.3 * Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 59430. A maximum of 1 postpartum visit is allowed per pregnancy.

**Refer to:** Subsection 8.2.46, “*Obstetrics and Prenatal Care,*” in this handbook for additional information about postpartum care.

### 6.2.4 Prior Authorization

Prior authorization is not required for services rendered in MSCs.

### 6.3 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client’s 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.
6.4 Claims Filing and Reimbursement

MSC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to:
Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

MSCs are reimbursed in accordance with 1 TAC §355.8081. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Note: Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.

7. NURSE PRACTITIONER (NP) AND CLINICAL NURSE SPECIALIST (CNS)

For other APRNs, see Section 4, “Certified Registered Nurse Anesthetist (CRNA)” in this handbook for information regarding CRNAs, and Section 3, “Certified Nurse Midwife (CNM)” in this handbook for information about certified nurse midwives (CNMs).

7.1 Enrollment

To enroll in Texas Medicaid, an NP or CNS must be licensed as a registered nurse and as an APRN by the Texas BON. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.
Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA),” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

Section 3, “Certified Nurse Midwife (CNM)” in this handbook for more information on CNM enrollment.

Section 4, “Certified Registered Nurse Anesthetist (CRNA)” in this handbook for more information on CRNA enrollment.

7.1.1 Enrollment in Texas Health Steps (THSteps)
APRNs who are recognized by the Texas BON and who are nationally certified in pediatrics, family practice, adult health (adolescents only), women’s health (adolescent females only), or is a certified nurse midwife (newborns and adolescent females only) can enroll as THSteps providers. Specific information is found in the Children’s Services Handbook.

Refer to: Subsection 5.2, “Enrollment,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on enrollment procedures.

7.2 Services, Benefits, Limitations, and Prior Authorization
Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for NPs and CNSs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Benefit limitation information for services can be found in the Section 8, “Physician” in this handbook, the Children’s Services Handbook (Vol. 2, Provider Handbooks), and the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

Payment for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Refer to: Section 2, “Medicaid Title XIX family planning services” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

Section 8, “Physician” in this handbook.

Subsection 5.1.6, “THSteps Medical Checkup Facilities,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information on THSteps services.

7.2.1 Prior Authorization
Services performed by an NP or CNS are subject to the same prior authorization guidelines as services performed by other provider types.

7.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including NP and CNS services. NP and CNS services are subject to retrospective review and recoupment if documentation does not support the service billed.
7.4 Claims Filing and Reimbursement

7.4.1 Claims Information
APRN services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

7.4.2 Reimbursement
According to 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. When NPs or CNSs bill Medicaid directly for services they performed, they must use their individual provider identifier. If the services are performed by the NP or CNS but billed by a physician or physician group, the billing provider is the physician or physician group.

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to: Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

8. PHYSICIAN

8.1 Enrollment

8.1.1 Physicians and Doctors
To enroll in Texas Medicaid to provide medical services, physicians (MD or DO), doctors of dental surgery [DDS], and doctors of podiatric medicine (DPM) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.
Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

**Important:** The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

### 8.2 Services, Benefits, Limitations, and Prior Authorization

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association’s (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided, based on the code’s description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim. The level of service provided and documented must be medically necessary, based on the clinical situation and needs of the client.

To receive reimbursement, providers must document the following information in the client’s medical record:

- The service
- The date rendered
- Pertinent information about the client’s condition supporting the need for the service
- The care given

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physician supervision that are within the scope of practice of their profession as defined by state law.

#### 8.2.1 Teaching Physician and Resident Physician

The roles of the teaching physician and resident physician occur in the context of an accredited graduate medical education (GME) training program.

The teaching physician is the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being submitted for reimbursement; the physician must be affiliated and in good standing with an accredited GME program and must possess all appropriate licensure.

Physician services must be performed personally by the teaching physician or by the person to whom the physician has delegated the responsibility. The level of supervision required may be direct or personal.

In all cases, the client’s medical record must clearly document that the teaching physician provided identifiable supervision of the resident. As defined below, the supervision must be direct or personal depending on the setting and the clinical circumstances:

- **Direct supervision** means that the teaching physician must be in the building of the office or facility when and where the service is provided.
• **Personal supervision** means that the teaching physician must be physically present in the room when and where the service is being provided.

The teaching physician must provide personal supervision during all medically complex situations, dangerous procedures, or major surgery. A service or procedure is complex or dangerous if deviation from the expected technique at the time the procedure or service is performed presents a medically reasonable and immediate risk to the patient’s life or health. This criterion applies regardless of the place of service.

The teaching physician must provide medically appropriate, identifiable direct supervision for all other services that do not require personal supervision.

The following prerequisites apply when the teaching physician submits claims for services performed, in whole or in part, by the resident physician in the inpatient hospital setting, the outpatient hospital setting, and surgical services and procedures.

### 8.2.1.1 Teaching Physician Prerequisites

#### Services provided in an outpatient setting.

For services provided in an outpatient setting, the teaching physician must demonstrate that personal supervision was provided. The following tasks must be performed and their completion must be documented in the patient’s medical record before the claims are submitted for consideration of reimbursement:

- Review the patient’s history and physical examination.
- Confirm or revise the patient’s diagnosis.
- Determine the course of treatment to be followed.

**Exception:** Exception for E/M services furnished in certain primary care centers. Teaching physicians that meet the primary care exception under Medicare are allowed to bill for low-level and mid-level E/M services for residents. Facilities that meet the primary care exception under Medicare may bill Texas Medicaid, Family Planning, or the Children with Special Health Care Needs (CSHCN) Services Program for new patient services (procedure codes 99201, 99202, and 99203) and established patient services (procedure codes 99211, 99212, and 99213).

**Note:** All services provided in an outpatient setting that do not qualify for the exception above require that the teaching physician examine the patient.

#### Services provided in an inpatient setting.

For services provided in an inpatient setting, the teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient’s medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient’s history, review the resident’s physical examination, and examine the patient within a reasonable period of time after the patient’s admission and before the patient’s discharge.
- Confirm or revise the patient’s diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician’s presence and participation in the major surgical or other complex and dangerous procedure or situation.
Surgical services and procedures.
The teaching surgeon is responsible for the patient’s preoperative, operative, and postoperative care. The teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient’s medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient’s history, review the resident’s physical examination, and examine the patient within a reasonable period of time after the patient’s admission and before the patient’s discharge.
- Confirm or revise the client’s diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician’s presence and participation in the major surgical or other complex and dangerous procedure or situation.

Important: Reimbursement may be reduced, denied, or recouped if the prerequisites are not documented in the medical record. The documentation must be made in the same manner as required by federal regulations under Medicare.

8.2.2 * Substitute Physician
Physicians may bill for the service of a substitute physician who sees clients in the billing physician’s practice under either a reciprocal or locum tenens arrangement of up to 60 days.

A reciprocal arrangement is one in which a substitute physician covers for the billing physician on an occasional basis when the billing physician is unavailable to provide services. Reciprocal arrangements do not have to be in writing.

A locum tenens arrangement is one in which a substitute physician assumes the practice of a billing physician who is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the armed forces. The locum tenens arrangement may be extended for a continuous period of longer than 60 days if the billing physician’s absence is due to being called or ordered to active duty as a member of a reserve component of the armed forces. Locum tenens arrangements must be in writing.

The substitute physician is not required to enroll in Texas Medicaid. The billing provider’s name, address, and national provider identifier must appear in Block 33 of the claim form. The name and office or mailing address of the substitute physician must be documented on the claim in Block 19, not Block 33.

When a physician bills for a substitute physician, modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a locum tenens arrangement.

When physicians in a group practice bill substitute physician services, the performing provider identifier of the physician for whom the substitute provided services must be in Block 24J.

Physicians must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation as detailed above will be subject to recoupment.

8.2.3 Aerosol Treatment
Aerosol treatment (procedure codes 94640, 94644, and 94645) for aerosol therapy is a benefit of Texas Medicaid and is limited to the following diagnosis codes:

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Diagnosis Codes

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Procedure codes J7605, J7608, J7622, J7626, J7631, J7633, J7639, J7644, and J7682 are limited to the following diagnosis codes:

Diagnosis Codes

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Diagnoses not listed above may be considered with supporting documentation of medical necessity.

Medications used in aerosol therapy, when billed by the provider, are reimbursed separately and must be billed using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code. A separate charge for saline used in aerosol therapy is denied as part of the aerosol therapy.

Refer to: Subsection 8.2.57, “Pentamidine Aerosol,” in this handbook for a list of diagnosis codes that are valid for pentamidine aerosol treatments.

Subsection 8.2.9, “Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer,” in this handbook for a list of diagnosis codes that are valid for the BCG vaccine.

8.2.4 Allergy Services

Texas Medicaid uses the following guidelines for reimbursement of allergy services.

8.2.4.1 Allergy Immunotherapy

Allergen immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.
Preparation of the allergy vial or extracts is a benefit of Texas Medicaid and should be submitted using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes for Preparation of Allergy Vial or Extract</th>
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<td>95145</td>
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Administration of the allergy extract may be reimbursed using procedure codes 95115 and 95117.

The preparation of the allergy vial or extract and the administration of an injection may be reimbursed for the following diagnosis codes:

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<th>Diagnosis Codes</th>
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8.2.4.1.1 Prior Authorization for Allergy Immunotherapy

Authorization is not required for immunotherapy services within the limitations outlined below. Requests for services beyond the established limits may be prior authorized with documentation of medical necessity. Documentation must be submitted to the Special Medical Prior Authorization Department and include the following information:

- Copy of the allergen testing results
- Severity and periodicity of symptoms
- Physical limitations created by the symptoms
- Anticipated treatment program
- Concurrent drug treatment
- Success or failure of previous therapy

8.2.4.1.2 Limitations of Allergy Immunotherapy

The quantity billed for the allergy extract preparation procedure must represent the total number of doses to be administered from the vial. If the number of doses is not stated on the claim, a quantity of one is allowed.

Procedure code 95165 is limited to a total of 160 doses per one-year period, which begins the date the immunotherapy is initiated. Additional doses may be considered for reimbursement through prior authorization with documentation of medical necessity.

When an injection is given from a vial, providers should use an administration-only procedure code (95115 or 95117).

An office visit, clinic visit, or observation room visit is not considered for reimbursement in addition to the fee for the preparation or the administration of the allergy vial or extract unless the additional visit results in a non-allergy-related diagnosis or a re-evaluation of the client’s condition.

The following E/M procedure codes submitted with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is provided:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99217</td>
</tr>
</tbody>
</table>
Modifier 25 may be used to identify the significant, separately identifiable E/M service performed by the same physician on the same day as the allergy-related procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Allergen immunotherapy that is considered experimental, investigational, or unproven is not a benefit of Texas Medicaid.

Single dose vials (procedure code 95144) are not a benefit of Texas Medicaid.

### 8.2.4.2 Allergy Testing

Texas Medicaid benefits include allergy testing for clients with clinically significant allergic symptoms. Allergy testing is focused on determining the allergens that cause a particular reaction and the degree of the reaction. Allergy testing also provides justification for recommendations of particular medicines, of immunotherapy, or of specific avoidance measures in the environment.

An initial evaluation of a new patient is considered for reimbursement in addition to allergy testing on the same day.

Established patient visits are not considered for reimbursement in addition to allergy testing on the same day. The allergy testing is considered for reimbursement and the visit is denied as part of another procedure on the same day.

The following allergy tests are benefits of Texas Medicaid:

- **Percutaneous and intracutaneous skin test.** The skin test for IgE-mediated disease with allergenic extracts is used in the assessment of allergic clients. The test involves the introduction of small quantities of test allergens below the epidermis. Procedure codes 95004, 95010, 95015, 95024, 95027, and/or 95028 should be used to submit skin tests for consideration of reimbursement.

- **Patch or application tests.** Patch testing (procedure code 95044) is used for diagnosing contact allergic dermatitis.

- **Photo or photo patch skin test.** Procedure codes 95052 and 95056 may be used for photo or photo patch skin tests.

- **Ophthalmic mucous membrane or direct nasal mucous membrane tests.** Nasal or ophthalmic mucous membrane tests (procedure codes 95060 and 95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.

- **Inhalation bronchial challenge testing (not including necessary pulmonary function tests).** Bronchial challenge testing with methacholine, histamine, or allergens (procedure codes 95070 and 95071) is used for defining asthma or airway hyperactivity when skin testing results are not consistent with the client’s medical history. Results of these tests are evaluated by objective measures of pulmonary function.

Procedure code 95199 may be used for an unlisted allergy or clinical immunologic service or procedure if there is not a specific procedure code that describes the service performed. Prior authorization is required for unlisted procedure codes. Every effort must be used to bill with the appropriate CPT code that describes the procedure being performed. If a code does not exist to describe the service performed, prior authorization may be requested using unlisted procedure code 95199 and must be submitted with documentation to assist in determining coverage. The documentation submitted must include all of the following:

- The client’s diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A CPT or HCPCS procedure code that is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service (POS) the procedure is to be performed
- The physician’s intended fee for this procedure

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

The type and number of allergy tests performed must be indicated on the claim. When the number of tests is not specified, a quantity of one is allowed.

### 8.2.4.2.1 RAST/MAST Tests

Radioallergosorbent tests (RAST) and multiple antigen simultaneous tests (MAST) are benefits of Texas Medicaid. RAST testing is a radioimmunoassay of the blood serum used to detect specific allergens. MAST is a RAST type test using an enzyme rather than a radioactive marker. RAST/MAST testing is usually performed by an independent lab; however, there are physicians who have the capability of performing these tests in their offices. Physicians who submit RAST/MAST tests performed in the office setting must use modifier SU to be considered for reimbursement. Without the use of the SU modifier, RAST/MAST testing submitted with POS 1 (office) is denied with the message, “Lab performed outside of office must be billed by the performing facility.”

RAST/MAST tests must be submitted using procedure codes 86003 and 86005.

Procedure code 86003 should be submitted with a quantity of 1 and is limited to 12 per year, same provider.

Procedure code 86005 should be submitted with a quantity of 1 and is limited to 4 per year, same provider.

### 8.2.4.2.2 Collagen Skin Test

Collagen skin tests are a benefit of Texas Medicaid using procedure code Q3031. Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure that utilizes collagen.

Collagen injections/implants are frequently used for cosmetic surgery, but are not a benefit of Texas Medicaid.

### 8.2.4.2.3 Prior Authorization for Collagen Skin Tests

Prior authorization is required for collagen skin test procedure code Q3031.

Surgeries performed on abnormal structures of the body are generally performed to improve function. Prior authorization may be requested for the treatment of abnormal structures of the body caused by:

- Congenital defects
- Developmental abnormalities
- Trauma, infection
- Tumors
- Disease

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the collagen skin test.
Documentation that supports medical necessity for the requested device, service, or supply must be submitted to the SMPA Department with the prior authorization request.

### 8.2.5 Ambulance Transport Services - Nonemergency

Nonemergency ambulance services require prior authorization in circumstances not involving an emergency. Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services.

**Refer to:** Form MD.6, “Nonemergency Ambulance Prior Authorization Request Form (2 Pages)” in this handbook.


### 8.2.6 Anesthesia

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement.

Medicaid may reimburse anesthesiologists and certified registered nurse anesthetists (CRNAs) for administering anesthesia as defined within their individual scope of practice.

#### 8.2.6.1 Medical Direction by an Anesthesiologist

Medical direction by an anesthesiologist of an anesthesia practitioner is a benefit of Texas Medicaid if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.
- The anesthesiologist is physically present in the operating suite.

**Exception:** *Anesthesiologists may be considered for reimbursement when they medically direct more than four anesthesia services or simultaneously supervise a combination of more than four CRNAs or other qualified professionals under emergency circumstances only.*

Medical direction provided by an anesthesiologist is a benefit of Texas Medicaid if the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical portions of the anesthesia plan, including induction and emergence.
- The anesthesiologist ensures that a qualified professional can perform the procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at intervals.
- The anesthesiologist provides direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.
- The anesthesiologist provides postanesthesia care.

The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist who directs the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:

- Address an emergency of short duration in the immediate area
- Administer an epidural or caudal anesthetic to ease labor pain
- Provide periodic, rather than continuous, monitoring of an obstetrical patient
• Receive clients entering the operating suite for the next surgery
• Check or discharge clients in the recovery room
• Handle scheduling matters

As noted above, an anesthesiologist may concurrently medically direct up to four anesthesia procedures. Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicaid client. For example, if three procedures are medically directed but only two involve Medicaid clients, the Medicaid claims must be billed as concurrent medical direction of three procedures.

For medical direction, the anesthesiologist must document in the client’s medical record that he or she did the following:
• Performed the pre-anesthetic exam and evaluation.
• Provided indicated post-anesthesia care.
• Was present during the critical and key portions of the anesthesia procedure, including, if applicable, induction and emergence.
• Was present during the anesthesia procedure to monitor the client’s status.

The following information must be available to state agencies upon request and is subject to retrospective review:
• The name of each CRNA or other qualified professional that was concurrently medically directed or supervised and a description of the procedure that was performed must be documented and maintained.
• Signatures of the anesthesiologist, CRNAs, or other qualified professionals involved in administering anesthesia services must be documented in the client’s medical record.

8.2.6.2 Anesthesia for Sterilization
Refer to: Subsection 2.2, “* Services, Benefits, Limitations, and Prior Authorization,*” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for the complete list of family planning diagnosis codes.
Section 4, “Federally Qualified Health Center (FQHC)” in Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for more information about FQHCs and billing the annual family planning examination for Title XIX clients.

8.2.6.3 Anesthesia for Labor and Delivery
Providers must bill the most appropriate procedure code for the service provided. Other time-based procedure codes cannot be submitted if either 01960 or 01967 is the most appropriate procedure code.

The following procedure codes must be used for obstetrical anesthesia:

| Procedure Codes | 01960 | 01961 | 01963 | 01967 | 01968 | 01969 |
Procedure codes 01960 and 01967 are limited to once every 210 days when billed by any provider and are reimbursed a flat fee. The time reported must be in minutes and must represent the total minutes between the start and stop times for these procedures, regardless of the time actually spent with the client. Providers are not required to report actual face-to-face minutes with the client for these procedure codes. Providers should refer to the definition of time in the CPT manual in the “Anesthesia Guidelines—Time Reporting” section.

Procedure code 01968 or 01969 may be considered for reimbursement when submitted with procedure code 01967. For a Cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a Cesarean delivery must be submitted using procedure code 01968 or 01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

For continuous epidural analgesia procedure codes (other than procedure codes 01960 and 01967), Texas Medicaid reimburses providers for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences.

Texas Medicaid reimburses the epidural anesthesia services and the delivery at full allowance when they are provided by the delivering obstetrician.

**8.2.6.4 Anesthesia Provided by the Surgeon (Other Than Labor and Delivery)**

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. The anesthesia service is included in the global surgical fee.

**8.2.6.5 Complicated Anesthesia**

The following procedure codes may be reimbursed in addition to an anesthesia procedure or service: 99100, 99116, 99135, and 99140. Documentation supporting the medical necessity for use of the procedure codes may be subject to retrospective review.

Procedure code 99140 is not reimbursed for diagnosis codes 650, 66970, or 66971 when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the emergency condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

**8.2.6.6 Multiple Procedures**

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items.

When billing for multiple anesthesia services performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.
**8.2.6.7 Monitored Anesthesia Care**

Monitored anesthesia care may include any of the following:

- Intraoperative monitoring by an anesthesiologist or qualified professional under the medical direction of an anesthesiologist
- Monitoring of the client’s vital physiological signs in anticipation of the need for general anesthesia
- Monitoring of the client’s development of an adverse physiological reaction to a surgical procedure

Anesthesiologists or CRNAs may use modifier QS to report monitored anesthesia care. The QS modifier is an informational modifier.

**8.2.6.8 Reimbursement Methodology**

There are two types of reimbursement for anesthesia procedure codes.

- Flat fee
- Time-based fees, which require documentation of the exact amount of face-to-face time with the client

The anesthesiologist’s reimbursement for medical direction of CRNAs and non-CRNA qualified professionals is 100 percent of the maximum allowable fee.

If multiple CRNAs or anesthesiologists are providing anesthesia services for a client, only one CRNA and one anesthesiologist may be reimbursed.

Both the flat-fee and time-based-fee procedure codes must be submitted with modifiers and are subject to medical direction/supervision reimbursement adjustments.

**Flat Fees**

Both OB related anesthesia procedure codes 01960 and 01967 are considered for reimbursement with a flat-fee rate.

- Flat fees are subject to medically-directed modifier combination adjustments based on the modifier submitted with the anesthesia procedure code.
- The time-based add-on procedure code 01968 must be billed in addition to the flat fee when anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia has occurred.

For flat-fee anesthesia codes, anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance, that is, when the client may be safely placed under postoperative supervision.

**Time-Based Fees**

For time-based anesthesia codes, anesthesia time is the time during which an anesthesia practitioner is present with the client. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

For time-based anesthesia codes, anesthesia practitioners must document interruptions in anesthesia time in the client’s medical record.

The documented time must be the same in the records or claims of the anesthesiologist and other anesthesia practitioners who were medically directed by the anesthesiologist.

One time unit is equal to 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.
Reimbursement of time-based anesthesia services is derived by adding the RVUs (e.g., base units) for the procedures performed (when multiple procedures are performed use the procedure with the highest RVUs) to the total face-to-face anesthesia time in minutes divided by 15 minutes, multiplied by the appropriate conversion factor, and then by the appropriate modifier combination adjustment:

\[
\text{[RVUs + \left( \frac{\text{Minutes}}{15} \right) \times \text{Conversion Factor} \times \text{Modifier Combination Adjustment} = \text{Anesthesia Reimbursement}}
\]

<table>
<thead>
<tr>
<th>Provider Type Description - Physician Pricing Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time: 120 minutes</td>
</tr>
<tr>
<td>Procedure code: 00851</td>
</tr>
<tr>
<td>Conversion factor: $19.58</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>= 120/15</td>
</tr>
<tr>
<td>= (6 RVUs) 6.00 + 8</td>
</tr>
<tr>
<td>= 14.00 x 19.58</td>
</tr>
<tr>
<td>= $274.12 (physician reimbursement)</td>
</tr>
</tbody>
</table>

**Conversion Factor**

A conversion factor is the multiplier that transforms relative values into payment amounts. There is a standard conversion factor for anesthesia services.

**8.2.6.9 Anesthesia Modifiers**

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier combination whether billing as the sole provider or for the medical direction of CRNAs or other qualified professionals.

When an anesthesia service is billed without the appropriate reimbursement modifiers or is billed with modifier combinations other than those listed below in the Modifier Combinations section, the claim will be denied.

A procedure billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) will be denied if another claim has been paid indicating the service was personally performed by, and reimbursed to, a CRNA (modifier QZ) for the same client, date of service, and procedure code. The opposite is also true—a CRNA-administered procedure will be denied if a previous claim was paid to an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

**8.2.6.9.1 State-Defined Modifiers**

Modifiers U1 (indicating one Medicaid claim) and U2 (indicating two Medicaid claims, one by the supervising anesthesiologist and one by the CRNA) are state-defined modifiers that must be billed by an anesthesiologist or CRNA.

Modifier U1, indicating that only one Medicaid claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two Medicaid claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit the U1 or U2 modifier with an appropriate pricing modifier when billing for anesthesia procedure codes.

**8.2.6.9.2 Modifier Combinations**

Modifiers AA and U1 must be submitted when an anesthesiologist has personally performed the anesthesia service.
Anesthesiologists may be reimbursed for medical direction of anesthesia practitioners by using one of the following modifier combinations:

<table>
<thead>
<tr>
<th>Modifier Combination Submitted by Anesthesiologist</th>
<th>When is it used?</th>
<th>Who will submit claims?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anesthesiologist Directing Non-CRNA Qualified Professionals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QY and U1</td>
<td>When directing one procedure provided by a non-CRNA qualified professional.</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td>QK and U1</td>
<td>When directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals.</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td>AD and U1 (Emergency circumstances only)</td>
<td>When directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td><strong>Anesthesiologist Directing CRNAs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QY and U2</td>
<td>When directing one procedure provided by a CRNA.</td>
<td>Both the anesthesiologist and CRNA</td>
</tr>
<tr>
<td>QK and U2</td>
<td>When directing two, three, or four concurrent procedures involving CRNA(s).</td>
<td>Both the anesthesiologist and CRNA</td>
</tr>
<tr>
<td>AD and U2 (Emergency circumstances only)</td>
<td>When directing five or more concurrent procedures involving CRNA(s). Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.</td>
<td>Both the anesthesiologist and CRNA</td>
</tr>
</tbody>
</table>

**8.2.6.9.3 CRNA Services**

Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the surgeon.

Modifiers QX and U2 must be submitted by a CRNA who provided services under the medical direction of an anesthesiologist.

**8.2.6.10 Prior Authorization for Anesthesia**

**Anesthesia for Medical Services**

Anesthesia services provided in combination with most medical surgical procedures do not require prior authorization. However, some medical surgical procedures may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon will be denied.

**8.2.6.11 Claims Filing**

Texas Medicaid reimburses anesthesiologists based on the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 paper claim form).
- Person (physician or CRNA) administering anesthesia (modifiers must be used to designate this provider type).
• Time in minutes.
• Any other appropriate modifier (refer to subsection 6.3.5, “Modifiers” in Section 6, “Claims Filing” (Vol. 1, General Information) for a list of the most common modifiers).

8.2.6.12 Anesthesia (General) for THSteps Dental

Refer to: Section 4, “Texas Health Steps (THSteps) Dental” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for additional information.

8.2.7 Abdominal Aortic Aneurysm Screening

Procedure code G0389 is a benefit for male clients who are 65 through 75 years of age with diagnosis codes V700 or V1582.

Procedure code G0389 is limited to once per lifetime any provider.

8.2.8 Bariatric Surgery

Bariatric surgery is considered medically necessary when used as a means to treat covered medical conditions that are caused or significantly worsened by the client’s obesity in cases where those comorbid conditions cannot be adequately treated by standard measures unless significant weight reduction takes place. The pathophysiology of the covered comorbid conditions must be sufficiently severe that the expected benefits of weight loss subsequent to this surgery significantly outweigh the risks associated with bariatric surgery.

The following procedure codes may be reimbursed for medically necessary bariatric surgery services with prior authorization: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, and 43888.

Bariatric surgery is not a benefit when the primary purpose of the surgery is any of the following:

• For weight loss for its own sake
• For cosmetic purposes
• For reasons of psychological dissatisfaction with personal body image
• For the client’s or provider’s convenience or preference

8.2.8.1 Prior Authorization for Bariatric Surgery

All clients must meet the criteria outlined below.

The same contraindications exist for bariatric surgery as for any other elective abdominal surgery. Documentation provided for prior authorization must attest that none of the following additional contraindications exist:

• Endocrine cause for obesity, inflammatory bowel disease, chronic pancreatitis, cirrhosis, portal hypertension, or abnormalities of the gastrointestinal tract
• Chronic, long-term steroid treatment
• Pregnant, or plans to become pregnant within 18 months
• Noncompliance with medical treatment
• Significant psychological disorders that would be exacerbated or interfere with the long-term management of the client after the operation
• Active malignancy

Note: Clients with known serious mental illness must be assessed prior to surgery to ascertain that their illness is not a contraindication to surgery. Clients must be referred for appropriate professional evaluation any time the presence of serious mental illness is suspected.
Bariatric surgery may be prior authorized when the client meets all of the following criteria:

- The client is a female at least 13 years of age and menstruating, or a male at least 15 years of age, who has reached a Tanner stage IV plus 95 percent of adult height based on bone age.
- Clients who are birth through 20 years of age must have a body mass index (BMI) of greater than or equal to 40 kg/m2.
- Clients who are 21 years of age and older must have a BMI of greater than or equal to 35 kg/m2.
- The client, regardless of age, has at least one major or two lesser comorbid conditions as follows:
  - Major comorbid conditions include:
    - Obesity-associated hypoventilation
    - Obstructive sleep apnea
    - Congestive heart failure
    - Uncontrolled malignant hypertension resistant to pharmacotherapy
    - Pseudotumor cerebri
  - Lesser comorbid conditions include:
    - Adult onset (Type II) diabetes (with or without complications)
    - Cardiovascular or peripheral vascular disease
    - Increased blood lipid levels resistant to pharmacotherapy
    - Recurrent or chronic skin ulcerations with infection
    - Pulmonary hypertension
    - Accelerated weight-bearing joint disease
    - Gastroesophageal reflux disease with aspiration

Documentation submitted for prior authorization must include all of the following:

- Summary of treatment provided for the client’s co-morbid conditions.
- Description of how the client’s response to standard treatment measures is unsatisfactory.
- Description of why the bariatric surgery is medically necessary in the context of current treatment and the medically reasonable alternatives that are available.
- The name of the facility in Texas in which the procedure will be performed. (The facility must be recognized as a Bariatric Surgery Center of Excellence® [BSCOE] by CMS as certified by the American Society for Metabolic and Bariatric Surgery, or must be accredited as a Level 1 bariatric surgery center as designated by the American College of Surgeons, or must be a children’s hospital with an Adolescent Bariatric Surgery Program.)
- Documentation that the client has demonstrated compliance with medical treatment. (The client must also have demonstrated at least 6 months of compliance with a physician-directed, nonsurgical weight-loss program within 12 months of the request date.)
- Documentation of the following:
  - The client is psychologically mature and able to cope with the postsurgical changes.
  - The client and the parent/guardian (as applicable) understand and will support the changes in eating habits that must accompany the surgery and the extensive postoperative follow-up.
  - Adequate preoperative nutritional and psychological services.
  - How the client will receive postoperative surgical, nutritional, and psychological services.
Repeat bariatric surgery may be considered medically necessary in either of the following circumstances:

- To correct complications from bariatric surgery such as band malfunction, obstruction, or stricture.
- To convert to a Roux-en-Y gastroenterostomy or to correct pouch failure in an otherwise compliant client when the initial bariatric surgery met medical necessity criteria.

**Note:** Conversion to a Roux-en-Y gastroenterostomy may be considered medically necessary for clients who have not had adequate success (defined as a loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure, and the client has been compliant with a prescribed nutrition and exercise program following the procedure.

Providers may fax or mail prior authorization requests for bariatric surgery services for clients who are 20 years of age and younger to the TMHP Comprehensive Care Program (CCP) Prior Authorization Department. Prior authorization requests for clients who are 21 years of age and older may be faxed or mailed to the TMHP Special Medical Prior Authorization Department.

Clients may be eligible under Texas Medicaid or CCP for separate reimbursement for nutritional and psychological assessment and counseling associated with bariatric surgery.

Behavioral health services provided as part of the preoperative or postoperative phase of bariatric surgery are subject to behavioral health guidelines, and are not considered part of the bariatric surgery.


### 8.2.9 Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer

Live BCG for intravesical (procedure code 90586) or transvesical (procedure code J9031) are benefits of Texas Medicaid for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1880</td>
</tr>
<tr>
<td>2337</td>
</tr>
</tbody>
</table>

Procedure code 90585 is a benefit of Texas Medicaid for diagnosis code V032. Authorization is not required for the BCG vaccine.

Bladder instillation of anticarcinogenic agent (procedure code 51720) may be reimbursed separately when billed with BCG instillation (procedure code 90586 or J9031).

### 8.2.10 Behavioral Health Services

**Refer to:** Behavioral Health, Rehabilitation, and Case Management Services Handbook (Vol. 2, Provider Handbooks).

### 8.2.11 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

### 8.2.12 Biofeedback Services

Biofeedback services are a benefit of Texas Medicaid for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence
- Fecal incontinence
• Migraine and tension headache
Biofeedback services may be reimbursed using procedure codes 90901 and 90911.
Biofeedback services are limited to a maximum of 18 sessions rendered by any provider for the lifetime of each client for each condition.
Biofeedback services that are not a benefit of Texas Medicaid are the following:
• Biofeedback performed in the home setting
• Neurofeedback (such as, but not limited to, electroencephalography [EEG])
• Treatment for muscle tension, except tension headache
• Psychological, psychophysiological, and behavioral health therapy and psychosomatic conditions
• Investigational or experimental biofeedback services and procedures
Procedure code 90901 or 90911 are limited to one service per day. The reimbursement for procedure codes 90901 and 90911 include all modalities of the biofeedback training performed on the same day, regardless of the time increments or the number of modalities performed.
Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

8.2.12.1 Biofeedback Certification
A staff member who is certified by Biofeedback Certification International Alliance (BCIA) must perform biofeedback services.
The certification types accepted by Texas Medicaid are the following:
• General biofeedback certification (BCB)
• Pelvic muscle dysfunction biofeedback certification (BCB-PMD)
Providers must maintain documentation in the client’s medical record to support the medical necessity of the biofeedback service provided. Documentation must include the name of the staff person who provided the biofeedback and the prescribing physician must maintain in the office a record of the current certification of the staff member(s) who perform biofeedback. Documentation is subject to retrospective review.

8.2.12.2 Prior Authorization for Biofeedback Services
Prior authorization is required for biofeedback services.
• Any combination of procedure codes 90901 and 90911 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older.
• Procedure code 90901 is a benefit for biofeedback sessions for migraine or tension headache conditions.
The initial request may include up to 12 visits and not exceed a total duration of 12 weeks. Documentation of the following must be submitted for consideration of prior authorization:
• Conventional treatments that were given but were not successful, including, but not limited to, pharmacotherapy, exercise, rest, and heating and cooling modalities.
• Statements from the prescribing physician that the client is capable of understanding the requirements and agrees actively to participate in the biofeedback sessions.
• Name and certification information for the person performing the training.
In addition, documentation must be submitted to support the specific type of biofeedback requested.
Urinary and Fecal Incontinence

• Diagnosis of fecal or urinary stress, urge, overflow, or a mix of stress and urge incontinence in a client who is 4 years of age or older.

• Exclusion by the physician of any underlying medical conditions that could be causing the problem.

• Failed pelvic floor muscle exercise (PME) training for clients who are 21 years of age and older.

  Note: Failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PME exercises.

Migraine and tension headache

• A diagnosis of migraine, tension headache, or mixed migraine and tension headache.

• Symptoms that occur with a duration of at least 4 hours for at least 15 days a month over at least 3 months.

• Failure of first-line approaches, including avoidance of precipitating stimuli and pharmacological prophylaxis.

Prior authorization requests must be submitted by the physician to the Special Medical Prior Authorization (SMPA) Department. The request must be submitted with documentation that supports medical necessity. Providers may submit prior authorization requests online through the TMHP website at www.tmhp.com, by fax to (512) 514-4213, or by mail to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727

After the client completes the initial biofeedback treatment course, prior authorization may be considered for a total of six follow-up sessions not to exceed three sessions per week and total duration not to exceed eight weeks. Providers must submit prior authorization documentation for the same condition as the original request, and must include each original symptom and how it has objectively improved. Documentation may include, but is not limited to, the following:

• For treatment of urinary incontinence, improvement in continence scores, vitality, health, a decrease in high-grade stress incontinence, nocturnal enuresis, and urine loss with activity. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.

• For treatment of fecal incontinence, improvement in continence scores, squeeze and anal pressures, squeeze duration, vitality, and health. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.

• For migraine and tension headaches, diminished intensity, frequency, and duration of the headache activity.

8.2.13 Blepharoplasty Procedures

Procedure codes 67901, 67902, 67903, 67904, 67906, and 67909 may be reimbursed for clients who are 20 years of age and younger without prior authorization when performed for one of the following diagnosis codes: 74361, 74362, or 7439.

Procedure codes 67901, 67902, 67903, 67904, and 67908 do not require prior authorization for clients who are 21 years of age and older when billed for the following diagnosis codes: 37431, 37432, 37433, and 37434.
Blepharoplasty and eyelid repair for clients who are 21 years of age and older require mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty or eyelid repair for procedure codes 15820, 15821, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67961, 67966, 67971, 67973, 67974, and 67975:

- A brief history and physical evaluation
- Photographs of the eyelid problem
- Visual field measurements
- ICD-9-CM diagnosis(es)

The following blepharoplasty procedures do not require prior authorization: 67916, 67917, 67923, and 67924.

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

8.2.14 * BRCA Testing

BRCA procedure codes are benefits of Texas Medicaid when billed with the following procedure codes: 81211, 81212, 81214, 81215, 81216, and 81217.

Breast cancer gene 1, early onset (BRCA1) and breast cancer gene 2, susceptibility protein (BRCA2) are tumor repressor genes responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast cancer.

**Note:** Guidelines for BRCA mutation testing are based on guidelines established by the U.S. Preventative Services Task Force.

Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the physician E/M service.

The following procedure codes, which describe the three basic steps for testing for a BRCA mutation, are not considered for reimbursement when submitted with a breast cancer diagnosis code (1740, 1741, 1742, 1744, 1745, 1746, 1748, 1749, 1750, 1759, 1982, 19881, and 2330):

- B-hexasominidase (procedure code 83080)
- Isolation and separation of DNA (procedure codes 83890, 83891, 83892, 83893, 83894, 83896, and 83897)
- Molecular diagnostics (procedure codes 83898, 83900, 83901, 83902, 83907, 83908, 83909, and 83912)
- Mutation scanning or identification (procedure codes 83903, 83904, 83905, and 83906)

Claims filed using these procedure codes with a diagnosis of breast cancer may be reviewed on appeal. BRCA1 and BRCA2 analyses (procedure codes 81211, 81212, 81214, 81215, 81216, and 81217) are limited to once per lifetime. Additional services may be considered on appeal.

BRACAnalysis® Rearrangement Tests (BART) are not a benefit of Texas Medicaid. Procedure codes 83891, 83898, 83909, and 83912 will not be reimbursed in combination for a BART.
8.2.14.1 * Prior Authorization for BRCA Testing

Prior authorization is required for BRCA testing (procedure codes 81211, 81212, 81214, 81215, 81216, and 81217). The prior authorization request must include documentation that indicates that the client meets one or more of the criteria below:

- A woman who is 18 years of age or older, has no personal history of breast cancer or epithelial ovarian cancer, and has one of the following:
  - Two first-degree or second-degree relatives with epithelial ovarian or breast cancer who were 50 years of age and younger when they were diagnosed with breast cancer, or were any age when they were diagnosed with epithelial ovarian cancer
  - A combination of three or more first- or second-degree relatives with breast or epithelial ovarian cancer, regardless of age at diagnosis
  - One or more first- or second-degree relatives with epithelial ovarian cancer and one or more first- or second-degree relatives with breast cancer at any age
  - A male relative with a history of breast cancer
- One or more first- or second-degree relatives with:
  - Epithelial ovarian cancer and one or more first- or second-degree relatives with breast cancer at any age
  - Multiple primary or bilateral breast cancers in a single individual and another first- or second-degree relative diagnosed with breast cancer at 50 years of age or younger
  - Multiple primary or bilateral breast cancers in a single individual and another first- or second-degree relative with epithelial ovarian cancer
  - Both breast and ovarian cancer at any age
  - Breast cancer or epithelial ovarian cancer at any age and are at increased risk for specific mutations due to ethnic background (for example, Ashkenazi Jewish descent)
- One or more relatives with a BRCA1 or BRCA2 mutation
- A woman of any age who has a personal history of breast cancer (including a diagnosis of carcinoma in situ [DCIS]), and any of the following:
  - Breast cancer that was diagnosed at 50 years of age or younger, with or without family history
  - Breast cancer is diagnosed at any age, with one of the following:
    - A personal history of epithelial ovarian cancer
    - At least two relatives with breast cancer and/or epithelial ovarian cancer at any age
    - Two primary breast cancers in a single individual with at least one relative who was diagnosed with breast cancer at 50 years of age or younger
    - Two primary breast cancers in a single individual with at least one relative with epithelial ovarian cancer
    - Male relative with breast cancer
    - At least one relative who has a BRCA1 or BRCA2 mutation
    - Ashkenazi Jewish descent, or other ethnic descent associated with deleterious mutations (for example, populations of Icelandic, Swedish, Hungarian or other), with or without family history
- A woman of any age who has a personal history of epithelial ovarian cancer (includes fallopian tube cancer and primary peritoneal carcinoma)
- A man of any age who has a personal history of breast cancer and one of the following:
  - At least one male relative with breast cancer
• At least one female relative with breast cancer or epithelial ovarian cancer
• At least one relative who has a BRCA1 or BRCA2 mutation
• Ashkenazi Jewish descent (no additional family history is required)

**Note:** The term “relative” means close blood relatives including first-degree male or female relatives (e.g., parents, siblings, children), second-degree relatives (e.g., aunts, uncles, grandparents, nieces, nephews), and third-degree relatives (e.g., first cousin, great grandparent), all of whom are on the same side of the family as the client.

A completed Special Medical Prior Authorization (SMPA) Request Form that has been signed and dated by the referring provider must be submitted. A provider’s signature, including the prescribing provider’s, on a submitted document indicates that the provider certifies, to the best of the provider’s knowledge, that the information in the document is true, accurate, and complete.

Requests and supporting documentation with electronic signatures may be accepted by mail or fax when the national and state standards set by the Department of Health and Human Services, Department of Commerce, and the Texas Uniform Electronic Transactions Act (UETA) are met. Electronically signed documents must have an electronic date on the same page as the signature. All electronically signed transactions and electronically signed documents must be kept in the client’s medical record. A printed copy of electronic transactions and signed documents must be available upon request.

All documentation that is submitted with a handwritten provider’s signature must have a handwritten date next to the signature and must be kept in the client’s medical record.

Stamped or digitalized signatures will not be accepted.

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results.

The medical record must include documentation of formal pretest counseling, including an assessment of the client’s ability to understand the risks and limitations of the test and the client’s informed choice to proceed with testing for the BRCA1 and BRCA2 mutations. The medical record is subject to retrospective review.

The medical record documentation that is submitted by the provider must establish the client’s diagnosis or family history. Requisition forms from the laboratory are not sufficient for the establishment of a client’s personal and family history.

For comprehensive panel procedure codes 81211 and 81212, the provider must make every reasonable effort to obtain from the client any available positive familial BRCA testing results. The prior authorization request must include either the positive familial BRCA testing results that were obtained or an attestation that the information could not be obtained.

To facilitate a determination of medical necessity and avoid unnecessary denials, the provider must provide correct and complete information, including accurate medical necessity of the services requested.

**8.2.14.2 Retroactive Authorization**

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.
8.2.15 Mammography (Screening and Diagnostic Studies of the Breast)

The following breast imaging studies are benefits of Texas Medicaid:

- Screening mammogram
- Diagnostic mammogram
- Diagnostic breast ultrasound

A screening mammogram may be billed using procedure code 77057 or G0202. Procedure code 77057 will be denied when billed if it is submitted for the same date of service as procedure code G0202 by any provider.

*Note: The American Cancer Society recommends annual screening mammography for women beginning at 40 years of age.*

A diagnostic mammogram may be billed using procedure code 77055, 77056, G0204, or G0206. Procedure code 77055 will be denied if it is submitted for the same date of service as procedure code 77056, G0204, or G0206 by any provider.

Procedure code 77056 will be denied if it is submitted for the same date of service as procedure code G0204 by any provider.

Procedure code G0206 will be denied if it is submitted for the same date of service as procedure code 77056 or G0204 by any provider.

Screening mammograms may be reimbursed for the same date of service as a diagnostic mammogram if the diagnostic mammography procedure codes are submitted with a GG modifier.

A mammogram may be indicated for a male client based on medical necessity due to existing signs and symptoms. In such rare circumstances, procedure codes 77055, 77056, G0204, and G0206 may be considered for reimbursement.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement using procedure code 76098, 77031, 77032, 77053, or 77054. Procedure code 77053 will be denied if it is submitted for the same date of service as procedure code 77054 by any provider. Procedure code 76098 may be reimbursed for both male and female clients.

Computer-aided detection (CAD) procedure codes 77051 and 77052 may be reimbursed in addition to screening and diagnostic mammography.

Procedure codes 77051 and 77052 are add-on codes and must be submitted with the primary procedure code to be considered for reimbursement. Procedure code 77051 must be submitted for reimbursement with procedure code 77055, 77056, G0204, or G0206. Procedure code 77052 must be submitted for reimbursement with procedure code 77057 or G0202.

Breast ultrasound may be considered for reimbursement using procedure code 76645.

Authorization is not required for these services.

The prescribing physician must maintain documentation of medical necessity in the client’s medical record. The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician.

8.2.16 Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of Texas Medicaid when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.
Prognostic breast and gynecological cancer studies are divided into two categories: Receptor assays and Her-2/neu.

- **Receptor Assays (procedure codes 84233 and 84234)** - The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and endometrial cancer.

- **Her-2/neu (procedure codes 83890, 88237, 88239, 88274, 88291, 88342, 88360, 88361, and 88365)** - Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The overexpression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.

Reimbursement for receptor assays (procedure codes 84233, 84234, 88360, and 88361) are limited to claims with a diagnosis of breast or uterine cancer as listed in the following table.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tr>
<td>1740</td>
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<td>1759</td>
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</table>

Receptor testing for other diagnoses will be denied.

Interpretation of receptor assays, and Her-2/neu results is not considered separately for reimbursement. Interpretation is part of the physician’s E/M service.

Claims filed using the gene mutation analysis procedure codes may be considered upon appeal.

### 8.2.16.1 Colorectal Cancer Screening

Fecal occult blood tests, barium enemas, screening colonoscopies, and sigmoidoscopies are benefits of Texas Medicaid. Screening refers to the testing of asymptomatic persons in order to assess their risk for the development of colorectal cancer. Screening has been shown to decrease mortality due to this cancer by detecting cancers at earlier stages and allowing the removal of adenomas, thus preventing the subsequent development of cancer.

The American Cancer Society (ACS) and U.S. Preventive Services Task Force (USPSTF) both recommend screening people at average risk for colorectal cancer beginning at 50 years of age by any of the following methods:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year
- Flexible sigmoidoscopy every five years
- A FOBT* or FIT every year plus flexible sigmoidoscopy every five years, or (of these three options, the combination of FOBT or FIT every year plus flexible sigmoidoscopy every five years is preferable)
- Double-contrast barium enema every five years
- Colonoscopy every ten years

*For FOBT, the take-home multiple sample method should be used.

The ACS and USPSTF recommends screening for people at high-risk for colorectal cancer once every two years.

Indications/characteristics of a high-risk individual:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- There is a family history of familial adenomatous polyposis.
There is a family history of hereditary nonpolyposis colorectal cancer.

• There is a personal history of adenomatous polyps.
• There is a personal history of colorectal cancer.
• There is a personal history of colonic polyps.
• There is a personal history of inflammatory bowel disease, including Crohn’s disease and ulcerative colitis.

Colorectal screening services are considered for reimbursement when submitted using procedure codes G0104, G0105, G0106, G0120, G0121, G0122, and G0328 by associated risk category based on the ACS and USPSTF frequency recommendations. Reimbursement for these procedure codes is considered when medical necessity is documented in the client’s record.

**Fecal Occult Blood Tests**

Procedure code G0328 may be reimbursed once per year for clients who are 50 years of age and older.

**Barium Enemas**

Procedure code G0122 is considered for reimbursement once every 5 years for clients who are 50 years of age and older.

**Sigmoidoscopies**

Procedure codes G0104 and G0106 are considered for reimbursement once every five years when submitted with diagnosis codes V1090, V1272, V7650, V7651, V7652, or V700, as recommended by the ACS and USPSTF. Diagnosis code V700 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

A screening barium enema may be substituted for a screening flexible sigmoidoscopy if the effectiveness has been established by the physician for substitution. Procedure code G0106 may be used as an alternative to procedure code G0104 respectively.

If during the course of screening flexible sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal must be reported rather than procedure code G0104 or G0106.

**Colonoscopies: Average Risk**

Procedure code G0121 is considered for reimbursement once every ten years when submitted with diagnosis codes V1272, V7650, V7651, V7652, or V700 as recommended by the ACS and USPSTF for clients who do not meet the criteria for high-risk.

If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported rather than procedure code G0121.

**Colonoscopies: High-Risk**

Procedure codes G0105 and G0120 are considered for reimbursement once every two years for clients who meet the definition of high-risk. Procedure codes G0105 and G0120 must be submitted with one of the following diagnosis codes:

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<th>Diagnosis Codes</th>
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<tr>
<td>5550</td>
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<td>55841</td>
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A screening barium enema may be substituted for a screening colonoscopy if the effectiveness has been established by the physician for substitution. Procedure code G0120 may be used as an alternative to procedure code G0105 respectively.
If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported rather than procedure code G0105 or G0120.

8.2.16.2 Prior Authorization for Colorectal Cancer Screening
Prior authorization is not required for colorectal screening.

8.2.16.3 Genetic Testing for Colorectal Cancer
Genetic testing for colorectal cancer may be considered for reimbursement to independent laboratories with prior authorization.

Genetic testing may be provided to clients who have a known predisposition (i.e., having a first- or second-degree relative) for colorectal cancer. Results of the testing may indicate whether the client has an increased risk of developing colorectal cancer. A first-degree relative is defined as a sibling, parent, or offspring. A second-degree relative is defined as an uncle, aunt, grandparent, nephew, niece, or half-sibling.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client or family members have been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions before the genetic testing.

Genetic testing for colorectal cancer may be considered for reimbursement with the following procedure codes:

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<th>Procedure Codes</th>
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<tr>
<td>81210 81275</td>
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<td>81292 81293</td>
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<td>81300 81301</td>
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<td>81317 81318</td>
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<tr>
<td>81319 S3833</td>
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<td>S3834</td>
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Interpretation of gene mutation analysis results is not reimbursed separately. Interpretation is part of the physician E/M service.

The following procedure codes are limited to once per lifetime for any procedure code by any provider. Testing is limited to once per lifetime for any procedure code by any provider, regardless of whether additional services are authorized. The documentation requirements for specific procedure codes are available in the following sections titled, "Testing for Familial Adenomatous Polyposis" and "Hereditary Non-Polyposis Colorectal Cancer (HNPCC)."

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<thead>
<tr>
<th>Procedure Codes</th>
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<td>81292 81293</td>
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<td>81298 81299</td>
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<td>81300 81301</td>
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<td>81317 81319</td>
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<td>S3833 S3834</td>
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8.2.16.3.1 Testing for Familial Adenomatous Polyposis
Testing for familial adenomatous polyposis (procedure codes S3833 and S3834) may be offered to clients who have well-defined hereditary cancer syndromes and for whom a positive or negative result will change medical care. Genetic testing should only be offered to clients who are 8 years of age and older. Testing for familial adenomatous polyposis may be considered for reimbursement with documentation of at least one of the following:

- The client has more than 20 polyps.
- The client has a first-degree relative with familial adenomatous polyposis and a documented mutation.
8.2.16.3.2 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

Testing for HNPCC (procedure codes 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, and 81319) is used to determine whether a client has an increased risk of colorectal cancer or other HNPCC-associated cancers. Results of the test may influence clinical management decisions. Genetic testing should be offered only to clients who are 21 years of age and older. Testing for HNPCC may be considered for reimbursement with documentation of at least one of the following:

- The client has three or more family members, one of whom is a first-degree relative, with colorectal cancer; two successive generations are affected; one or more of the colorectal cancers was diagnosed before the family member was 50 years of age; and familial adenomatous polyposis has been ruled out for the client.
- The client has had two previous HNPCCs.
- The client has colorectal cancer and a first-degree relative who has one of the following:
  - Colorectal cancer or HNPCC extracolonic cancer at 50 years of age and younger
  - Colorectal adenoma at 40 years of age and younger
- The client has had colorectal cancer or endometrial cancer at 50 years of age and younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern of histology at 50 years of age and younger.
- The client has had signet-cell type colorectal cancer at 50 years of age and younger.
- The client has had a colorectal adenoma at 40 years of age and younger.
- The client is asymptomatic and has a first- or second-degree relative who has a documented HNPCC mutation.

8.2.16.3.3 Prior Authorization for Genetic Testing for Colorectal Cancer

Prior authorization is required for genetic testing for colorectal cancer. A written authorization request that is signed and dated by the referring provider must be submitted. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures are not accepted. The original signature copy must be kept in the physician’s medical record for the client. Complete documentation must be submitted with prior authorization requests.

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity. The form may be faxed to 1-512-514-4213 or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including the accurate medical necessity of the services requested.

8.2.17 Capsulotomy

A capsulotomy is a benefit when not performed with a joint surgery.
8.2.18 * Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. Cardiac rehabilitation programs must include all of the following:

- Physician-prescribed exercise for each day on which cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to a client’s individual needs
- Psychosocial assessment
- Outcomes assessment
- An individual treatment plan that specifies how components are used for a client and that is reviewed and signed by the prescribing physician every 30 days

Cardiac rehabilitation procedure codes 93797 and 93798 are benefits of Texas Medicaid.

The appropriate procedure code must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>40201 41000 41001 41002 41010 41011 41012 41020 41021 41022 41030 41031 41032 41040 41041 41042 41050 41051 41052 41051 41052 41060 41062 41070 41071 41072 41080 41081 41082 41090 41091 41092 4139 4148 4149 4271 42741 4280 4281 42820 42821 42822 42823 42830 42831 42832 42833 42840 42841 42842 42843 4289 V151 V421 V422 V433 V4581 V4582</td>
</tr>
</tbody>
</table>

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients for whom there is documentation of any of the following conditions within the 12 months immediately preceding the beginning of the program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

**Note:** A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms (ECGs) to a remote site is not a benefit of Texas Medicaid.

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use.

Cardiac rehabilitation is limited to 2 one-hour sessions per day for 18 weeks per rolling year and can not exceed 36 sessions.
Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the client has another documented cardiac event or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. To confirm that a continuation of cardiac rehabilitation is at the request of or is coordinated with the prescribing physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and the prescribing physician. If the physician responsible for such follow-up is the medical director, then the physician’s notes must be evident in each client’s chart.

Additional cardiac rehabilitation sessions must be prior authorized and must not exceed a total of 36 sessions for 52 weeks from the date of authorization of additional sessions.

If no clinically-significant arrhythmia is documented during the first three weeks of the program, the physician may give the order for the client to complete the remaining portion of the cardiac rehabilitation without telemetry monitoring.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program that is conducted by personnel who are not physicians but are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease and who provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs.

### 8.2.18.1 Prior Authorization for Cardiac Rehabilitation

Prior authorization is not required for the initial 36 sessions of cardiac rehabilitation.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions in the following circumstances:

- The medical record must support the client has had another cardiac event; or
- The prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Documentation must include the following:
  - Progress made from the beginning of cardiac rehabilitation period to the current service request date, including progress towards previous goals.
  - Information that supports the client’s capability of continued measurable progress.
  - A proposed treatment plan for the requested extension dates with specific goals related to the client’s individual needs.

Requests for prior authorization for additional sessions that exceed a total of 36 sessions in 52 weeks will not be granted. Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department.

### 8.2.18.2 Reimbursement

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be billed with modifier 25 appended to the E/M code when a separately identifiable E/M service was provided on the same day by the provider that rendered cardiac rehabilitation. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.
Physical and occupational therapy will not be reimbursed when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition that requires such therapy, e.g., a client who is recuperating from an acute phase of heart disease and may have had a stroke that requires physical and/or occupational therapy.

Client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity, that help a client adjust living habits because of the cardiac condition; will not be separately reimbursed when the services are provided as part of the cardiac rehabilitation program.

Procedure code 93797 will be denied when billed for the same date of service as procedure code 93798 by any provider.

The following cardiography and pulmonary procedure codes will be denied when billed with cardiac rehabilitation procedure code 93798 for the same date of service by any provider:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>93000 93005 93010 93040 93041 93042 93268 94760 94761</td>
</tr>
</tbody>
</table>

### 8.2.19 Casting, Splinting, and Strapping

Casting, splinting, and strapping supplies are considered part of the procedure and are not reimbursed separately. The following procedure codes for casting, splinting, and strapping are a benefit of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29000 29010 29015 29020 29025 29035 29040 29044 29046 29049</td>
</tr>
<tr>
<td>29055 29058 29065 29075 29085 29086 29105 29125 29126 29130</td>
</tr>
<tr>
<td>29131 29200 29220 29240 29260 29280 29305 29325 29345 29355</td>
</tr>
<tr>
<td>29358 29365 29405 29425 29435 29440 29445 29450 29505 29515</td>
</tr>
<tr>
<td>29520 29530 29540 29550 29580 29590</td>
</tr>
</tbody>
</table>

When a claim for casting, splinting, or strapping is submitted with the same date of service as a surgery, the surgery may be reimbursed and the procedure codes listed in the table above will be denied as part of another procedure.

The replacement of a cast, splint, or strapping is not included in the original surgical fee and may be reimbursed separately. Reimbursement for cast removal, windowing, wedging, or repair will be denied if submitted for reimbursement within six weeks of the initial cast application, splinting, or strapping by the same provider.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29700 29705 29710 29715 29720 29730 29740</td>
</tr>
</tbody>
</table>

The following procedure codes for cast removal, windowing, wedging, or repair may be reimbursed to a provider other than the provider who applied the initial cast, splint, or strap:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29700 29705 29710 29715 29720 29730 29740 29750 29799</td>
</tr>
</tbody>
</table>

Authorization is not required for casting, splinting, or strapping services.
The following table includes the procedure codes that will be denied when submitted for reimbursement with other casting, splinting, and strapping procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes That Will Be Denied</th>
<th>When Submitted With Any of These Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36000, 36410, 37202, 51701, 51702, 51703, 62318, 62319, 64415, 64416, 64417, 64450, 96360, 96365, 96372, 96374, or 96375</td>
<td>29000, 29010, 29015, 29020, 29025, 29035, 29040, 29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29086, 29105, 29125, 29126, 29130, 29131, 29200, 29220, 29240, 29260, 29280, 29305, 29325, 29345, 29355, 29358, 29365, 29405, 29425, 29435, 29440, 29445, 29450, 29505, 29515, 29520, 29530, 29540, 29550, 29580, 29590, 29700, 29705, 29710, 29715, 29720, 29730, 29740, 29750, or 29799</td>
</tr>
<tr>
<td>29035</td>
<td>29040, 29044, or 29046</td>
</tr>
<tr>
<td>29044</td>
<td>29046</td>
</tr>
<tr>
<td>29075</td>
<td>29065, 29105, or 29425</td>
</tr>
<tr>
<td>29085, 29125, 29126, or 29705</td>
<td>29065 or 29075</td>
</tr>
<tr>
<td>29105</td>
<td>29065</td>
</tr>
<tr>
<td>11055, 11056, 11057, or 29125</td>
<td>29425</td>
</tr>
<tr>
<td>12001, 12002, 12035, 29125, or 29705</td>
<td>29105</td>
</tr>
<tr>
<td>12001, 28190, 28192, 28193, 29130, 29131, 29260, or 29700</td>
<td>29075</td>
</tr>
<tr>
<td>29705</td>
<td>29435</td>
</tr>
<tr>
<td>12002</td>
<td>29125, 29530, or 29580</td>
</tr>
<tr>
<td>12001, 12032, 12042, 12044, 13121, 13132, 29130, or 29260</td>
<td>29125</td>
</tr>
<tr>
<td>29305</td>
<td>29325</td>
</tr>
<tr>
<td>29365 or 29425</td>
<td>29345</td>
</tr>
<tr>
<td>29405</td>
<td>29345, 29425, or 29740</td>
</tr>
<tr>
<td>29345, 29365, 29405, or 29425</td>
<td>29355</td>
</tr>
<tr>
<td>29440, 29580, 29700, or 29705</td>
<td>29405 or 29425</td>
</tr>
<tr>
<td>29580</td>
<td>29515, 29590, or 29705</td>
</tr>
<tr>
<td>29730</td>
<td>29405</td>
</tr>
<tr>
<td>29540</td>
<td>29425, 29505, 29515, 29580, or 29590</td>
</tr>
<tr>
<td>29730 or 29740</td>
<td>29445</td>
</tr>
<tr>
<td>29515</td>
<td>29505</td>
</tr>
<tr>
<td>11055, 11056, or 29550</td>
<td>29515</td>
</tr>
<tr>
<td>11900, 12004, or 29550</td>
<td>29540</td>
</tr>
<tr>
<td>12004, 15852, 29550, or 29700</td>
<td>29580</td>
</tr>
<tr>
<td>G0127, 11719, or 11900</td>
<td>29550</td>
</tr>
<tr>
<td>15852</td>
<td>29705</td>
</tr>
</tbody>
</table>

### 8.2.20 Cardiopulmonary Resuscitation (CPR)

CPR (procedure code 92950) is a benefit of Texas Medicaid and may be reimbursed when medical necessity is documented in the client’s medical record. Only the primary provider performing CPR may be reimbursed for procedure code 92950. CPR billed as an ambulance service by an ambulance provider will be denied.
CPR may be billed with the same date of service as critical care when reported as a separately identifiable procedure. The time spent performing CPR must not be included in the time reported as critical care.

### 8.2.21 Chemotherapy

Chemotherapy infusion procedure codes listed in the following table are comprehensive codes that include all supplies, catheters, and solutions necessary to safely administer the necessary chemotherapeutic agents either by or under the supervision of the physician, but do not include the provision of the chemotherapeutic agents:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>96401 96402 96405 96406 96409 96411 96413 96415 96416 96417</td>
</tr>
<tr>
<td>96420 96422 96423 96425 96440 96446 96450 96521 96522 96523</td>
</tr>
<tr>
<td>96542 96549</td>
</tr>
</tbody>
</table>

The appropriate E/M procedure code must be billed by a physician for a face-to-face visit with the patient to review chemotherapy options.

#### 8.2.21.1 Chemotherapy Procedure Codes

Procedure code 51720 should be used for intravesical instillation of anti-carcinogenic agents into the bladder including retention time.

The chemotherapy administration procedure codes 96440, 96446, and 96450 include payment for the surgical procedure; separate reimbursement for the surgical codes will not be allowed. These procedure codes may be paid in addition to E/M procedure codes billed on the same day, regardless of the place of service billed.

Chemotherapeutic drugs and other injections given in the course of chemotherapy may be billed separately and reimbursed using the appropriate procedure codes.

For the first 15 minutes, up to the first hour of chemotherapy infusion, procedure code 96409 or 96413 must be used for a single or initial chemotherapeutic medication. Procedure code 96411 must be used for each additional chemotherapeutic medication given and must be billed with procedure code 96409 or 96413.

Procedure code 96415 must be used for each additional hour beyond the initial hour and must be used in conjunction with procedure code 96413.

Procedure code 96417 must be used for one additional hour per subsequent infusion and must be used in conjunction with procedure code 96413. Procedure code 96415 may be used for each additional hour.

Procedure code 96425 must be used when initiating an infusion that will take more than eight hours and requires using an implanted pump or a portable pump.

Procedure code 96422 must be used for the first hour of intra-arterial push administration. Procedure code 96423 must be used for each additional hour in conjunction with procedure code 96422.

Chemotherapy administration by push technique (procedure codes 96409 and 96420) and by infusion technique (procedure codes 96413 and 96422) are reimbursed when billed for the same date of service.

Only one intravenous push administration (procedure code 96409) and only one intra-arterial push administration (procedure code 96420) will be allowed per day, regardless of whether separate drugs are given.

Evaluation and management (E/M) services related to other services and procedures being performed may be billed with modifier 25 appended to the E/M code. Documentation that supports the provision of that significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request. Modifier 25 use is subject to retrospective review.
Prolonged infusion of chemotherapeutic agents is reimbursed using procedure codes 95991, 96413, 96415, 96416, 96417, 96422, 96423, and 96425.

Inpatient and outpatient hospitals must use revenue code 636 for the reimbursement of the technical component. The appropriate chemotherapy procedure code must be listed on the claim.

**8.2.22 Circumcisions**

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54161. Circumcisions performed on clients who are 1 year of age and older must be documented with medical necessity.

Refer to: Subsection 8.2.45.1, “Circumcisions for Newborns,” in this handbook for additional benefit information.

**8.2.23 Closure of Wounds**

The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures.

Wound closures may use sutures, staples, or tissue adhesives. Wounds closed with adhesive strips must not be reported using wound closure procedure codes. When adhesive strips are the only wound closure material used, providers must report the most appropriate E/M visit procedure code on their claim.

Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is considered inclusive to the wound closure and will not be reimbursed separately.

The lengths of multiple closures of wounds must be added together and billed as one procedure code if they meet at least one of the following criteria:

- The closures have the same CPT classification (see “Repair [Closure]” in the CPT manual).
- The closures are in anatomic sites that are grouped together in the same procedure code descriptor.

Providers must submit the procedure code that represents the total length of the repairs. Lengths of repairs from different CPT classifications or groupings of anatomic sites must be billed as separate procedure codes.

Wound closures must be billed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Repair Simple</th>
<th>Repair Intermediate</th>
<th>Repair Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12001</td>
<td>12031</td>
<td>13100</td>
</tr>
<tr>
<td>12002</td>
<td>12004</td>
<td>12032</td>
<td>13101</td>
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<tr>
<td>12005</td>
<td>12006</td>
<td>12034</td>
<td>13102</td>
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<tr>
<td>12007</td>
<td>12008</td>
<td>12035</td>
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<tr>
<td>12011</td>
<td>12013</td>
<td>12036</td>
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<td>12014</td>
<td>12015</td>
<td>12037</td>
<td>13122</td>
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<td></td>
<td>12030</td>
<td>12041</td>
<td>13131</td>
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<tr>
<td>12016</td>
<td>12017</td>
<td>12042</td>
<td>13132</td>
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<tr>
<td>12018</td>
<td>12020</td>
<td>12044</td>
<td>13133</td>
</tr>
<tr>
<td>12021</td>
<td></td>
<td>12045</td>
<td>13150</td>
</tr>
</tbody>
</table>

Multiple wounds on the same day will be paid the full-allowed amount for the major (largest total length of the repair at the same anatomic site) wound and one-half the allowed amount for each additional laceration (total length of the repair at the same anatomic site).
No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

When the debridement is carried out separately without immediate primary closure, when gross contamination requires prolonged cleansing, or when large amounts of devitalized or contaminated tissue are removed, debridement may be reimbursed separately. Debridement rendered during the same surgical session as wound closure is considered inclusive to the closure and is not reimbursed separately.

Refer to: Subsection 8.2.72.11, “Supplies, Trays, and Drugs,” in this handbook for the hospital-based emergency department.

Wound suture and wound closure are considered part of any surgical procedure performed on the same area, except for excision of benign or malignant lesion procedure codes that require more than simple closure. Providers may be reimbursed for the appropriate intermediate or complex closure procedure code. Multiple surgery guidelines apply.

The exceptions listed above apply to the following excision and closure procedure codes:

<table>
<thead>
<tr>
<th>Excision of Benign Lesion Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>11400</td>
</tr>
<tr>
<td>11424</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excision of Malignant Lesion Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11600</td>
</tr>
<tr>
<td>11624</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intermediate Closure Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>12031</td>
</tr>
<tr>
<td>12046</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complex Closure Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>13100</td>
</tr>
<tr>
<td>13151</td>
</tr>
</tbody>
</table>

8.2.24 Cochlear Implants

Cochlear implants, when medically indicated, are benefits of Texas Medicaid with prior authorization. A cochlear implant device (procedure code 69930) is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multichannel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

Refer to: Subsection 3.2.1, “Cochlear Implants,” in Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks) for additional information on benefit and authorization requirements for cochlear implants.

8.2.25 Continuous Glucose Monitoring (CGM)

CGM (procedure codes 95250 and 95251) is a benefit of Texas Medicaid with prior authorization. Procedure codes 95250 and 95251 are limited to once per 12 calendar months by any provider.
The rental or purchase of a continuous glucose monitoring system (CGMS) is considered part of the CGM and is not reimbursed separately.

8.2.25.1 Prior Authorization for Continuous Glucose Monitoring

CGM requires prior authorization and must be prescribed by a physician performing the glucose monitoring.

CGM may be prior authorized for clients with Type I diabetes or diabetes during pregnancy, including gestational diabetes. The client must be compliant with his or her current medical regimen, use insulin injections three or more times per day or be on an insulin pump, and have documented self-blood glucose monitoring at least four times per day. At least one or more of the following conditions must also be present:

- Frequent unexplained hypoglycemic episodes
- Unexplained large fluctuations in daily, preprandial blood glucose
- Episodes of ketoacidosis or hospitalization for uncontrolled glucose

Additional CGM services may be considered with documentation of medical necessity that indicates the client meets the criteria above and has a change in condition that would warrant a second procedure within 12 calendar months.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested services. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the use of CGM.

8.2.26 Developmental and Neurological Assessment and Testing

The following types of developmental and neurological assessment and testing are benefits of Texas Medicaid when medically necessary:

- Assessment of aphasia (procedure code 96105)
- Developmental screening when performed outside of a Texas Health Steps (THSteps) medical checkup (procedure code 96110)
- Developmental testing (procedure code 96111)
- Neurobehavioral testing (procedure code 96116)

The physician must maintain documentation of medical necessity in the client’s medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service. The following information is required at least every six months to establish medical necessity:

- The physician’s prescription that includes a description of the specific service being prescribed
- The treatment plan that includes a copy of the current evaluation and documented age of the child at the time of the evaluation

Re-evaluations are a benefit of Texas Medicaid only to address a clinical need, to provide the documentation needed to measure a client’s status over time, and to direct the plan of care.

Procedure codes 96105, 96110, 96111, and 96116 are used to report medically necessary developmental and neurological assessment and testing.

Administration of the Mini-Mental State Exam (MMSE) is considered part of an E/M service and will not be reimbursed separately.

Prior authorization is not required for aphasia assessment, developmental screening, developmental testing, and neurobehavioral status exam.
8.2.26.1 Assessment of Aphasia

Aphasia assessment (procedure code 96105) is a benefit of Texas Medicaid when medically necessary and is limited to diagnosis codes 7843, 78451, and 78459. Procedure code 96105 is limited to two services per rolling year, any provider.

8.2.26.2 Developmental Screening

Developmental screening using a recommended standardized screening tool (procedure code 96110) is a benefit of Texas Medicaid for clients who are birth through 20 years of age. Separate reimbursement for developmental screening completed without the use of one of the recommended standardized screening tools is not a benefit.

Developmental screening is limited to once per rolling year, any provider, outside of a THSteps medical checkup when medically necessary. This screening should only be completed for a diagnosis of suspected developmental delay or to evaluate a change in the client’s developmental status outside of a THSteps medical checkup.

Developmental screening should be used to identify clients who are birth through 6 years of age and who may need a more comprehensive evaluation. Results of developmental screening may guide or identify the need for further testing. Clients who have abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age with suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) within 48 hours.


Subsection 5.3.9.1.2, “Developmental Surveillance or Screening,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for additional information on developmental screening for THSteps checkups.

Standardized screening (procedure code 96110) is not a benefit when completed to meet day care, Head Start, or school program requirements unless completed during an acute care visit in a clinic setting.

8.2.26.3 Developmental Testing

Developmental testing (procedure code 96111) is a benefit of Texas Medicaid for clients who are birth through 20 years of age.

Developmental testing must consist of an extended evaluation and include the use of a standardized assessment tool. Developmental testing is medically necessary when there is suspected developmental delay supported by clinical evidence. Developmental testing is only medically indicated when clinical evidence suggests the following:

- Suspected developmental delay or atypical development cannot be clearly diagnosed through clinical interview or standardized screening tools alone.
- Retesting of a client to evaluate a change in developmental status that results in a change of treatment plan.

Procedure code 96111 is limited to two services per rolling year, any provider.

The procedure codes listed in the following table will be denied as part of another service when billed on the same day by the same provider as procedure code 96111:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801 90802 90804 90805 90806 90807 90808 90809 90810 90811</td>
</tr>
<tr>
<td>90812 90813 90814 90815 90816 90817 90818 90819 90821 90822</td>
</tr>
<tr>
<td>90823 90824 90826 90827 90828 90829 90845 90846 90847 90849</td>
</tr>
</tbody>
</table>
Developmental testing performed when a development delay or a change in the client’s developmental status is not suspected, is not a benefit of Texas Medicaid. Standardized testing (procedure code 96111) is not a benefit when completed to meet day care, Head Start, or school program requirements unless completed during an acute care visit in a clinic setting.

Providers cannot bill the client for developmental testing that is considered developmental screening.

### 8.2.26.4 Neurobehavioral Testing

A neurobehavioral examination (procedure code 96116) is a benefit of Texas Medicaid only when a medical or psychiatric diagnosis exists that establishes the need for a detailed evaluation of neurological impairment. Neurobehavioral testing is not medically necessary if a clinical interview alone would provide all the necessary diagnostic information.

Neurobehavioral testing is limited to the diagnosis codes listed in the following table:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>90853</td>
</tr>
<tr>
<td>97001</td>
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<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
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<tr>
<td>Diagnosis Codes</td>
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</tr>
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</tr>
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<tr>
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</tr>
<tr>
<td>30754 30759 3076 3077 30780 30781 30789 3079 3080 3081</td>
</tr>
<tr>
<td>3082 3083 3084 3089 3090 3091 30921 30922 30923 30924</td>
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Testing performed for other diagnoses constitute screening and are not covered by Texas Medicaid. Documentation maintained in the client’s medical record must support medical necessity for each test performed.

Procedure code 96116 is limited to four hours per day and eight hours per calendar year, any provider. Providers must bill the preponderance of each half hour of neurobehavioral testing and indicate that number of units on the claim form.

### 8.2.26.5 12-Hour Limitation for Procedure Codes 96110, 96111, and 96116

APRNs, PAs, and psychologists are limited to a maximum, combined total of 12 hours per day for developmental screening and testing, neurobehavioral testing, and inpatient and outpatient behavioral health services.

Because physicians (M.D. and D.O.) can delegate and may submit claims for services in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Developmental screening, developmental testing, and neurobehavioral testing are included in the 12-hour per day, per provider, system limitation. The following table lists the procedure codes that are included in the 12-hour per day system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Time Assigned by Procedure Code Description</th>
<th>Time Applied by System</th>
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</thead>
<tbody>
<tr>
<td>96110</td>
<td>N/A</td>
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<tr>
<td>96111</td>
<td>N/A</td>
<td>60 Minutes</td>
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<tr>
<td>96116</td>
<td>60 Minutes</td>
<td>60 Minutes</td>
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</tbody>
</table>

All providers, including physicians and all providers to whom they delegate services, are subject to retrospective review. HHSC and TMHP routinely perform retrospective reviews of all providers. All providers are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day. Retrospective review may include:

- All E/M procedure codes, including those listed in the Evaluation and Management Section of the *CPT Manual*, billed with a diagnosis listed in the diagnosis table above under Neurobehavioral Testing
- All developmental and neurological assessment and testing procedure codes included in the 12-hour system limitation

Note: Developmental and neurological assessment and testing procedure codes and behavioral health procedure codes are included in the review. If a provider provides developmental and neurological assessment and testing at more than one location, any of these services may be retrospectively reviewed.

### 8.2.27 Diagnostic Tests

#### 8.2.27.1 Ambulatory Blood Pressure Monitoring

Ambulatory blood pressure monitoring is a covered benefit for clients when hypertension is suspected but not defined by history or physical. Ambulatory blood pressure monitoring has been shown to be effective when used in the differential diagnosis of hypertension not elucidated by conventional studies.

Benefits are limited to the following medical necessities:

- Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
- At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
- There is no evidence of end-organ damage.

Ambulatory blood pressure monitoring is for diagnostic purposes only.

Use procedure codes 93784, 93786, 93788, and/or 93790 to bill in 24-hour increments for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is a benefit when submitted with diagnosis code 7962.

#### 8.2.27.2 Ambulatory Electroencephalogram (Ambulatory EEG)

Ambulatory EEG monitoring or 24-hour ambulatory monitoring is a covered benefit for clients in whom a seizure diathesis is suspected but not defined by history, physical, or resting EEG.

Benefits are limited to 3 units (each unit 24 hours) for each physician for the same client per 6 months when medically necessary.

Use the following procedure codes to bill ambulatory EEG: 95950, 95951, 95953, and 95956.

Procedure codes 95950, 95951, 95953, and 95956 may be reimbursed when billed with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>2930</td>
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<tr>
<td>34511</td>
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</table>
Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

**8.2.27.3 Bone Marrow Aspiration, Biopsy**

Physicians may bill procedure code 85097 if interpretation is for smear interpretation, or procedure code 88305 if interpretation is for preparation and interpretation of cell block. If both procedure codes 85097 and 88305 are billed, procedure code 88305 is paid and procedure code 85097 is denied.

Physicians may bill procedure code 85097 or 88305 for preparation and interpretation of the specimen.

**8.2.27.4 Cytopathology Studies—Other Than Gynecological**

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client’s E/M and will not be reimbursed separately.

Procedure codes 88160, 88161, and 88162 are reimbursed according to the POS where the cytopathology smear is interpreted.

**8.2.27.5 Echoencephalography**

Echoencephalography (procedure code 76506) is medically indicated for the following conditions or diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>34571</td>
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<tr>
<td>7790</td>
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</table>
### 8.2.27.6 Electrocardiogram (ECG)

Electrocardiograms (ECG) are a benefit of Texas Medicaid when used for the evaluation and management (E/M) of a confirmed or suspected primary disease of the heart, pericardium, and coronary arteries or when necessary for management of diseases that are not primarily cardiac, but can affect the heart directly or indirectly.

ECGs are limited to six treatments for each client, by any provider per benefit period.

For ECGs, a benefit period is defined as 12 consecutive months, beginning with the month the client receives the first ECG.

The following procedure codes may be reimbursed for ECGs: 93000, 93005, 93010, 93040, 93041, and 93042.

Claims that are denied for exceeding the six-ECG limitation may be appealed with documentation supporting medical necessity. The documentation must include the following:

- Diagnosis
- Treatment history
- Documentation of why additional ECGs are needed

The report of the professional component (the interpretation) for the ECG must be a complete written report that includes relevant findings and appropriate comparisons.

The interpretation may appear on the actual tracing.

When the ECG is performed in conjunction with the performance of an evaluation and management (E/M) service, the interpretation may appear with a progress note or other report of the E/M service; however, if the ECG is billed as a separate service from the E/M service, the interpretation should contain the same information as a report made upon the tracing itself.
A simple notation of “ECG/EKG normal” without an accompanying tracing will not suffice as documentation of a separately payable interpretation.

Appropriate documentation, which includes a copy of the ECG tracing, must be kept in the client’s medical record. Documentation must support the medical necessity of the ECG. Documentation may appear on the actual tracing or with a progress note or report. Documentation is subject to retrospective review.

Only an ECG interpretation that directly contributes to the diagnosis and treatment of a client may be considered for reimbursement. Services, such as routine admission ECGs performed without medical indications, that do not directly contribute to the diagnosis and treatment of an individual client are not considered medically necessary.

8.2.27.6.1 Prior Authorization for ECG

Prior authorization is not required for ECGs performed in the emergency room or inpatient hospital setting.

Prior authorization is required for more than six ECGs in a rolling 12-month period.

Requests for additional ECGs must be submitted on the Special Medical Prior Authorization (SMPA) Request Form along with documentation of medical necessity.

Providers may request a prior authorization up to 12 months in advance. When requesting retroactive authorization, a provider must submit the request no later than 14 calendar days after the ECG is completed.

Before submitting a prior authorization request for an ECG, a provider must have a completed SMPA Request Form that has been signed and dated by a physician who is familiar with the client. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. The completed SMPA Request Form must include the procedure codes and numerical quantities for the services requested. The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician in the client’s medical record.

The SMPA Request Form must include all of the following information, which is related to medical necessity:

- Procedure requested (CPT)
- Diagnosis
- Treatment history
- Treatment plan

Prior authorization requests submitted by paper, must be faxed or mailed with the completed SMPA Request Form to the SMPA department and a copy of the signed and dated form must be retained in the client’s medical record at the provider’s place of business. Requests may be faxed or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512 -514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.
8.2.27.7 Electrodiagnostic (EDX) Testing

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as EDX testing, must be medically indicated and may be reimbursed with the diagnosis codes listed below. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

The needle EMG examination must be performed by a physician specially trained in EDX medicine, as these tests are simultaneously performed and interpreted.

NCS must be performed by one of the following:

- A physician
- A trained individual under the direct supervision of a physician (Direct supervision means that the physician is in the building while testing is underway and is immediately available to provide the trained individual with assistance and direction. The supervising physician is responsible for selecting the appropriate NCS to be performed.)

### Diagnosis Codes for Electrodiagnostic Testing

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In addition to the diagnoses listed in the preceding table the following procedure codes may also be reimbursed with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Diagnosis Codes</th>
</tr>
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<tbody>
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</table>

### 8.2.27.7.1 Electromyography (EMG)

Surface or macro-EMG testing is considered experimental and is not a benefit of Texas Medicaid.

The following EMG procedure codes may be reimbursed for one service per day, each procedure, by the same provider:

<table>
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<tr>
<th>Procedure Codes</th>
<th>Limitation</th>
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<tbody>
<tr>
<td>51784</td>
<td>Reimbursed once per extremity up to 4 units, using any combination of procedure codes, per day, any provider.</td>
</tr>
<tr>
<td>51785, 95860</td>
<td>Must be billed with one of the primary procedure codes 95900, 95903, or 95904. The same diagnosis must be submitted for both the primary and add on procedure code.</td>
</tr>
<tr>
<td>95861, 95863</td>
<td>Reimbursed at the full fee (100 percent) for the first nerve study and half fee (50 percent) for each additional study, regardless of the number of studies. Reimbursed only once when multiple sites on the same nerve are stimulated or recorded.</td>
</tr>
<tr>
<td>95864, 95867</td>
<td>Up to 5 studies per day, per procedure, same provider without prior authorization.</td>
</tr>
</tbody>
</table>

### 8.2.27.7.2 Nerve Conduction Studies (NCS)

NCS are reimbursed by Texas Medicaid with documentation of medical necessity using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>51784</td>
<td>Reimbursed once per extremity up to 4 units, using any combination of procedure codes, per day, any provider.</td>
</tr>
<tr>
<td>51785, 95860</td>
<td>Must be billed with one of the primary procedure codes 95900, 95903, or 95904. The same diagnosis must be submitted for both the primary and add on procedure code.</td>
</tr>
<tr>
<td>95861, 95863</td>
<td>Reimbursed at the full fee (100 percent) for the first nerve study and half fee (50 percent) for each additional study, regardless of the number of studies. Reimbursed only once when multiple sites on the same nerve are stimulated or recorded.</td>
</tr>
<tr>
<td>95864, 95867</td>
<td>Up to 5 studies per day, per procedure, same provider without prior authorization.</td>
</tr>
</tbody>
</table>

**Limitations**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>95885, 95886</td>
<td>Reimbursed once per extremity up to 4 units, using any combination of procedure codes, per day, any provider.</td>
</tr>
<tr>
<td>95885, 95886, 95887</td>
<td>Must be billed with one of the primary procedure codes 95900, 95903, or 95904. The same diagnosis must be submitted for both the primary and add on procedure code.</td>
</tr>
<tr>
<td>95900, 95903, 95904</td>
<td>Reimbursed at the full fee (100 percent) for the first nerve study and half fee (50 percent) for each additional study, regardless of the number of studies. Reimbursed only once when multiple sites on the same nerve are stimulated or recorded.</td>
</tr>
<tr>
<td>95900 and 95903</td>
<td>Up to 5 studies per day, per procedure, same provider without prior authorization.</td>
</tr>
</tbody>
</table>
When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with modifier 59, indicating a distinct procedural service.

8.2.27.7.3 Documentation Requirements for EDX Testing

The reason for the referral, the specific site(s) tested, and a clear diagnostic impression must be documented in the client's medical record for each NCS or EMG study performed.

The client’s medical records must clearly document the medical necessity for the NCS and EMG testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client’s medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis. Examples may include suspected:
  - Peripheral nerve entrapment syndromes
  - Other neuropathies (traumatic, metabolic, or demyelinating)
  - Neuromuscular junction disorders (myasthenia gravis, botulism)
  - Myopathies (dermatomyositis, congenital myopathies)
  - Unexplained symptoms suggestive of peripheral nerve, muscle or neuromuscular junction pathology, manifested by muscle weakness, muscle atrophy, loss of dexterity, spasticity, sensory deficits, swallowing dysfunction, diplopia, or dysarthria
- The client’s diagnosis could not be confirmed on previous studies, although suspected.
- Evidence exists that the client’s condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional electrodiagnostic studies.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
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</thead>
<tbody>
<tr>
<td>95904</td>
<td>Up to 6 studies per day, per procedure, same provider without prior authorization.</td>
</tr>
<tr>
<td>95905</td>
<td>1 study per limb, per day, same provider. Claims may be submitted with a quantity of no more than 2 per detail line.</td>
</tr>
<tr>
<td>95930</td>
<td>1 study per day, same provider.</td>
</tr>
<tr>
<td>95933</td>
<td>Up to 2 studies per day, same provider.</td>
</tr>
<tr>
<td>95934, 95936</td>
<td>Reimbursed at the full fee (100 percent) for the first nerve study and half fee (50 percent) for each additional study, regardless of the number of studies. Up to 2 studies per day, per procedure, same provider without prior authorization.</td>
</tr>
<tr>
<td>95937</td>
<td>Up to 3 studies per day, per procedure, same provider without prior authorization.</td>
</tr>
</tbody>
</table>
The client’s medical records are subject to retrospective review. NCS hard copies of the wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

8.2.27.7.4 Prior and Retrospective Authorization for EDX Testing

EMG services procedure codes 95860, 95861, 95863, 95864, 95867, 95868, 95869, and 95870 do not require prior authorization and are allowed at the maximum per procedure code description.

Authorization is required when the number of nerve conduction studies performed during an evaluation exceeds the maximum number of studies outlined in the limitations table in subsection 8.2.27.7.2, “Nerve Conduction Studies (NCS)” in this handbook.

Since the need for additional NCS or alternate procedures may be determined following initiation of the evaluation, a request for retroactive authorization may be submitted no later than seven calendar days beginning the day after testing is completed.

Medical record documentation must establish medical necessity for the additional studies, including:

- Other diagnosis in the differential that require consideration. The provider should note:
  - The additional diagnoses considered.
  - The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
  - Multiple diagnoses are established by nerve conduction studies; the recommendations in the table above for a single diagnostic category do not apply. The provider should document all diagnoses established as a result of EDX testing.
  - Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol [ETOH] usage).
  - Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms, for example:
    - Underlying metabolic disease (such as thyroid condition or diabetes mellitus)
    - Nutritional deficiency (alcoholism)
    - Malignant disease
    - Inflammatory disorder (including but not limited to lupus, sarcoidosis or Sjögren’s syndrome)

Texas Medicaid recognizes that EDX testing is tailored to the clinical findings of an individual client. It is, however, the expectation that testing be guided by accepted practice parameters and physician guidelines. The number of studies performed should be the minimum needed to establish an accurate diagnosis. Texas Medicaid, consistent with the American Association of Neuromuscular & Electodiagnostic Medicine (AANEM) recommendations, believes the recommendations of the AANEM to be a reasonable maximum number of studies for the documented clinical conditions as noted in the CPT manual on page 499. The AANEM recommendations will be used in determination of medical necessity of additional tests requested with prior authorization.

Reimbursement

Any EDX testing procedures may be reimbursed up to four different dates of service per calendar year, same provider. Any E/M service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

Maximum Number of Studies for EDX Testing

The AANEM recommendations include a reasonable maximum number of studies performed per diagnostic category and can be found in the CPT manual.
8.2.27.8 **Esophageal pH Probe Monitoring**

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

Esophageal pH probe monitoring should be coded with procedure codes 91034, 91035, and 78262.

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) are limited to two services per rolling year, same procedure, any provider.

Claims that are denied for exceeding two services per rolling year may be considered on appeal with documentation of one of the following:

- The client is new and the provider has been unsuccessful in obtaining the client’s previous records from a different provider.
- The provider is not aware that the client received previous esophageal testing.

Only one appeal will be considered per client, for the same provider. Providers must request prior authorization for any additional esophageal testing performed after the appealed service.

8.2.27.8.1 **Prior Authorization**

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) require prior authorization for services that exceed two per rolling year.

Requests for additional testing may be considered when submitted with documentation of medical necessity that supports, but is not limited to, the following:

- Adult’s unintentional weight loss is more than 5 percent of their normal body weight in a span of 12 months or less
- Child’s weight loss is 3 to 5 percent of their body mass in less than 30 days
- Symptoms of gastroesophageal reflux disease (GERD) that include heartburn and regurgitation that do not respond to treatment with medication
- Atypical symptoms of GERD, such as chest pain, coughing, wheezing, hoarseness, and sore throat

Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The completed prior authorization request form must be maintained by the requesting provider and the prescribing physician. The original, signed copy must be kept by the physician in the client’s medical record.

8.2.27.9 **Helicobacter Pylori (H. pylori)**

Testing for H. pylori may be performed using the following tests:

- Serology testing (procedure codes 83009 and 86677 are allowed once per year when submitted by any provider)
- Stool testing (procedure code 87338)
- Breath testing (procedure codes 78267, 78268, 83013, and 83014)

Serology testing for H. pylori is a noninvasive diagnostic procedure that is preferred for initial diagnosis but is not indicated after a diagnosis has been made. Serology testing is not indicated or covered for monitoring a response to therapy.
Stool testing for H. pylori is a noninvasive diagnostic procedure that is appropriate for both diagnosis and determining a response to therapy.

Breath testing for H. pylori is a noninvasive diagnostic procedure that uses an analysis of breath samples to determine the presence of H. pylori.

The interpretation/professional component is not considered separately for reimbursement.

H. pylori is accepted as an etiologic factor in duodenal ulcers, peptic ulcer disease, gastric carcinoma, and primary B cell gastric lymphoma. H. pylori testing may be indicated for symptomatic clients who have a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. The history must delineate the failed conservative treatment for the condition.

H. pylori serology or stool testing is not indicated or covered for any of the following:

- New onset uncomplicated dyspepsia.
- New onset dyspepsia responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAID] and/or use of antisecretory agents). If the treatment does not prove successful in eliminating the symptoms, further testing may be indicated to determine the presence of H. pylori.
- Screening for H. pylori in asymptomatic clients.
- Dyspeptic clients requiring endoscopy and biopsy.

H. pylori testing is not indicated under the following circumstances:

- There has been a negative endoscopy in the previous six weeks.
- An endoscopy is planned.
- H. pylori is of new onset and still being treated.

If a follow-up breath or stool test is used to document eradication of H. pylori, the medical record documentation must verify the history of the following previous complication(s):

- The client remains symptomatic after a treatment regimen for H. pylori.
- The client is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
- The client has a history of ulcer on chronic NSAID or anticoagulant therapy.

Only C-13 breath tests (procedure codes 83013 and 83014) or C-14 breath tests (procedure codes 78267 and 78268) may be reimbursed separately when billed with the same date of service. Only one of the following procedure codes may be reimbursed when submitted with the same date of service: 83009, 86677, or 87338.

Reimbursement for the H. pylori serology, breath, and stool test is restricted to the following diagnosis codes:

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<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>1510</td>
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<tr>
<td>53101</td>
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<tr>
<td>53151</td>
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<tr>
<td>53211</td>
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<tr>
<td>53261</td>
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<tr>
<td>53321</td>
</tr>
<tr>
<td>53371</td>
</tr>
</tbody>
</table>
Refer to: Subsection 3.2.1, “Cardiac Nuclear Imaging,” in *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).*

**8.2.27.11 Pediatric Pneumogram**

A pediatric pneumogram (procedure code 94772) is a 12-hour to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

The following diagnosis codes may be reimbursed for a pediatric pneumogram in infants from birth through 11 months of age:

A pediatric pneumogram is limited to two services without prior authorization when submitted with one of the diagnosis codes listed above. Additional studies may be considered under CCP with documentation of medical necessity, and will require prior authorization.

Refer to: Section 5, “THSteps Medical” in *Children’s Services Handbook (Vol. 2, Provider Handbooks).*

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms are reimbursed on the same day as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component and are denied if billed separately.

**8.2.28 Diagnostic Doppler Sonography**

Diagnostic Doppler sonography is a benefit of Texas Medicaid when treatment decisions depend on the results. Authorization is not required for diagnostic Doppler services.

A vascular diagnostic study may be personally performed by a physician or by a technologist. The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and physician performing and interpreting the study. Consequently, the physician who performs and/or interprets the study must be able to document training through recent residency training or post-graduate continuing medical education and experience and must maintain that documentation for post-payment review.
If noninvasive vascular diagnostic studies are performed by a technologist, the technologist must have demonstrated competency in ultrasound by receiving one of the following credentials in vascular ultrasound technology:

- Registered Vascular Specialist (RVS) provided by Cardiovascular Credentialing International (CCI)
- Registered Vascular Technologist (RVT) provided by the American Registry of Diagnostic Medical Sonographers (ARDMS)
- Vascular Sonographer (VS) provided by the American Registry of Radiologic Technologists (ARRT), Sonography

Alternately, such studies must be performed in a facility or vascular laboratory accredited by one of the following nationally recognized accreditation organizations. If a vascular laboratory or facility is accredited, the technologists performing noninvasive cerebrovascular arterial studies in that laboratory are considered to have demonstrated competency in cerebrovascular ultrasound:

- American College of Radiology (ACR) Vascular Ultrasound Accreditation Program
- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)

**Cerebrovascular Doppler Studies**

Cerebrovascular Doppler sonography includes both extracranial and transcranial (intracranial) studies. Cerebrovascular Doppler sonography should not be used when treatment decisions will not be affected by the findings.

Cerebrovascular Doppler studies for the diagnosis of migraine are considered experimental and are not a benefit of Texas Medicaid.

Extracranial arterial Doppler (procedure codes 93880 and 93882) are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2373</td>
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<td>34290</td>
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<td>36237</td>
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<tr>
<td>99975</td>
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<tr>
<td>V4589</td>
</tr>
</tbody>
</table>

*Use diagnosis code 7802 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency.

** Use diagnosis code 7842 to report pulsatile neck mass

*** Use diagnosis code 7859 to report carotid bruit
Transcranial Doppler (procedure codes 93886, 93888, 93890, 93892, and 93893) are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>34200 34201 34202 34210 34211 34212 34280 34281 34282 34290</td>
</tr>
<tr>
<td>34291 34292 34400 34401 34402 34403 34404 34409 3441 3442</td>
</tr>
<tr>
<td>34430 34431 34432 34440 34441 34442 3445 3449 34881 34882</td>
</tr>
<tr>
<td>34889* 36230 36231 36232 36233 36234 36235 36236 36237 36284</td>
</tr>
<tr>
<td>36810 36811 36812 3682 36841 36842 36843 36844 36845</td>
</tr>
<tr>
<td>36846 36847 37850 37851 37852 37853 37854 37855 37856 430</td>
</tr>
<tr>
<td>431 43300 43301 43310 43311 43320 43321 43380 43381 43390</td>
</tr>
<tr>
<td>43391 43400 43401 43410 43411 43490 43491 4350 4351 4352</td>
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<tr>
<td>4353 4358 4359 436 4370 4371 4373 4374 4375 4377</td>
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<tr>
<td>4379 4409 44281 44282 4449** 4460 4461 44620 44621 44629</td>
</tr>
<tr>
<td>4463 4464 4465 4466 4467 4470 4471 4472 4476 4478</td>
</tr>
<tr>
<td>4479 74781 7802*** 7803 7804 78066 7812 7813 7814 7815</td>
</tr>
<tr>
<td>7820 7843 78451 7859**** 90000 90001 90002 90003 9001 90081</td>
</tr>
<tr>
<td>90082 90089 9009 9011 9584 9961 99674 99811 99812 99813</td>
</tr>
<tr>
<td>9982 99830 99831 99832 99833 9984 9986 9987 99960 99961</td>
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<tr>
<td>99962 99963 99969 99970 99971 99972 99973 99974 99975 99976</td>
</tr>
<tr>
<td>99977 99978 99979 9998 99983 99984 99985 V434 V6700 V6709</td>
</tr>
</tbody>
</table>

* Use diagnosis code 34889 to identify assessment of suspected brain death
** Use diagnosis code 4449 to report paradoxical cerebral embolism
*** Use diagnosis code 7802 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency
**** Use diagnosis code 7859 to report carotid bruit

In addition to the diagnosis codes listed in the table above, procedure codes 93886 and 93888 are benefits for clients who are 2 through 16 years of age with sickle cell disease to evaluate the risk of stroke when submitted with the following diagnosis codes: 28260, 28261, 28262, 28263, 28264, 28265, or 28269.

Peripheral Arterial Doppler Studies
Peripheral arterial Doppler (procedure codes 93922, 93923, 93924, 93925, 93926, 93930, and 93931) are limited to the following diagnosis codes (unless otherwise indicated):

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>25070 25071 25072 25073 3530 41000 41001 41002 41010</td>
</tr>
<tr>
<td>41011 41012 41020 41021 41022 41030 41031 41032 41040</td>
</tr>
<tr>
<td>41041 41042 41050 41051 41052 41060 41061 41062 41070</td>
</tr>
<tr>
<td>41071 41072 41080 41081 41082 4110 4111 41181 41189</td>
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<tr>
<td>412 4130 4131 4139 41400 41401 41402 41403 41404</td>
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<tr>
<td>41405 41406 41407 41410 41411 41412 41419 4148 41513</td>
</tr>
</tbody>
</table>

* Use diagnosis code 7295 to report only limb pain that is clinically suggestive of ischemia
** This diagnosis code may not be reimbursed when submitted with procedure code 93924, 93925, or 93926
*** This diagnosis code may not be reimbursed when submitted with procedure code 93930 or 93931
Peripheral Venous Doppler Studies
Peripheral venous Doppler (procedure codes 93965, 93970, and 93971) are limited to the following diagnosis codes:

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Codes</th>
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<td>99974</td>
<td>99975</td>
<td>99976</td>
<td>99977</td>
<td>99978</td>
<td>99979</td>
<td>9998</td>
<td>99983</td>
<td>99984</td>
</tr>
<tr>
<td>99985</td>
<td>V1255</td>
<td>V434</td>
<td>V4581</td>
<td>V4582</td>
<td>V5849</td>
<td>V5873</td>
<td>V6709</td>
<td>V7281</td>
</tr>
</tbody>
</table>

* Use diagnosis code 7295 to report only limb pain that is clinically suggestive of ischemia
** This diagnosis code may not be reimbursed when submitted with procedure code 93924, 93925, or 93926
*** This diagnosis code may not be reimbursed when submitted with procedure code 93930 or 93931

* Use diagnosis code 4449 only for paradoxical embolism
** Use diagnosis code V7283 only for preoperative venous studies
Doppler echocardiography color flow velocity mapping (procedure code 93325) must be billed with one of the corresponding procedure codes in column B to be considered for reimbursement:

<table>
<thead>
<tr>
<th>Column A Procedure Code</th>
<th>Column B Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>93325</td>
<td>76825, 76826, 76827, 76828, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, or 93350</td>
</tr>
</tbody>
</table>

Limitations for Diagnostic Doppler Sonography

Documentation of medical necessity for the diagnostic Doppler study must be maintained by the ordering provider in the client’s medical record.

Procedure codes described as complete bilateral studies are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Diagnostic Doppler procedure codes are limited to one study per day, same provider.

When medically necessary, multiple Doppler procedures (e.g., studies of extracranial arteries and intracranial arteries) billed on the same day by the same provider will be reimbursed at full fee for the first study and one-half fee for each additional study, regardless of the number of services billed.

The use of transcranial Doppler studies performed for the assessment of stroke risk in clients who are 2 through 16 years of age who have sickle cell anemia should be limited to once every 6 months.

The use of a simple hand-held or other Doppler device that does not produce hard copy output or that does not permit analysis of bidirectional vascular flow is considered part of the physical examination of the vascular system and is not separately reported.

8.2.29 Extracorporeal Membrane Oxygenation (ECMO)

ECMO may be effective on a short-term basis for clients with life-threatening respiratory and/or cardiac insufficiency.

Procedure codes 36822, 33960, and 33961 may be used when billing ECMO for clients who have the following clinical indications (this is not an all-inclusive list):

- Persistent pulmonary hypertension
- Meconium aspiration syndrome
- Respiratory distress syndrome
- Adult respiratory distress syndrome
- Congenital diaphragmatic hernia
- Sepsis
- Pneumonia
- Preoperative and postoperative congenital heart disease or heart transplantation
- Reversible causes of cardiac failure
- Cardiomyopathy
- Myocarditis
- Aspiration pneumonia
- Pulmonary contusion
- Pulmonary embolism

Terminal disease with expectation of short survival, advanced multiple organ failure syndrome, irreversible central nervous system injury and severe immunosuppression are contra-indications to ECMO. Claims for ECMO services may be recouped if the services are provided in the presence of these conditions.

The initial 24 hours of ECMO should be submitted using procedure code 33960. Procedure code 33961 should be used for each additional 24 hours. Procedure code 33960 is denied as part of procedure code 33961 if submitted with the same date of service. Procedure codes 33960 and 33961 are limited to one per day when billed by any provider.

If insertion of cannula (procedure code 36822) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33960 or 33961, the insertion of the cannula is denied, and the ECMO (procedure codes 33960 and 33961) is considered for reimbursement.

8.2.30 Family Planning

Physicians, PAs, NPs, CNSs, and CNMs are encouraged to provide family planning services to Texas Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through Texas Medicaid (Title XIX) or through the DSHS Family Planning Program.

Refer to: Section 2, “Medicaid Title XIX family planning services” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

Section 3, “* Texas Women’s Health Program” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

8.2.31 Gynecological Health Services

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

Refer to: Section 5, “Gynecological Health Services” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks) for information about contraception, sterilizations, and family planning annual examinations.

8.2.32 Hospital Visits

Refer to: Subsection 8.2.60, “Physician Evaluation and Management (E/M) Services,” in this handbook.
8.2.33 * Hyperbaric Oxygen Therapy (HBOT)

Physicians who bill for the professional component of HBOT must use procedure code 99183. Hospital providers who bill for the chamber time must use procedure code C1300 with revenue code 413.

**Note:** Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.

Texas Medicaid recognizes the following indications for HBOT, as approved by the Undersea and Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps
- Crush injuries, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Delayed radiation injury (soft tissue and bony necrosis)
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Intracranial abscess
- Necrotizing soft tissue infections
- Refractory osteomyelitis
- Acute thermal burn injuries

HBOT is not a replacement for other standard successful therapeutic measures.

Texas Medicaid considers HBOT experimental and investigational for any indications other than the ones approved by UHMS and outlined in this section. Non-covered indications include, but are not limited to, autism and traumatic brain injury.

Oxygen administered outside of a hyperbaric chamber, by any means, is not considered hyperbaric treatment.

The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber and may not delegate the rendering of the service. Both the facility’s medical record and the client’s medical record must contain documentation to support that there was a physician in attendance who provided direct supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

8.2.33.1 * Prior Authorization for HBOT

HBOT procedure codes 99183 and C1300 require prior authorization. Prior authorization requests submitted for procedure code C1300 must also include revenue code 413. When requesting prior authorization, providers should use the “Special Medicaid Prior Authorization (SMPA) Request Form” in this handbook.

**Refer to:** Section 5: Fee-for-Service Prior Authorizations for detailed information about prior authorization requirements.
The prior authorization request must include documentation that supports medical necessity and is specific to each appropriate covered indication as listed in the following table:

<table>
<thead>
<tr>
<th>Covered Indication</th>
<th>Total 30-Minute Intervals Allowed for Procedure Code C1300</th>
<th>Total Professional Sessions Allowed for Procedure Code 99183</th>
<th>Medical Necessity Documentation of the Following is Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air or gas embolism</td>
<td>6</td>
<td>2</td>
<td>Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics</td>
</tr>
<tr>
<td>Carbon monoxide poisoning - initial authorization</td>
<td>15</td>
<td>5</td>
<td>Persistent neurological dysfunction secondary to carbon monoxide inhalation</td>
</tr>
<tr>
<td>Carbon monoxide poisoning - one subsequent authorization</td>
<td>9</td>
<td>3</td>
<td>Evidence of continuing improvement in cognitive functioning</td>
</tr>
<tr>
<td>Central retinal artery occlusion</td>
<td>36</td>
<td>6</td>
<td>Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion</td>
</tr>
<tr>
<td>Compromised skin grafts and flaps - initial authorization</td>
<td>80</td>
<td>10</td>
<td>Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia</td>
</tr>
<tr>
<td>Compromised skin grafts and flaps - one subsequent authorization</td>
<td>40</td>
<td>5</td>
<td>Evidence of stabilization of graft or flap</td>
</tr>
<tr>
<td>Crush injury, compartment syndrome and other acute traumatic ischemias</td>
<td>36</td>
<td>12</td>
<td>Adjunct to standard medical and surgical interventions</td>
</tr>
<tr>
<td>Decompression sickness</td>
<td>28</td>
<td>1</td>
<td>Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure</td>
</tr>
<tr>
<td>Diabetic foot ulcer - initial authorization</td>
<td>60</td>
<td>30</td>
<td>After at least 30 days of standard medical wound therapy, with a wound pO2 less than 40 mmHg AND wound classified as Wagner grade 3 or higher. *</td>
</tr>
<tr>
<td>Diabetic foot ulcer - two subsequent authorizations</td>
<td>60</td>
<td>20</td>
<td>Evidence of continuing healing and wound pO2 less than 40 mmHg</td>
</tr>
<tr>
<td>Severe anemia</td>
<td>50</td>
<td>10</td>
<td>Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs</td>
</tr>
</tbody>
</table>

Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:
- Grade 1: Superficial diabetic ulcer
- Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- Grade 3: Deep ulcer with abscess or osteomyelitis
- Grade 4: Gangrene to portion of forefoot
- Grade 5: Extensive gangrene of foot
<table>
<thead>
<tr>
<th>Covered Indication</th>
<th>Total 30-Minute Intervals Allowed for Procedure Code C1300</th>
<th>Total Professional Sessions Allowed for Procedure Code 99183</th>
<th>Medical Necessity Documentation of the Following is Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridial myositis and myonecrosis (gas gangrene)</td>
<td>39</td>
<td>13</td>
<td>Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid</td>
</tr>
<tr>
<td>Necrotizing soft tissue infections - initial authorization</td>
<td>36</td>
<td>12</td>
<td>Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue</td>
</tr>
<tr>
<td>Necrotizing soft tissue infections - two subsequent authorizations</td>
<td>15</td>
<td>5</td>
<td>Evidence that advancement of dying tissue has slowed</td>
</tr>
<tr>
<td>Delayed radiation injury (soft tissue and bony necrosis) - initial authorization</td>
<td>40</td>
<td>10</td>
<td>Evidence of unsatisfactory clinical response to conventional treatment</td>
</tr>
<tr>
<td>Delayed radiation injury - one subsequent authorization</td>
<td>40</td>
<td>10</td>
<td>Evidence of improvement demonstrated by clinical response</td>
</tr>
<tr>
<td>Refractory osteomyelitis - initial authorization</td>
<td>40</td>
<td>10</td>
<td>Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment</td>
</tr>
<tr>
<td>Refractory osteomyelitis - one subsequent authorization</td>
<td>15</td>
<td>5</td>
<td>Evidence of improvement demonstrated by clinical response</td>
</tr>
<tr>
<td>Acute thermal burn injury - initial authorization</td>
<td>45</td>
<td>15</td>
<td>Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum</td>
</tr>
<tr>
<td>Acute thermal burn injury - three subsequent authorizations</td>
<td>30</td>
<td>10</td>
<td>Evidence of continuing improvement demonstrated by clinical response</td>
</tr>
<tr>
<td>Intracranial abscess - initial authorization</td>
<td>15</td>
<td>5</td>
<td>Adjunct to standard medical and surgical interventions when one or more of the following conditions exist:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Multiple abscesses</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Abscesses in a deep or dominant location</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Compromised host</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Surgery contraindicated or client is a poor surgical risk</td>
</tr>
<tr>
<td>Intracranial abscess - one subsequent authorization</td>
<td>15</td>
<td>5</td>
<td>Evidence of improvement demonstrated by clinical response and radiological findings</td>
</tr>
</tbody>
</table>

**Note:** The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:

- **Grade 1:** Superficial diabetic ulcer
- **Grade 2:** Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)
- **Grade 3:** Deep ulcer with abscess or osteomyelitis
- **Grade 4:** Gangrene to portion of forefoot
- **Grade 5:** Extensive gangrene of foot
Procedure code 99183 is authorized according to the number of professional sessions (total HBOT treatments), and procedure code C1300 is authorized according to the number of 30-minute intervals of chamber time. The units in the columns for procedure codes 99183 and C1300 represent the maximum number of sessions and intervals that are allowed for that procedure code per authorization.

Limitations beyond those listed in the table above are considered experimental and investigational.

In emergency situations, the prior authorization request must be submitted no later than three business days after the date the service is rendered. Providers must not submit a claim until the prior authorization request has been approved. If the request has not been approved, the claim will be denied.

8.2.34 Ilizarov Device and Procedure

Providers must use procedure codes 20692, 20693, 20694, and 20999 when submitting claims for the Ilizarov procedure. A global fee payment methodology is applied to the Ilizarov device procedure codes. Procedure codes 20692, 20693, 20694, and 20999 include the preconstruction, surgical application, adjustments to the device for up to 6 months, and the removal of the device.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 20690 or 20692, where applicable, when billing for the surgical applications.

8.2.35 Immunization Guidelines and Administration

Texas Medicaid reimburses immunizations (vaccines and toxoids) that the Advisory Committee on Immunization Practices (ACIP) recommends as either routine or medically necessary.

Providers must follow the most current ACIP recommendations. Providers must also provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC). VISs explain the benefits and risks of the vaccines and toxoids administered.

Note: Administered vaccines and toxoids must be reported to DSHS. After obtaining parental consent, DSHS submits all reported vaccines and toxoids to a centralized repository of immunization histories for children who are 17 years of age and younger. This repository is known in Texas as ImmTrac.

8.2.35.1 Administration Fee

An administration fee may be reimbursed for all covered vaccines and toxoids that are administered. The following procedure codes may be reimbursed when billed for vaccine and toxoid administration:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>90460</th>
<th>90461</th>
<th>90471</th>
<th>90472</th>
<th>90473</th>
<th>90474</th>
</tr>
</thead>
</table>

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473, and 90474 are benefits when counseling is not provided for the immunization administered. Procedure codes 90471 and 90472 may be reimbursed for services rendered to clients of any age. Procedure codes 90473 and 90474 are restricted to clients who are 20 years of age and younger.

The administration fee may be reimbursed when the procedure code for the vaccine or toxoid administered (regardless of the source of the vaccine or toxoid) and the administration fee procedure code are billed on the same claim with the same date of service. Only one administration fee may be reimbursed to any provider for each vaccine or toxoid administered per day.
The following vaccines and toxoids procedure codes are a benefit of Texas Medicaid for clients who are 20 years of age and younger based on the number of recognized components as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Number of Recognized Components**</th>
<th>Procedure Code</th>
<th>Number of Recognized Components*</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>1</td>
<td>90702*</td>
<td>2</td>
</tr>
<tr>
<td>90633*</td>
<td>1</td>
<td>90703</td>
<td>1</td>
</tr>
<tr>
<td>90636</td>
<td>2</td>
<td>90707*</td>
<td>3</td>
</tr>
<tr>
<td>90647*</td>
<td>1</td>
<td>90710*</td>
<td>4</td>
</tr>
<tr>
<td>90648*</td>
<td>1</td>
<td>90713*</td>
<td>1</td>
</tr>
<tr>
<td>90649*</td>
<td>1</td>
<td>90714*</td>
<td>2</td>
</tr>
<tr>
<td>90650*</td>
<td>1</td>
<td>90715*</td>
<td>3</td>
</tr>
<tr>
<td>90654</td>
<td>1</td>
<td>90716*</td>
<td>1</td>
</tr>
<tr>
<td>90655*</td>
<td>1</td>
<td>90718</td>
<td>2</td>
</tr>
<tr>
<td>90656*</td>
<td>1</td>
<td>90721</td>
<td>4</td>
</tr>
<tr>
<td>90657*</td>
<td>1</td>
<td>90723*</td>
<td>5</td>
</tr>
<tr>
<td>90658*</td>
<td>1</td>
<td>90732*</td>
<td>1</td>
</tr>
<tr>
<td>90660*</td>
<td>1</td>
<td>90733</td>
<td>1</td>
</tr>
<tr>
<td>90669</td>
<td>1</td>
<td>90734*</td>
<td>1</td>
</tr>
<tr>
<td>90670*</td>
<td>1</td>
<td>90740</td>
<td>1</td>
</tr>
<tr>
<td>90680*</td>
<td>1</td>
<td>90743</td>
<td>1</td>
</tr>
<tr>
<td>90681*</td>
<td>1</td>
<td>90744*</td>
<td>1</td>
</tr>
<tr>
<td>90696</td>
<td>4</td>
<td>90746*</td>
<td>1</td>
</tr>
<tr>
<td>90698*</td>
<td>5</td>
<td>90748*</td>
<td>2</td>
</tr>
<tr>
<td>90700*</td>
<td>3</td>
<td>90749</td>
<td>1</td>
</tr>
</tbody>
</table>

* TVFC-distributed vaccine/toxoid
** The number of components applies if counseling is provided and procedure codes 90460 and 90461 are submitted.

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate “administration with counseling” procedure code(s) (procedure codes 90460 and 90461) or the most appropriate “administration without counseling” procedure code (procedure code 90471, 90472, 90473, or 90474). If an “administration with counseling” procedure code is submitted with an “administration without counseling” procedure code for the same vaccine or toxoid, the second administration of the vaccine or toxoid will be denied.

**Administration with Counseling**

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the first component.
• Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client’s medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code with 1 component</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code with 3 components</td>
<td>1</td>
</tr>
<tr>
<td>90460 (1st component)</td>
<td>1</td>
</tr>
<tr>
<td>90461 (2nd and 3rd components)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Note:** The term “components” refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.

**Administration without Counseling**

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90471 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
<tr>
<td>Vaccine or toxoid procedure code</td>
<td>1</td>
</tr>
<tr>
<td>90472 (Injection administration)</td>
<td>1</td>
</tr>
</tbody>
</table>

**8.2.35.2 Documentation**

Providers must document the following information in the client’s medical record, which is subject to retrospective review to determine appropriate utilization and reimbursement of this service:

• The vaccine or toxoid given
• The date of the vaccine or toxoid administration (day, month, year)
• The name of the vaccine or toxoid manufacturer and the vaccine or toxoid lot number
• The signature and title of the person administering the vaccine or toxoid
• The organization and address of the clinic location
• The publication date of the VIS issued to the client, parent, or guardian
8.2.35.3 Vaccine Adverse Event Reporting System (VAERS)

The National Childhood Vaccine Injury Act (NCVIA) requires health-care providers to report:

- Any reaction listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Documentation of the injection site is recommended but not required.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from http://vaers.hhs.gov/esub/index.

8.2.36 Immunizations for Clients Birth through 20 Years of Age

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of THSteps when provided as part of a THSteps medical checkup. A THSteps provider who bills vaccines and toxoids with diagnosis or age restrictions is subject to those restrictions. Providers must bill the claim with the diagnosis code that indicates the condition that necessitates the vaccine or toxoid. For clients who are birth through 20 years of age, diagnosis code V202 may be used.

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of CCP when the vaccine or toxoid is provided as part of an acute medical visit outside of a THSteps medical checkup.

Modifier U1 must be used in the following situations:

- The client is birth through 18 years of age and the vaccine or toxoid is provided as part of a THSteps medical checkup and the state has issued a statement that the vaccine was currently unavailable through TVFC.
- The client is birth through 18 years of age and the vaccine or toxoid is provided as part of an acute medical visit outside of a THSteps medical checkup and was unavailable for distribution through TVFC.
- The vaccine or toxoid is normally distributed by TVFC but is currently officially declared unavailable, and the provider uses privately purchased vaccine or toxoid.
- The TVFC, based on their federal resolution (distribution/guidelines), does not distribute an HHSC-approved vaccine or toxoid following the ACIP recommendation, and the provider purchases vaccine to administer to all ACIP-recommended ages and cohorts. (The vaccine or toxoid administered outside the TVFC age or cohort may be reimbursed with modifier U1.)

Note: ‘Not available’ is defined as: a new vaccine approved by the ACIP has not been negotiated or added to a TVFC contract; funding for new vaccine has not been established by TVFC; national supply and distribution issues.

Modifier U1 must not be used in the following situations:

- Provider’s failure to enroll in TVFC or to maintain sufficient TVFC vaccine or toxoid inventory.
- For clients who are 19 through 20 years of age.

At every encounter all providers must assess the immunization status of clients who are birth through 17 years of age or of clients who are birth through 20 years of age when part of a THSteps medical checkup. Providers must administer any medically indicated immunizations unless the immunization is medically contraindicated or because of the parent’s reason of conscience,
including a religious belief. The reason the indicated vaccine or toxoid was not administered must be documented in the client’s medical record. Providers may refer to the CFR and the TAC for additional information.

8.2.36.1 Vaccine Coverage Through the TVFC Program

The TVFC Program provides vaccines and toxoids for Texas Medicaid clients who are birth through 18 years of age according to the Recommended Childhood Immunization Schedule approved by the following:

- ACIP
- American Academy of Pediatrics (AAP)
- American Academy of Family Physicians (AAFP)

Providers may refer to the TVFC web site at www.dshs.state.tx.us/immunize/tvfc/default.shtm for more information and for a list of vaccines available through the program.

**Note:** TVFC program resolutions do not always match the ACIP’s general usage recommendations, but rather represent the rules that providers must follow when administering each specific vaccine under the TVFC.

When a single antigen vaccine or toxoid or a comparable antigen vaccine or toxoid is available through TVFC, but the provider chooses to use a different ACIP-recommended product, the administration fee will be reimbursed but the vaccine or toxoid will not be reimbursed.

Although Texas Medicaid does not mandate that providers enroll in TVFC, Texas Medicaid will not reimburse providers when the vaccine is available through TVFC. Only the administration fee will be reimbursed through Texas Medicaid when the vaccine or toxoid procedure code is identified on the claim. Clients may not be billed for vaccines and toxoids that are available through TVFC.

**Refer to:** Subsection 5.1.3, “Texas Vaccines for Children (TVFC) Program,” in *Children’s Services Handbook* (Vol. 2, Provider Handbooks) for additional information about TVFC and immunizations for infants and children.

8.2.36.2 Vaccine and Toxoid Procedure Codes

The following vaccine and toxoid procedure codes may be reimbursed for Texas Medicaid clients who are birth through 20 years of age:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Bacillus Calmette-Guérin (BCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Refer to:</strong></td>
<td>Subsection 8.2.9, “Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer,” in this handbook.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Hepatitis A and B</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>90633*</td>
</tr>
<tr>
<td>90744*</td>
<td>90746</td>
</tr>
<tr>
<td>90743</td>
<td>90748*</td>
</tr>
</tbody>
</table>

* Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.
Procedure codes 90740, 90744, and 90747: For clients who are birth through 18 years of age, the state-mandated administration of the hepatitis B vaccine to newborns before discharge from the hospital has been established as the accepted standard of care and will not be considered as a reason to up-code to a different diagnosis-related group (DRG). The administration of the hepatitis B vaccine to newborns is included in the DRG payment and will not be reimbursed separately.

Texas Medicaid-eligible clients residing in a private (nonstate) institution for persons with intellectual disabilities (ICF-MR), are classified as at a continuing high risk for hepatitis B with an ongoing exposure potential. When provided by and billed by the attending physician, Texas Medicaid may reimburse the hepatitis B vaccine for all in clients of an ICF-MR (private) facility.

When the hepatitis B vaccine is provided to clients with end-stage renal disease who are directly exposed to the virus, the administration fee and the vaccine may be reimbursed in addition to the dialysis services.

Providers are expected to follow the ACIP recommendations for administration.

### Hepatitis B Immune Globulin

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>90371</td>
<td>96372</td>
</tr>
</tbody>
</table>

Providers must document in the client’s medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service.

Intramuscular hepatitis B immune globulin (HBIg) may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC.

Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code V0179.

Only one HBIg procedure code will be paid if billed with the same date of service by the same provider as any other HBIg procedure code.

Procedure codes 96372 and 96374 may be reimbursed for HBIg administration. Providers are expected to follow the ACIP recommendations for administrations.

### Hib

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90647*</td>
</tr>
</tbody>
</table>

### Human Papilloma (HPV)

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90649*</td>
</tr>
</tbody>
</table>

### Influenza

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90654</td>
</tr>
<tr>
<td>90660*</td>
</tr>
</tbody>
</table>

Influenza vaccine is a benefit of Texas Medicaid for high-risk clients who are not covered by THSteps or TVFC or when the vaccine is not declared available through the TVFC.

Texas Medicaid considers the influenza season in the United States to be October through the end of May.

### MMR and MMRV

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>90707*</td>
</tr>
</tbody>
</table>

The MMR vaccine (procedure code 90707) is a benefit of Texas Medicaid for high-risk females of childbearing age who are 21 years of age and older.

### Pneumococcal and Meningococcal

* Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.
8.2.37 Immunizations for Clients Who Are 21 Years of Age and Older

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary. Providers are expected to follow the ACIP recommendations for administration.

The following immunizations are identified and recommended by the ACIP as medically-necessary for clients who are 21 years of age and older (this list is not all-inclusive):

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>90669</th>
<th>90670*</th>
<th>90732*</th>
<th>90733</th>
<th>90734*</th>
</tr>
</thead>
</table>

The pneumococcal polysaccharide vaccine (procedure code 90732) is a benefit for Texas Medicaid clients who are not covered by the THSteps or TVFC programs.

The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. For high-risk clients, revaccination is recommended once in a lifetime five years after the initial dose. Revaccination after a second dose is not a benefit of Texas Medicaid.

Pneumococcal polysaccharide vaccine is not recommended for children who are birth through 23 months of age.

Providers are expected to follow the ACIP recommendations for administrations.

Poliovirus (IPV)

90713*

Rotavirus

90680* 90681*

Tetanus and Diphtheria

90696* 90698* 90700* 90702* 90703 90714* 90715* 90718* 90721* 90723*

Unlisted

90749

Varicella Virus

90716*

* Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.
The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code.

**Immunization Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90371</td>
<td>Hepatitis B Immune Globulin</td>
</tr>
<tr>
<td>96372</td>
<td></td>
</tr>
<tr>
<td>96374</td>
<td></td>
</tr>
<tr>
<td>J1571</td>
<td></td>
</tr>
<tr>
<td>J1573</td>
<td></td>
</tr>
</tbody>
</table>

Providers must document in the client’s medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service.

Intramuscular HBIG may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIG is not provided through TVFC.

Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code V0179.

Only one HBIG procedure code will be paid if billed with the same date of service by the same provider as any other HBIG procedure code.

Procedure codes 96372 and 96374 may be reimbursed for HBIG administration.

**Hepatitis A and B**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90636</td>
<td>Hepatitis A and B</td>
</tr>
<tr>
<td>90649</td>
<td>Human Papilloma (HPV)</td>
</tr>
<tr>
<td>90650</td>
<td></td>
</tr>
</tbody>
</table>

**Influenza**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90654</td>
<td>Influenza vaccine</td>
</tr>
<tr>
<td>90655</td>
<td></td>
</tr>
<tr>
<td>90656</td>
<td></td>
</tr>
<tr>
<td>90657</td>
<td></td>
</tr>
<tr>
<td>90658</td>
<td></td>
</tr>
</tbody>
</table>

Influenza vaccine is a benefit of Texas Medicaid for all clients.

Texas Medicaid considers the influenza season in the United States to be October through the end of May. The optimal time to receive influenza vaccine is as early in the season as it is available. However, clients should continue to receive influenza vaccine through March. The vaccine may be administered one time per influenza season.

**Measles, Mumps, Rubella Vaccine (MMR)**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90707</td>
<td>MMR vaccine</td>
</tr>
</tbody>
</table>

MMR vaccine is a benefit of Texas Medicaid for high-risk females of child-bearing age who are 21 years of age and older.

**Pneumococcal Polysaccharide Vaccine**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90732</td>
<td>The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. Revaccination is recommended five years (not interpreted to mean every five years) after the initial dose for high-risk individuals. Revaccination after a second dose is not reimbursed.</td>
</tr>
</tbody>
</table>

**Tetanus**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90703</td>
<td>Tetanus</td>
</tr>
<tr>
<td>90714</td>
<td></td>
</tr>
<tr>
<td>90715</td>
<td></td>
</tr>
<tr>
<td>90718</td>
<td></td>
</tr>
</tbody>
</table>
8.2.38 Postexposure Prophylaxis for Rabies
Postexposure prophylaxis for rabies procedure codes 90375, 90376, and 90675 is a benefit of Texas Medicaid. Rabies vaccine for pre-exposure procedure code 90676 is not a benefit of Texas Medicaid.

Postexposure rabies vaccine is limited to clients with diagnosis code V015.

Animal bites to people must be reported as soon as possible to the Local Rabies Control Authority (LRCA).

Postexposure prophylaxis for rabies is not necessary following exposure to an animal that tests negative for the rabies virus.

An exposed person who has never received a complete pre- or postexposure rabies vaccine series will first receive a dose of rabies immune globulin (HRIG). This is a blood product that contains antibodies against rabies and gives immediate, short-term protection. The injection should be given in or near the wound area.

HRIG that is not administered when vaccination begins can be administered up to seven days after the administration of the first dose of vaccine. Beyond the seventh day, HRIG is not recommended since an antibody response to the vaccine is presumed to have occurred, and HRIG may inhibit the immune response to the vaccine.

The recommended dose of HRIG is 20 IU/kg body weight. This formula is applicable to all age groups, including children.

The postexposure treatment will also include five doses of rabies vaccine (1.0 ml. intramuscular). The first dose should be given as soon as possible after the exposure (day 0). Additional doses should be given on days 3, 7, 14, and 28 after the first shot. For an exposed person who has previously been vaccinated with a complete pre- or postexposure vaccine series, two doses of rabies vaccine should be given on days 0 and 3.

Health care providers, who determine their client requires the preventative rabies vaccination series after valid rabies exposure, may obtain the biologicals directly from the manufacturer or through one of the DSHS depots around the state.

Injection administration is a benefit for administration of rabies vaccine for post exposure.

8.2.38.1 Prior Authorization for Postexposure Rabies Vaccine
Prior authorization is not required for postexposure rabies vaccine. The physician must maintain documentation of the exposure in the client’s medical record.

8.2.38.2 Limitations for Postexposure Rabies Vaccine
Reimbursement for postexposure rabies vaccine is limited to one per client per day, by any provider.

Reimbursement for postexposure rabies vaccine is limited to 5 occurrences per 90 rolling days. Claims billed for any vaccine given beyond 90 rolling days will be denied.

8.2.38.2.1 Obtaining Rabies Vaccine and HRIG from DSHS for PEP Use
Providers may obtain the vaccine and HRIG directly from the manufacturer. If a provider is not able to obtain the vaccine and/or HRIG directly, providers may contact DSHS local or state public health professionals.

For each potential rabies exposure, providers must consult with their local health department or the DSHS regional ZC program office that serves their area. Requests for consultations made to DSHS after-hours or on holidays should be directed to the DSHS On-Call Physician at 1-888-963-7111.

Local public health professionals or regional ZC staff will help providers determine whether or not the exposure situation warrants PEP. If the exposure situation is determined to be valid, providers will be given detailed information about how to obtain rabies vaccine and HRIG for the patient.
Providers can refer to the following DSHS web pages for the contact information of local public health professionals:

- Full Service Local Health Departments and Districts of Texas at www.dshs.state.tx.us/regions/lhds.shtm
- Zoonosis Control Branch at www.dshs.state.tx.us/idcu/health/zoonosis/contact/
- DSHS rabies website at www.dshs.state.tx.us/idcu/disease/Rabies/
- Regional DSHS ZC offices
- "Human Rabies Prevention—United States, 2008 Recommendations of the Advisory Committee on Immunization Practices"
- CDC rabies website at www.cdc.gov/rabies/

8.2.39 Medications - Injectable

Providers are responsible for administering drugs based on the FDA-approved guidelines. In the absence of FDA indications, a drug needs to meet the following criteria:

- The drug is recognized by the American Medical Association Drug Evaluations (AMA-DE), American Hospital Formulary Service Drug Information, the U.S. Pharmacopoeia Dispensing Information, Volume I, or two articles from major peer-reviewed journals that have validated and uncontested data supporting the proposed use for the specific medical condition as safe and effective.
- It is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic and seriously debilitating conditions.
- The off-label use of the drug is not investigational or experimental.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

Injections given in the physician’s office, the client’s home, or the nursing home may be reimbursed using the correct procedure code for the specific drug and dosage given. The following injections are benefits of Texas Medicaid and are subject to the indicated limitations:

<table>
<thead>
<tr>
<th>Injected Drug</th>
<th>Procedure Code(s)</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adalimumab</td>
<td>J0135</td>
<td>Benefit for clients who are 18 years of age and older. Diagnosis limitations: 5550, 5551, 5552, 5559, 6960, 7140, 7141, 7142</td>
</tr>
<tr>
<td>Azacitidine (Vidaza)</td>
<td>J9025</td>
<td>Restricted to clients who are 13 years of age and older. Diagnosis limitations: 20502, 20510, 20512, 20522, 20532, 20582, 20592, 23872, 23873, 23874, 23875, 2850</td>
</tr>
</tbody>
</table>

(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.
<table>
<thead>
<tr>
<th>Injected Drug</th>
<th>Procedure Code(s)</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cladribine (Leustatin)</td>
<td>J9065</td>
<td>Diagnosis limitations: 20240, 20241, 20242, 20243, 20244, 20245, 20246, 20247, 20248, 20270, 20271, 20272, 20273, 20274, 20275, 20276, 20277, 20278</td>
</tr>
<tr>
<td>Denileukin diftitox (Ontak)</td>
<td>J9160</td>
<td>Benefit for clients who have advanced or recurrent cutaneous T-cell lymphoma with the CD25 component of IL-2 and failure of at least one type of traditional therapy. Documentation of diagnosis and treatment must be submitted with the claim.</td>
</tr>
<tr>
<td>Galsulfase</td>
<td>J1458</td>
<td>Diagnosis limitation: 2775</td>
</tr>
<tr>
<td>Granisetron hydrochloride</td>
<td>J1626</td>
<td>Diagnosis limitations: V580, V5811, V5812, V661, or V662</td>
</tr>
<tr>
<td>Ibutilide fumarate</td>
<td>J1742</td>
<td>Diagnosis limitations: 42731 or 42732</td>
</tr>
<tr>
<td>Idursulfase (Elaprase)</td>
<td>J1743</td>
<td>Diagnosis limitation: 2775</td>
</tr>
<tr>
<td>Infliximab (Remicade)</td>
<td>J1745</td>
<td>Diagnosis limitations: 5550, 5551, 5552, 5559, 5560, 5561, 5562, 5563, 5565, 5566, 5568, 5569, 5611, 56981, 6960, 6961, 7140, 7141, 7142, 71430, or 7200 Documentation supporting the client’s inadequate response to methotrexate-only therapy must be maintained in the client’s file. The documentation is subject to retrospective review.</td>
</tr>
<tr>
<td>Iron Dextran</td>
<td>J1750</td>
<td>Treatment may be indicated for, but is not limited to, the following condition: Iron deficiency anemia when oral administration is unsatisfactory or impossible.</td>
</tr>
<tr>
<td>Iron Sucrose (Venofer)</td>
<td>J1756</td>
<td>Treatment may be indicated for, but is not limited to, the following conditions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Non-dialysis-dependent chronic kidney disease (NDD-CKD) for clients who are receiving erythropoietin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NDD-CKD for clients who are not receiving erythropoietin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hemodialysis-dependent chronic kidney disease (HDD-CKD) for clients who are receiving erythropoietin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Peritoneal dialysis-dependent chronic kidney disease (PDD-CKD) clients who are receiving erythropoietin.</td>
</tr>
<tr>
<td>Melaphalan</td>
<td>J9245</td>
<td>Diagnosis limitations: 1740, 1741, 1742, 1743, 1744, 1745, 1746, 1748, 1749, 1750, 1759, 1830, 1860, 1869, 20300, or 20301</td>
</tr>
<tr>
<td>Natalizmab</td>
<td>J2323</td>
<td>Diagnosis limitations: 340, 5550, 5551, 5552, or 5559</td>
</tr>
<tr>
<td>Porfimer (Photofrin)</td>
<td>J9600</td>
<td>Diagnosis limitations: 1500, 1501, 1502, 01503, 1504, 1505, 1508, 1509, or 1978</td>
</tr>
</tbody>
</table>

(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.
Important: The 11-digit National Drug Code (NDC) must be submitted on the claim with the appropriate procedure code. The NDC submitted to Texas Medicaid must be the NDC on the package or container from which the medication was administered.

Refer to: Subsection 6.3.4, “National Drug Code (NDC),” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about filing claims with the NDC.

Note: Physicians billing for injections, either intramuscular (IM) or subcutaneous (SQ) or intravenous administration (IV) in the inpatient hospital setting, skilled nursing facility or outpatient hospital will be denied, as these costs are included in the reimbursement methodology of the inpatient facility, skilled nursing facility, or the outpatient facility.

Refer to: Subsection 2.2.1.3, “* Drugs and Biologicals,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for the reimbursement methodology for injections.

### 8.2.39.1 Abatacept (Orencia)

Abatacept is a benefit of Texas Medicaid for clients who have moderately to severely active rheumatoid arthritis. These clients may also have an inadequate response to one or more non-biological, disease-modifying antirheumatic drugs (DMARDs).

#### 8.2.39.1.1 Prior Authorization for Abatacept (Orencia)

Providers must obtain prior authorization for procedure code J0129 to request reimbursement for abatacept. The prior authorization requests must include medical necessity documentation that contains the following information:

- Dates of treatment

<table>
<thead>
<tr>
<th>Injected Drug</th>
<th>Procedure Code(s)</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium Ferric Gluconate Complex in Sucrose (Ferrlecit)</td>
<td>J2916</td>
<td>Treatment may be indicated for, but is not limited to the following condition: Iron deficiency anemia in clients who are six years of age and older who are undergoing long term hemodialysis treatments and who are receiving supplemental epoetin therapy.</td>
</tr>
<tr>
<td>Sumatriptan succinate (Imitrex)</td>
<td>J3030</td>
<td>Diagnosis limitations: 34600, 34601, 34610, 34611, 34620, 34621, 34680, 34681, 34690, or 34691</td>
</tr>
<tr>
<td>Thyrotropin alpha for injection (Thyrogen)</td>
<td>J3240</td>
<td>Diagnosis limitations: 1613, 193, 2310, 2348, 2356, 2374, 2397, 2409, 24200, 24220, or V1087</td>
</tr>
<tr>
<td>Topotecan</td>
<td>J9350</td>
<td>Diagnosis limitations: 1588, 1589, 1623, 1624, 1625, 1628, 1629, 1800, 1801, 1808, 1809, 1830, 1970, 1986, or 19882</td>
</tr>
<tr>
<td>Valrubicin sterile solution for intravesical instillation (Valstar)</td>
<td>J9357</td>
<td>Benefit for clients with the diagnosis of bladder cancer in situ who have been treated unsuccessfully with BCG therapy and have an unacceptable morbidity or mortality risk if immediate cystectomy should be performed. Documentation of diagnosis and treatment must be submitted with the claim.</td>
</tr>
</tbody>
</table>

(Diagnosis limitations) The procedure code must be billed with one of the diagnosis codes listed.
- Diagnosis of adult RA or juvenile idiopathic arthritis (JIA)

  **Note:** A diagnosis of adult RA must conform to the American College of Rheumatology (ACR) RA classification that requires the following:

  - Presence of synovitis in at least one joint
  - Absence of an alternative diagnosis to explain the synovitis
  - A combined score of at least six out of ten on the level of involved joints, abnormality, and symptom duration from the individual scores in four domains:
    - The number and sites of involved joints
    - Serologic abnormality
    - Elevated acute-phase response
    - Symptom duration
  - The number of anticipated doses
  - The dosage to be administered

  Prior authorization for an initial request for abatacept injections may be granted for six months for eight doses. Prior authorization will be considered when the client has an inadequate response after 12 weeks to a nonbiological DMARD such as methotrexate or sulfasalazine or one or more biological (injectable) DMARDs, such as adalimumab, etanercept, or tumor necrosis factor (TNF) antagonists. The inadequate response must be indicated by all of the following commonly used prognostic factors:

  - Visual Analogue scale (VAS) (4 or greater on a pain scale from 0-10)
  - Global Arthritis Score (GAS) (3 or greater with remission defined as less than 3)
  - Health Assessment Questionnaire Disability Index (HAQDI) score (greater than 1)
  - Evidence of radiographic erosions
  - Elevated erythrocyte sedimentation rate (greater than 20 millimeters/hour)
  - Elevated C-reactive protein level (greater than zero milligrams/deciliter)
  - Elevated rheumatoid factor (RF) level (greater than 60 units/millimeter or a titer greater than 1:80 titer)
  - Elevated anti-cyclic citrullinated peptide (anti-CCP) antibody level (20 units/millimeter or greater)

  Prior authorization for a subsequent request must include all of the following:

  - Documentation from the physician stating that there has been at least a 20-percent improvement as defined by the ACR
  - The number of anticipated doses
  - The dosage to be administered

  Prior authorization for subsequent dosing may be given for a maximum of six doses when documentation supports medical necessity for continued treatment with abatacept.

  The documentation of medical necessity must be maintained by the requesting provider in the client's medical record and is subject to retrospective review.
Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail the prior authorization request to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization Department  
12357-B Riata Trace Parkway, Suite 150  
Austin, TX 78727  
Fax: 1-512-514-4213

8.2.39.2  *Alatrofloxacin Mesylate (Trovan)*

Texas Medicaid follows the recommendation of the FDA about the use of intravenous alatrofloxacin mesylate, (Trovan). Alatrofloxacin mesylate should be reserved for use only in the treatment of clients who meet all the following treatment criteria:

- Have at least one of the following infections judged by the treating physician to be serious and life-or limb-threatening:
  - Nosocomial pneumonia
  - Community-acquired pneumonia
  - Complicated intra-abdominal infections (including postsurgical infections)
  - Gynecologic and pelvic infections
  - Complicated skin and skin-structure infections (including diabetic foot infections)
- Receive initial therapy in an inpatient health-care facility
- The treating physician believes that, given the new safety information, the benefit of the product to the client outweighs the risk.

8.2.39.3  *Alglucosidase Alfa (Myozyme)*

Alglucosidase alfa is a benefit of Texas Medicaid for clients of any age who are diagnosed with glycogenosis, or Pompe disease (diagnosis code 2710).

8.2.39.3.1  *Prior Authorization for Alglucosidase Alfa (Myozyme)*

Providers must obtain prior authorization for procedure code J0220 or J0221 to request reimbursement for alglucosidase alfa. The prior authorization request must include medical necessity documentation that contains laboratory evidence of acid alpha-glucosidase (GAA) deficiency (i.e., below the laboratory-defined cutoff value as determined by the laboratory performing the GAA enzyme activity assay). Tissues used for the determination of GAA deficiency include blood, muscle, or skin fibroblasts.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail prior authorization requests, including all required documentation, to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization Department  
12357-B Riata Trace Parkway, Suite 150  
Austin, TX 78727  
Fax: 1-512-514-4213

8.2.39.4  *17-Alpha Hydroxyprogesterone Caproate*

17P-alpha hydroxyprogesterone caproate is a benefit of Texas Medicaid. 17P-alpha hydroxyprogesterone caproate, whether compounded or the trademarked drug is restricted to diagnosis code V2341, and is a benefit for clients who are 10 through 55 years of age.
8.2.39.4.1 Compounded 17P-alpha hydroxyprogesterone caproate

For 17P-alpha hydroxyprogesterone caproate that has been compounded by a pharmacy provider, prior authorization is not required, and providers are not required to include documentation that supports medical necessity with the claim; however, the provider must keep the documentation in the client’s medical record.

Providers must submit claims for a compounded drug using procedure code J1725.

8.2.39.4.2 Prior Authorization for Trademarked 17P-alpha hydroxyprogesterone caproate (Makena)

17P-alpha hydroxyprogesterone caproate (Makena) is a benefit when prior authorized. Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. Documentation supporting medical necessity must be submitted with the prior authorization request.

17P-alpha hydroxyprogesterone caproate (Makena) is indicated when all of the following criteria are met:

• The client’s treatment is initiated between 16 weeks, 0 days and 20 weeks, 6 days gestation.
• The client’s treatment may continue, as medically indicated, through 36 weeks, 6 days gestation or delivery, whichever occurs first.
• The client has a singleton pregnancy.
• The client has had a prior, singleton spontaneous preterm delivery before 37 weeks gestation.
• The provider lacks access to the compounded product, including, but not limited to, one of the following reasons:
  • There is no pharmacy within 50 miles that compounds 17P-alpha hydroxyprogesterone caproate.
  • There is no pharmacy delivery to the prescribing provider’s office.

Requests for initiation of the client’s treatment after 20 weeks, 6 days gestation, but before 24 weeks gestation, must be approved by the Medical Director and must include documentation to support the medical necessity of starting treatment at that stage of gestation.

17P-alpha hydroxyprogesterone caproate (Makena) is administered intramuscularly at a dose of 250 mg (1ml) once a week (every 7 days). Prior authorization requests must indicate the total number of doses to be administered during the pregnancy. The maximum prior authorized amount for Makena is 21 doses.

Prior authorization requests and claims for Makena must be submitted with procedure code J3490, modifier U1, and the NDC number. Claims submitted without the required information will be subject to retrospective review and recoupment.

Procedure code J3490 with modifier U1 (trademarked drug - Makena) will be manually priced at the average wholesale price less 10.5 percent.

8.2.39.5 Amifostine

Amifostine is a benefit of Texas Medicaid for the reduction of the cumulative renal toxicity associated with administration of cisplatin in clients who have advanced ovarian cancer or non-small cell lung cancer with documentation of a creatinine clearance of 50 or less and where no other chemotherapeutic agent can be used.

Amifostine may also be used to reduce the incidence of moderate-to-severe xerostomia in clients undergoing postoperative radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid glands.
Amifostine may be reimbursed for the following indications:

- Bone marrow toxicity
- Cisplatin- and cyclophosphamide-induced (prophylaxis)
- Advanced solid tumors
- Head and neck carcinoma
- Malignant lymphoma
- Non-small cell lung cancer
- Myelodysplastic syndromes
- Nephrotoxicity
- Advanced ovarian carcinoma
- Melanoma
- Advanced solid tumors of non-germ cell origin
- Neurotoxicity
- Reduction in the incidence of mucositis in clients receiving radiation therapy, or radiation combined with chemotherapy
- Reduction in the incidence of xerostomia associated with postoperative radiation treatment of head and neck cancer, where the radiation port includes a substantial portion of the parotid glands

Providers must use procedure code J0207 with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>101 1400 1401 1403 1404 1405 1406 1408 1409 1410</td>
</tr>
<tr>
<td>1411 1412 1413 1414 1415 1416 1418 1419 1420 1421</td>
</tr>
<tr>
<td>1422 1428 1429 1430 1431 1438 1439 1440 1441 1448</td>
</tr>
<tr>
<td>1449 1450 1451 1452 1453 1454 1455 1456 1458 1459</td>
</tr>
<tr>
<td>1460 1461 1462 1463 1464 1465 1466 1467 1468 1469</td>
</tr>
<tr>
<td>1470 1471 1472 1473 1478 1479 1480 1481 1482 1483</td>
</tr>
<tr>
<td>1488 1489 1490 1491 1498 1499 20000 20001 20002 20003</td>
</tr>
<tr>
<td>20004 20005 20006 20007 20008 20010 20011 20012 20013 20014</td>
</tr>
<tr>
<td>20015 20016 20017 20018 20020 20021 20022 20023 20024 20025</td>
</tr>
<tr>
<td>20026 20027 20028 20080 20081 20082 20083 20084 20085 20086</td>
</tr>
<tr>
<td>20087 20088 20100 20101 20102 20103 20104 20105 20106 20107</td>
</tr>
<tr>
<td>20108 20110 20111 20112 20113 20114 20115 20116 20117 20118</td>
</tr>
<tr>
<td>20120 20212 20122 20123 20124 20125 20126 20127 20128 20140</td>
</tr>
<tr>
<td>20141 20142 20143 20144 20145 20146 20147 20148 20150 20151</td>
</tr>
<tr>
<td>20152 20153 20154 20155 20156 20157 20158 20160 20161 20162</td>
</tr>
<tr>
<td>20163 20164 20165 20166 20167 20168 20170 20171 20172 20173</td>
</tr>
<tr>
<td>20174 20175 20176 20177 20178 20190 20191 20192 20193 20194</td>
</tr>
<tr>
<td>20195 20196 20197 20198 20200 20201 20202 20203 20204 20205</td>
</tr>
<tr>
<td>20206 20207 20208 20210 20211 20212 20213 20214 20215 20216</td>
</tr>
<tr>
<td>20217 20218 20220 20221 20222 20223 20224 20225 20226 20227</td>
</tr>
</tbody>
</table>
8.2.39.6 Antibiotics and Steroids

Injectable antibiotic or steroid medications may be considered for reimbursement even if the same oral medications are appropriate and available. Injected antibiotics or steroid medications, when used in place of oral medications, require the use of the modifier KX.

Physicians billing for injectable antibiotic and steroid medications must indicate the appropriate modifiers with the appropriate injection code and quantity:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>For acute conditions*</td>
</tr>
<tr>
<td>KX</td>
<td>To indicate any of the following:</td>
</tr>
<tr>
<td></td>
<td>• Oral route contraindicated or an acceptable oral equivalent is not available.</td>
</tr>
<tr>
<td></td>
<td>• Injectable medication is the accepted treatment of choice. Oral medication regimen has proven ineffective or is not applicable.</td>
</tr>
<tr>
<td></td>
<td>• The patient has a temperature over 102 degrees and a high level of antibiotic is needed immediately.</td>
</tr>
<tr>
<td></td>
<td>• Injection is medically necessary into joints, bursae, tendon sheaths, or trigger points to treat an acute condition or the acute flare-up of a chronic condition.</td>
</tr>
</tbody>
</table>

* If a steroid medication is injected into joints, bursae, tendon sheaths, or trigger points, modifier AT must be used to indicate an acute condition. When performed for a chronic condition, these procedures are denied.

8.2.39.7 Antihemophilic Factor

Reimbursement is available when the antihemophilic product is administered by or under physician supervision.

Reimbursement for the following antihemophilic factor procedure codes is limited to the diagnosis codes of coagulation defects, noted in the second table below:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1680</td>
</tr>
<tr>
<td>J7195</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2860</td>
</tr>
</tbody>
</table>
Procedure codes J7193 and J7195 must be billed with diagnosis code 2861 to be considered for reimbursement.

Procedure code J7189 must be billed with diagnosis code 2860, 2861, 2863, or 2869 to be considered for reimbursement. Reimbursement is available when the antihemophilic product is administered by or under physician supervision. Procedure code J7196 must be billed with diagnosis code 28981.

Procedure code J7180 must be billed with diagnosis code 2863 to be considered for reimbursement.

Procedure code J7183 must be billed with diagnosis code 2864 to be considered for reimbursement.

**8.2.39.8 Botulinum Toxin Type A and Type B**

Procedure code J0585 is a benefit when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3331 3332 3336 33371 33379 33381 33382 33383 33384 33385</td>
</tr>
<tr>
<td>33389 3341 340 3410 3411 3418 3419 34210 34211 34212</td>
</tr>
<tr>
<td>3430 3431 3432 3433 3434 3438 3439 34400 34401 34402</td>
</tr>
<tr>
<td>34403 34404 34409 3441 3442 34430 34431 34432 34440 34441</td>
</tr>
<tr>
<td>34442 3445 34461 34670 34671 34672 34673 37800 37801 37802</td>
</tr>
<tr>
<td>37803 37804 37805 37806 37807 37808 37809 37810 37811 37812</td>
</tr>
<tr>
<td>37813 37814 37815 37816 37817 37818 37820 37821 37822 37823</td>
</tr>
<tr>
<td>37824 37830 37831 37832 37833 37834 37835 37840 37841 37842</td>
</tr>
<tr>
<td>37843 37844 37845 37850 37851 37852 37853 37854 37855 37856</td>
</tr>
<tr>
<td>37860 37861 37862 37863 37871 37872 37873 37881 37882 37883</td>
</tr>
<tr>
<td>37884 37885 37886 37887 3789 43820 43821 43822 43830 43831</td>
</tr>
<tr>
<td>43832 43840 43841 43842 43850 43851 43852 43853 43889 47875</td>
</tr>
<tr>
<td>5277 5300 5650 59654 7235 72871 72885 78442 78449</td>
</tr>
</tbody>
</table>

Procedure code J0586 is a benefit when billed with one of the following diagnosis codes.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3336 33381 33382 33383 33384 33389 3341 340 3410 3411</td>
</tr>
<tr>
<td>3418 3419 34210 34211 34212 3430 3431 3432 3433 3434</td>
</tr>
<tr>
<td>3438 3439 47875 7235 72871 72885</td>
</tr>
</tbody>
</table>

Procedure code J0587 is a benefit when billed with diagnosis code 33383 or 5277.

Procedure code J0588 is a benefit when billed with diagnosis code 33381, 33383, 34210, 34211, or 34212.

Claims for botulinum toxin type A and B must indicate the number of units used. If the number of units is not specified, the claim will be paid a quantity of one. Claims that exceed the following quantity limitations, per day, may be considered on appeal with documentation of medical necessity:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Quantity Limitations of Medication</th>
<th>Billing Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0585</td>
<td>360 units</td>
<td>One billing unit is equal to 1 unit of medication. <strong>Example:</strong> A provider that administers 360 units of medication would submit a claim for a quantity of 360.</td>
</tr>
</tbody>
</table>
If a client is administered botulinum toxins more frequently than every 12 weeks, the claims must be submitted with documentation of medical necessity that justifies why the medication was given at an interval sooner than 12 weeks. The following documentation must be included in the client’s medical record:

- Support for the medical necessity of the botulinum toxin injection
- A covered diagnosis
- Dosage and frequency of the injections
- Support for the clinical effectiveness of the injections
- Specific site(s) injected

All documentation is subject to retrospective review.

Procedures that are billed in conjunction with botulinum toxin injections are subject to current reimbursement guidelines. Any supplies billed by the physician for the administration of botulinum toxin type A or type B are not paid separately. Only the actual amount of drug that is administered is a benefit of Texas Medicaid. Providers cannot submit claims for discarded amounts of botulinum toxin drugs.

Procedure code J0588 will be denied when it is billed with procedure code J0585 or J0586.

Procedure code J0587 will be denied when it is billed with procedure code J0585, J0586, or J0588.

Procedure code J0586 will be denied when it is billed with procedure code J0585.

### 8.2.39.9 Chelating Agents

Chelating agent procedure codes J0470, J0600, J0895, and J3520 are benefits of Texas Medicaid.

#### 8.2.39.9.1 Dimercaprol

Procedure code J0470 is a benefit when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9840</td>
</tr>
</tbody>
</table>

#### 8.2.39.9.2 Edetate calcium disodium

Procedure code J0600 is a benefit when billed with one of the following diagnosis codes: 9840, 9841, 9848, 9849, or 9858.
8.2.39.9.3 Deferoxamine mesylate (Desferal)

Procedure code J0895 must be billed with one of the following diagnosis codes to be considered for reimbursement of deferoxamine mesylate:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0470</td>
</tr>
<tr>
<td>28264</td>
</tr>
<tr>
<td>586</td>
</tr>
</tbody>
</table>

8.2.39.9.4 Edetate disodium

Procedure code J3520 is a benefit when billed with diagnosis code 27542 or 9721.

Procedure codes J0470, J0600, J0895, and J3520 are denied if they are billed with diagnosis codes other than the codes listed above.

8.2.39.10 Clofarabine

Clofarabine is used for the treatment of relapsed or refractory acute lymphoblastic leukemia. Clofarabine is administered by IV infusion once daily for five days and is repeated every two to six weeks, as needed.

8.2.39.10.1 Prior Authorization for Clofarabine

Prior authorization is required for treatment with clofarabine (procedure code J9027) and may be granted for a maximum of six weeks.

Clofarabine may be prior authorized for the treatment of relapsed or refractory acute lymphoblastic leukemia (diagnosis code 20400). The following criteria apply to requests for prior authorization:

- The number of anticipated injections needed as well as the dosage per injection must be submitted with the request for prior authorization.
- Prior authorization must be obtained before services are rendered whenever possible. If authorization cannot be obtained prior to the rendering of the service, the authorization request must be submitted within three business days from the date the treatment is initiated.

Prior authorization requests may be considered with documentation of both of the following:

- A diagnosis of refractory or relapsed acute lymphoblastic leukemia (diagnosis code 20400)
- A history of at least two prior failed chemotherapy regimens

The prior authorization number must be included on the claim along with the number of units, based on the dosage given.

Failure to place the prior authorization number on the claim or to obtain prior authorization within the allotted timeframe will result in denied claims.

8.2.39.11 Colony Stimulating Factors (Filgrastim, Pegfilgrastim, and Sargramostim)

Colony stimulating factors (CSFs) are growth factors (glycoproteins) that support survival, clonal expansion and differentiation of blood forming cells and are a benefit of Texas Medicaid. CSFs reduce the likelihood of neutropenic complications due to chemotherapy and bone marrow transplant. Filgrastim (procedure codes J1440 and J1441) and pegfilgrastim (procedure code J2505) are granulocyte colony stimulating factors (G-CSFs). Sargramostim (procedure code J2820) is a granulocyte-macrophage colony stimulating factor (GM-CSF). GM-CSF and G-CSF stimulate neutrophil production after autologous bone marrow transplant and significantly reduce the duration and impact of neutropenia.

To submit claims for reimbursement of colony stimulating factors, providers must submit the most appropriate procedure code with the number of units administered.
One of the following diagnosis codes must be billed with the appropriate procedure code:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1400 1401 1403 1404 1405 1406 1408 1409 1410 1411</td>
</tr>
<tr>
<td>1412 1413 1414 1415 1416 1418 1419 1420 1421 1422</td>
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<tr>
<td>1428 1429 1430 1431 1438 1439 1440 1441 1448 1449</td>
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<tr>
<td>1450 1451 1452 1453 1454 1455 1456 1458 1459 1460</td>
</tr>
<tr>
<td>1461 1462 1463 1464 1465 1466 1467 1468 1469 1470</td>
</tr>
<tr>
<td>1471 1472 1473 1478 1479 1480 1481 1482 1483 1488</td>
</tr>
<tr>
<td>1489 1490 1491 1498 1499 1500 1501 1502 1503 1504</td>
</tr>
<tr>
<td>1505 1508 1509 1510 1511 1512 1513 1514 1515 1516</td>
</tr>
<tr>
<td>1518 1519 1520 1521 1522 1523 1528 1529 1530 1531</td>
</tr>
<tr>
<td>1532 1533 1534 1535 1536 1537 1538 1539 1540 1541</td>
</tr>
<tr>
<td>1542 1543 1548 1550 1551 1552 1560 1561 1562 1568</td>
</tr>
<tr>
<td>1569 1570 1571 1572 1573 1574 1578 1579 1580 1588</td>
</tr>
<tr>
<td>1589 1590 1591 1598 1599 1600 1601 1602 1603 1604</td>
</tr>
<tr>
<td>1605 1608 1609 1610 1611 1612 1614 1618 1619 1620</td>
</tr>
<tr>
<td>1622 1623 1624 1625 1628 1629 1630 1631 1638 1639</td>
</tr>
<tr>
<td>1640 1641 1642 1643 1648 1649 1650 1658 1659 1700</td>
</tr>
<tr>
<td>1701 1702 1703 1704 1705 1706 1707 1708 1709 1710</td>
</tr>
<tr>
<td>1712 1713 1714 1715 1716 1717 1718 1719 1720 1721</td>
</tr>
<tr>
<td>1722 1723 1724 1725 1726 1727 1728 1729 1730 1731</td>
</tr>
<tr>
<td>1732 1733 1734 1735 1736 1737 1738 1739 1740 1741</td>
</tr>
<tr>
<td>1742 1743 1744 1745 1746 1748 1749 1750 1759 1760</td>
</tr>
<tr>
<td>1761 1762 1763 1764 1765 1768 1769 179 1800 1801</td>
</tr>
<tr>
<td>1808 1809 181 1820 1821 1828 1830 1832 1833 1834</td>
</tr>
<tr>
<td>1835 1838 1839 1840 1841 1842 1843 1844 1848 1849</td>
</tr>
<tr>
<td>185 1860 1869 1871 1872 1873 1874 1875 1876 1877</td>
</tr>
<tr>
<td>1878 1879 1880 1881 1882 1883 1884 1885 1886 1887</td>
</tr>
<tr>
<td>1888 1889 1890 1891 1892 1893 1894 1898 1899 1900</td>
</tr>
<tr>
<td>1901 1902 1903 1904 1905 1906 1907 1908 1909 1910</td>
</tr>
<tr>
<td>1911 1912 1913 1914 1915 1916 1917 1918 1919 1920</td>
</tr>
<tr>
<td>1921 1922 1923 1928 1929 193 1940 1941 1943 1944</td>
</tr>
<tr>
<td>1991 1992 20000 20001 20002 20003 20004 20005 20006 20007</td>
</tr>
<tr>
<td>20008 20010 20011 20012 20013 20014 20015 20016 20017 20018</td>
</tr>
<tr>
<td>20020 20021 20022 20023 20024 20025 20026 20027 20028 20030</td>
</tr>
<tr>
<td>20031 20032 20033 20034 20035 20036 20037 20038 20040 20041</td>
</tr>
<tr>
<td>20042 20043 20044 20045 20046 20047 20048 20050 20051 20052</td>
</tr>
</tbody>
</table>
Procedure code J2505 is not reimbursed when submitted with the same date of service as procedure code J1440 or J1441.
8.2.39.12 Hematopoietic Injections

Hematopoietic agents erythropoietin alfa or epoetin alfa (EPO) and darbepoetin alfa are benefits of Texas Medicaid and reimbursed using procedure codes J0881, J0882, J0885, J0886, and Q2047 and an appropriate diagnosis code.

Providers must maintain medical records in their offices that document regular monitoring of hemoglobin or hematocrit levels and explain the rationale for the dosing of epoetin alfa and darbepoetin alfa. These records are subject to retrospective review to determine appropriate utilization and reimbursement for this service.

When billing procedure code J0882 or J0886, providers must submit the client’s most recent dated hemoglobin or hematocrit levels in the comments section of the claim form.

EPO and darbepoetin alfa injections are limited to specific diagnosis codes as indicated in this section.

8.2.39.12.1 Epoetin Alfa (EPO)

EPO (procedure codes J0885, J0886, and Q2047) is a glycoprotein that stimulates the formation of red blood cells and the production of the precursor red blood cells of the bone marrow. EPO is indicated for:

- Anemia associated with chronic renal failure (CRF), including clients on dialysis (end-stage renal disease or ESRD) and clients not on dialysis.
- Anemia related to therapy with zidovudine (AZT) in HIV-infected clients.
- Anemia due to the effects of concomitantly administered chemotherapy in clients who have non-myeloid malignancies.
- Anemia of prematurity.
- Clients scheduled to undergo elective noncardiac, nonvascular surgery to decrease need for allogenic blood transfusion.

Procedure code J0885 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>042 20300 20301 20302 23872 23873 23874 23875 23876 23879</td>
</tr>
<tr>
<td>28489 28521 28522 2853 2858 2859 5851 5852 5853 5854</td>
</tr>
<tr>
<td>5855 5856 5859 586 7766</td>
</tr>
</tbody>
</table>

Procedure code J0886 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>28521 5851 5852 5853 5854 5855 5856 5859 586</td>
</tr>
</tbody>
</table>

Procedure code Q2047 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>28521 5851 5852 5853 5854 5855 5856 5859</td>
</tr>
</tbody>
</table>

EPO may be considered for reimbursement when the dose is titrated consistent with prevailing, evidence-based clinical guidelines, as published by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative, including appropriate monitoring of the rise and fall of the hemoglobin or hematocrit levels.

EPO is limited to three injections per calendar week (Sunday through Saturday).
8.2.39.12.2 Darbepoetin Alfa

Darbepoetin alfa (procedure codes J0881 and J0882) is an erythropoiesis-stimulating protein closely related to erythropoietin. Darbepoetin stimulates erythropoiesis by the same mechanism as EPO. Darbepoetin alfa has approximately a three-fold longer half-life than EPO, resulting in a sustained erythropoietic effect and less frequent dosing. Darbepoetin alfa is indicated for:

- Treatment of anemia associated with chronic renal failure (CRF), including clients on dialysis and clients not on dialysis.
- Treatment of anemia in clients who have non-myeloid malignancies where anemia is due to the effect of chemotherapy.

Procedure code J0881 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20300</td>
</tr>
<tr>
<td>5851</td>
</tr>
</tbody>
</table>

Procedure code J0882 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>28521</td>
</tr>
</tbody>
</table>

Darbepoetin is limited to 100 units per day (100 mcg). Darbepoetin should be administered as follows:

- Once a week if the client was receiving EPO two to three times weekly
- Once every two weeks if the client was receiving EPO once a week

8.2.39.13 Fluocinolone Acetonide (Retisert)

Procedure code J7311 is a benefit of Texas Medicaid for clients of all ages.

Procedure code J7311 is only considered for reimbursement with a posterior uveitis diagnosis (36320) of more than six months in duration and only when the condition has been unresponsive to oral or systemic medication treatment. Prior authorization is required.

To request prior authorization, providers must submit requests to the Special Medical Prior Authorization Department by fax at (512) 514-4213.

8.2.39.14 Immune Globulin

Immune globulins may be indicated for treatment of certain immune disorders and states of immunodeficiency. The following immune globulin procedure codes are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90284</td>
</tr>
<tr>
<td>J1568</td>
</tr>
</tbody>
</table>

*Note: Procedure codes 90291 and J0850 may only be reimbursed when billed with diagnosis code V420, V421, V426, V427, or V4283.*

8.2.39.15 Medroxyprogesterone Acetate (Depo Provera)

Medroxyprogesterone acetate injectable suspension (Depo-Provera) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate given at 90-day intervals has been proven to be a long-term method of preventing pregnancy. Medroxyprogesterone acetate injectable suspension is reimbursed by Texas Medicaid to providers of family planning services.
Medroxyprogesterone acetate must be billed using procedure code J1055 and one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
</tbody>
</table>


### 8.2.39.16 Immunosuppressive Drugs

The following procedure codes are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0215</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Conditions</th>
</tr>
</thead>
</table>
| J0215          | **Plaque psoriasis:**  
Treatment of adult clients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy. |
| J0257          | **Alpha-1 proteinase inhibitor deficiency:**  
For the treatment of clients who have a deficiency of the alpha-1 proteinase inhibitor enzyme (also known as alpha-1 antitrypsin deficiency) in the treatment of emphysema. |
| J0480          | **Organ rejection:**  
For the prophylaxis of acute organ rejection in patients receiving renal transplantation when used as part of an immunosuppressive regimen that includes cyclosporine and corticosteroids. |
| J0490          | **Systemic lupus erythematosus (SLE):**  
For use in clients with moderate to severe SLE when other forms of treatment have failed to control moderate to severe symptoms |
| J1595          | **Multiple sclerosis (MS):**  
For the reduction of the frequency of relapses in clients with relapsing remitting MS, including clients who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS. |
| J7501          | **Renal homotransplantations:**  
Adjunct for the prevention of rejection in renal homotransplantation. |
| J7505          | **Renal allograft rejection:**  
Cardiac/hepatic allograft rejection. |
Oral, self-administered immunosuppressive drugs may be reimbursed for Medicaid fee-for-service clients through the Medicaid Vendor Drug Program (VDP).

Refer to: Subsection 8.2.40, “Medications - Oral,” in this handbook for more information about oral self-administered drugs.

Authorization is not required for immunosuppressive drugs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

8.2.39.17 Interferon

The following interferon procedure codes are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Condition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7513</td>
<td>Daclizumab is indicated for the prophylaxis of acute organ rejection in clients receiving renal transplants, to be used as a part of an immunosuppressive regimen that includes cyclosporine and corticosteroids.</td>
</tr>
<tr>
<td>J7516</td>
<td>Allogeneic transplants: For prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplants.</td>
</tr>
<tr>
<td>J7525</td>
<td>Organ rejection prophylaxis: For the prophylaxis of organ rejection in clients receiving allogeneic liver, kidney, or heart transplants.</td>
</tr>
</tbody>
</table>

Note: Oral, self-administered immunosuppressive drugs may be reimbursed for Medicaid fee-for-service clients through the Medicaid Vendor Drug Program (VDP).

Refer to: Subsection 8.2.40, “Medications - Oral,” in this handbook for more information about oral self-administered drugs.

Authorization is not required for immunosuppressive drugs.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

8.2.39.17 Interferon

The following interferon procedure codes are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Condition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7513</td>
<td>Daclizumab is indicated for the prophylaxis of acute organ rejection in clients receiving renal transplants, to be used as a part of an immunosuppressive regimen that includes cyclosporine and corticosteroids.</td>
</tr>
<tr>
<td>J7516</td>
<td>Allogeneic transplants: For prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplants.</td>
</tr>
<tr>
<td>J7525</td>
<td>Organ rejection prophylaxis: For the prophylaxis of organ rejection in clients receiving allogeneic liver, kidney, or heart transplants.</td>
</tr>
</tbody>
</table>

The following procedure codes may be indicated for, but are not limited to, treatment of the conditions listed below:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Condition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1826, J1830, Q3025, and Q3026</td>
<td>Relapsing forms of multiple sclerosis</td>
</tr>
<tr>
<td>J9212</td>
<td>Chronic hepatitis C virus</td>
</tr>
<tr>
<td>J9213</td>
<td>AIDS-related Kaposi sarcoma</td>
</tr>
<tr>
<td></td>
<td>Chronic hepatitis C virus</td>
</tr>
<tr>
<td></td>
<td>Chronic myelogenous leukemia</td>
</tr>
<tr>
<td></td>
<td>Hairy cell leukemia</td>
</tr>
<tr>
<td></td>
<td>Metastatic melanoma</td>
</tr>
<tr>
<td></td>
<td>Renal cell carcinoma</td>
</tr>
</tbody>
</table>
### Note:
Pegylated interferons are self-administered weekly and are available through Texas Medicaid Vendor Drug Program for Medicaid fee-for-service clients.

#### 8.2.39.18 Joint Injections and Trigger Point Injections

Procedure codes 20600, 20605, 20610, and 20612 must be used to submit claims for injections into joints.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Condition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9214 (Continued)</td>
<td>Melanoma</td>
</tr>
<tr>
<td></td>
<td>Multiple myeloma</td>
</tr>
<tr>
<td></td>
<td>Mycosis fungoides</td>
</tr>
<tr>
<td></td>
<td>Non-Hodgkin’s lymphoma</td>
</tr>
<tr>
<td></td>
<td>Ovarian and cervical carcinoma</td>
</tr>
<tr>
<td></td>
<td>Papilloma viruses</td>
</tr>
<tr>
<td></td>
<td>Polycythemia vera</td>
</tr>
<tr>
<td></td>
<td>Renal cell carcinoma</td>
</tr>
<tr>
<td></td>
<td>Rhinoviruses</td>
</tr>
<tr>
<td></td>
<td>Varicella zoster</td>
</tr>
<tr>
<td>J9215</td>
<td>Condylomata acuminata</td>
</tr>
<tr>
<td>J9216</td>
<td>Chronic granulomatous disease</td>
</tr>
<tr>
<td></td>
<td>Malignant osteoporosis</td>
</tr>
</tbody>
</table>
Procedure codes 20526, 20550, 20551, 20552, and 20553 must be used to submit claims for trigger point injections.

These procedures are valid only in the treatment of acute problems. Procedures billed for reimbursement with chronic diagnosis codes are denied. The provider must use the AT modifier to indicate an acute condition. The cost of the injection does not include the drugs used. The drug can be reimbursed separately.

Multiple joint injections may be reimbursed when billed with the same date of service if the claim indicates the specific site of each injection. The first injection or aspiration is reimbursed at the full profile allowance and any subsequent injections are reimbursed at half allowance.

8.2.39.19 Leuprolide Acetate (Lupron Depot)

Procedure codes J9217, J1950, J9218, or J9219 may be reimbursed for leuprolide acetate injections with the following limitations:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1950</td>
<td>Reimbursed once per month</td>
</tr>
<tr>
<td>J9219</td>
<td>Reimbursed once per year</td>
</tr>
</tbody>
</table>

Procedure code J9217 may be reimbursed in monthly, three-month, four-month, and six-month doses as follows:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Dosage</th>
<th>Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>7.5 mg</td>
<td>Billed with a quantity of 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once per month</td>
</tr>
<tr>
<td>3-month</td>
<td>22.5 mg</td>
<td>Billed with a quantity of 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once every three months</td>
</tr>
<tr>
<td>4-month</td>
<td>30 mg</td>
<td>Billed with a quantity of 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once every 4 months</td>
</tr>
<tr>
<td>6-month</td>
<td>45 mg</td>
<td>Billed with a quantity of 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reimbursed once every 6 months</td>
</tr>
</tbody>
</table>

The total dosage allowed within a 6-month period is 45 mg.

8.2.39.20 Omalizumab

Omalizumab is an injectable drug that is FDA approved for the treatment of clients who are 12 years of age and older with severe asthma.

8.2.39.20.1 Prior Authorization for Omalizumab

Omalizumab is a benefit to Medicaid-eligible clients when medically necessary and must be prior authorized. THSteps-eligible clients who are 11 years of age and younger will be considered on an exception basis through CCP.

When requesting prior authorization, the exact dosage must be included with the request using procedure code J2357. Doses and dosing frequency are determined by body weight and by serum IgE level (IU/mL) measured before the start of the treatment. Each prior authorization of omalizumab is based on provider documentation with the following medical necessity criteria:

- Diagnosis of asthma.
- Proof that the client is 12 years of age or older.
• Positive skin test or RAST to a perennial (not seasonal) aeroallergen within the past 36 months.
• Total IgE level greater than 30 IU/ml but less than 700 IU/ml within the past 12 months.

   **Note:** The total IgE level is required only for the initial prior authorization request and is not required for subsequent prior authorization requests.

• Documentation of client compliance with inhaled steroid regimen.
• Client is not currently smoking.
• Clinical evidence of inadequate asthma control. This evidence may include one or more of the following:
  • Dependence upon daily systemic steroids or maximal inhaled steroid regimen with frequent systemic steroid pulses.
  • Frequent hospitalizations or acute care visits for severe asthma exacerbations in the face of adequate maximal standard therapy. The client must have been on daily therapy for persistent asthma for at least one year with frequent use of beta agonist.
  • Persistence of significantly decreased pulmonary function testing (spirometry), demonstrating refractory lower airways’ obstruction and hyper-reactivity over time, despite the rigorous medical regimen delineated above.
  • Pulmonary function tests must have been performed within a three-month period and be documented for all clients when requesting prior authorization for omalizumab. Exceptions may be considered with documentation of medical reasons as to why the test cannot be performed.

Prior authorization approvals for omalizumab are for intervals of six months at a time. Clients must be fully compliant with their omalizumab regimen in order to qualify for any additional authorizations. The provider must submit a statement documenting full compliance with the requests for each renewal. After 12 continuous months of omalizumab authorizations, the requesting provider must submit documentation of satisfactory clinical response to omalizumab in order to qualify for any additional authorizations. Prior authorizations will be considered on an individual basis for lapses in treatment with provider documentation.

Requests for clients who are 20 years of age and younger who do not meet the criteria above will be reviewed for medical necessity, on a case-by-case basis, by the TMHP medical director.

**8.2.39.21 Paclitaxel**

Procedure code J9265 may be reimbursed when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1588 1620 1622 1623 1624 1625 1628 1629 1740 1741</td>
</tr>
<tr>
<td>1742 1743 1744 1745 1746 1748 1749 1750 1759 1760</td>
</tr>
<tr>
<td>1761 1762 1763 1764 1765 1768 1769 1780 1781 1782</td>
</tr>
<tr>
<td>1783 1784 1785 1786 1787 1788 1830 1832 1833 1834</td>
</tr>
<tr>
<td>1835 1836 1837 1838 1839 1880 1881 1882 1883 1884</td>
</tr>
</tbody>
</table>

**8.2.39.22 Implantable Infusion Pumps**

Implantable infusion pumps are a benefit of Texas Medicaid. An implantable infusion pump may be medically necessary in the following circumstances:

• Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
• Administration of Intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
• Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver
• Administration of intra-arterial chemotherapy in head and neck cancers

An implantable infusion pump is not a benefit for the following uses:
• Continuous insulin infusion for diabetes
• Continuous heparin infusion for recurrent thromboembolic disease
• Continuous intralesional infusion for severe chronic intractable pain
• Continuous intra-arterial infusion
• Continuous intra-articular infusion for severe chronic intractable pain
• Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786.

If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

8.2.39.22.1 Prior Authorization for Implantable Infusion Pumps

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

Providers must request prior authorization through the Special Medical Prior Authorization (SMPA) department. The ASC or DME provider may submit a request for prior authorization using the Special Medical Prior Authorization (SMPA) Form, which must be completed and signed by a physician.

All signatures and dates on the SMPA form must be current, unaltered, original, and handwritten. Computerized or stamped signatures or dates will not be accepted. The completed, signed, and dated SMPA form must be maintained by the provider and the prescribing physician in the client's medical record.

The completed SMPA Form must include the procedure code and quantity for the services that are requested. Documentation that is submitted with the prior authorization request must indicate whether the IIP will be provided by the ASC or the DME provider.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested IIP. The requesting provider may be asked for additional information to clarify or complete a request for the IIP.

Documentation submitted with the prior authorization request must indicate the client or caregiver has:
• The ability to provide a return demonstration performance.
• The attention, desire, interest, flexibility, and independence.
• An understanding of cause and effect and object permanence.

As indicated in the following sections, supporting documentation that is based on the type of IIP requested must be included with the request for prior authorization.
IIP for Administration of Anti-spasmodic Drug to Treat Severe Refractory Spasticity
The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
  - Degree of spasticity
  - Affected muscle groups
  - Functional impact
- Duration of symptoms
- Any recent hospitalizations (within past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- Treatment history of self administration with evidence of:
  - A minimum of six weeks of non-invasive methods of spasticity control, including, but not limited to, oral antispasmodics, that either:
    - Failed to adequately control the spasticity, or
    - Produced intolerable side effects
  - The role, participation, and compliance of the family or client that demonstrate the following:
    - The ability to provide a return demonstration performance
    - Attentiveness, desire, interest, flexibility, and independence
    - An understanding of cause and effect and object permanence
  - Favorable response to a trial intrathecal dose of the antispasmodic
- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Antispasmodic to be infused
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

IIP for Administration of Analgesic (Opioid or Nonopioid) Drug for Treatment of Severe Intratable Pain
The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
• Symptoms
  • Severity of pain
  • Functional impact
• Source of pain or location, including whether pain is malignant or non-malignant
• Duration of symptoms
• Any recent hospitalizations (within the past 12 months)
• Comorbid conditions
• All pertinent laboratory and radiology results
• A life expectancy of at least three months

  Note: The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.

• For malignant pain:
  • Treatment history with evidence of a favorable response to a trial intrathecal dose of the analgesic drug, defined as a minimum of 50 percent reduction in pain
  • Failure of more conservative methods of pain control, including, but not limited to, oral analgesics, surgery, or therapy, that were ineffective due to one of the following:
    • Failed to adequately control the pain, or
    • Produced intolerable side effects
• For nonmalignant pain:
  • A minimum of six months of more conservative methods of pain control, including but not limited to oral analgesics, surgery, attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated pain reaction, that were ineffective due to one of the following:
    • Failed to adequately control the pain, or
    • Intolerable side effects were produced
• Examples of non-malignant severe intractable pain include, but are not limited to, the following:
  • Complex regional pain syndrome I & II (causalgia/RSD) refractory to other treatments.
  • Post herpetic neuralgia
  • Failed back syndrome
  • Phantom limb pain
  • Arachnoiditis (proven with MRI/increased CSF protein levels)
  • Spinal cord myelopathy (refractory to conservative measurements)
• The role, participation, and compliance of the family or client that demonstrate the following:
  • The ability to provide a return demonstration performance
  • Attentiveness, desire, interest, flexibility, and independence
  • An understanding of cause and effect and object permanence
• No contraindications to implantation exist, including, but not limited to, the following:
  • Coagulopathy
  • Infection
• Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
• Tumor encroachment on the thecal sac
• Allergy or hypersensitivity to the drug being administered

• Treatment plan, including the following:
  • Analgesic to be infused
  • Follow-up including pump refilling, maintenance, and monitoring of changes in infusion rate
  • Expected outcome
  • Treatment goals

IIP for Administration of Intrahepatic Chemotherapy in Primary Liver Cancer or Colorectal Cancer with Liver Metastases

The following documentation is required for prior authorization:

• The initial evaluation

• Type of surgical implantation and description of IIP requested

• Diagnosis of one of the following:
  • Primary liver cancer
  • Metastatic cancer with metastases limited to the liver

• Any recent hospitalizations (within the past 12 months)

• Comorbid conditions

• All pertinent laboratory and radiology results

• The role, participation, and compliance of the family and/or client demonstrating:
  • The ability to provide a return demonstration performance
  • Attentiveness, desire, interest, flexibility, and independence
  • An understanding of cause and effect and object permanence

• No contraindications to implantation exist, including, but not limited to, the following:
  • Coagulopathy
  • Infection

• Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription

• Allergy or hypersensitivity to the drug being administered

• Treatment plan, including the following:
  • Chemotherapeutic agent to be infused. The prescribed drug must be approved by the U.S. Food and Drug Administration (FDA) for the intended use and must be compatible with the implantable device (such as floxuridine or methotrexate)
  • Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  • Expected outcome
  • Treatment goals
IIP for Administration of Intra-Arterial Chemotherapy in Head and Neck Cancers

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis and site(s) of any metastases
- Any hospitalizations (within the past 12 months) and all other diagnoses
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family or client that demonstrates the following:
  - The ability to provide a return demonstrate performance
  - Attentiveness, desire, interest, flexibility, and independence
  - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Chemotherapeutic agent to be infused
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

Replacement of an IIP

An IIP is expected to last a minimum of five years. Prior authorization for replacement of an IIP is considered within five years when one of the following occurs:

- There has been a significant change in the client’s condition and the current equipment no longer meets the client’s needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.
- Loss or irreparable damage to the IIP has occurred. The following must be submitted with the prior authorization request:
  - A copy of the police or fire report, when appropriate
  - A statement about the measures to be taken in order to prevent reoccurrence

Replacement of an IIP for a client who is birth through 20 years of age that does not meet the criteria above may be considered for prior authorization through CCP.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.
The DME provider must maintain the signed and dated form in the client’s medical record.

Refer to: Subsection 2.4.3.5, “DME Certification and Receipt Form,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about this form.

8.2.39.22.2 Implantation of Catheters, Reservoirs, and Pumps

The following procedure codes may be used to bill the implantation of catheters and infusion pumps or devices for long term medication administration:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>62350</td>
</tr>
</tbody>
</table>

Procedure code 62350 or 63251 may be reimbursed when billed for the same date of service as procedure code 62360, 62361, or 62362.

Procedure codes 62355 and 62365 do not require prior authorization.

The following procedure codes are denied as included in the total anesthesia time when billed with the same date of service as an anesthesia procedure by the same physician:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>62350</td>
</tr>
</tbody>
</table>

These procedure codes are considered for reimbursement according to multiple surgery guidelines when billed with the same date of service as another surgical procedure performed by the same physician.

Procedure codes 95990, 96521, and 96522 are considered for reimbursement when used for refilling an implantable pump.

Procedure codes 62367, 62368, 62369, and 62370 may be used to bill for electronic analysis of an implantable infusion pump.

Procedure codes 62369 and 62370 will be denied when billed for the same date of service by the same provider as procedure code 62362.

The following procedure codes may be used to bill the insertion, revision, removal, or repair associated with implantable infusion pumps:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36260</td>
</tr>
</tbody>
</table>

8.2.39.23 Trastuzumab

Procedure code J9355 is a benefit of Texas Medicaid. Reimbursement for this drug is considered when it is used as a single agent for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have received one or more chemotherapy regimens for their metastatic disease.

Trastuzumab may also be reimbursed when:

- Used in combination with paclitaxel for the treatment of clients who have metastatic breast cancer whose tumors overexpress the Her-2 protein and who have not received chemotherapy for their metastatic disease.
- Used as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients who have Her-2-overexpressing, node-positive breast cancer.
Trastuzumab is a benefit for clients whose tumors have Her-2 protein overexpression.

When billing for procedure code J9355, one of the following appropriate diagnosis codes must appear on the claim:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1740</td>
</tr>
<tr>
<td>1759</td>
</tr>
</tbody>
</table>

When billing for the test used to determine whether a client overexpresses the Her-2 protein, use procedure code 83950. Diagnosis of overexpression of the Her-2 protein must be made before Texas Medicaid will consider reimbursement for trastuzumab. This test may be reimbursed only once in a client’s lifetime to the same provider. An additional test by the same provider requires documentation to support the medical necessity.

8.2.39.24 Vitamin B12 (Cyanocobalamin) Injections

Vitamin B12 injections are a benefit of Texas Medicaid. Vitamin B12 injections should only be considered for clients with conditions that are refractory to, or have a contraindication to, oral therapy.

Vitamin B12 injections may be considered for the following indications:
- Dementia secondary to vitamin B12 deficiency
- Resection of the small intestine
- Schilling test (vitamin B12 absorption test)

Procedure code J3420 must be used when billing for Vitamin B12 (cyanocobalamin) injections.

Vitamin B12 (cyanocobalamin) injections are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234</td>
</tr>
<tr>
<td>3574</td>
</tr>
<tr>
<td>5792</td>
</tr>
</tbody>
</table>

Claims that are denied for indications or other diagnosis codes may be considered on appeal with documentation of medical necessity. Documentation must include rationale as to why the client was unable to be treated with oral therapy.

8.2.39.25 Injection Administration

Injectable medications and the administration of medications via the intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route is a benefit of Texas Medicaid.

For the administration of drugs via intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route providers should submit claims using procedure codes 96372, 96374, 96375, and 96376.

Injection administration is reimbursed separate from the medication.

Procedure codes 96372 and 96374 are limited to one per day, unless the claim clearly indicates that the medication could not be mixed.

Procedure codes 96375 and 96376 will only be reimbursed when billed in conjunction with 96374 on the same date of service by the same provider on the same claim.
8.2.39.26 Billing for Injectable Medications

Providers must use oral medication in preference to injectable medication in the office and outpatient hospital. If an oral medication cannot be used, the claim must be billed as follows:

<table>
<thead>
<tr>
<th>Claim Form</th>
<th>Reason for Injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier KX</td>
<td>• No acceptable oral equivalent is available.</td>
</tr>
<tr>
<td></td>
<td>• Injectable medication is the standard treatment of choice.</td>
</tr>
<tr>
<td></td>
<td>• The oral route is contraindicated.</td>
</tr>
<tr>
<td></td>
<td>• The client has a temperature over 102 degrees Fahrenheit (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.</td>
</tr>
<tr>
<td></td>
<td>• The client has demonstrated noncompliance with orally prescribed medication (must be documented on the claim and in the medical record).</td>
</tr>
<tr>
<td></td>
<td>• Previously attempted oral medication regimens have proven ineffective (must be supported by documentation in the medical record).</td>
</tr>
<tr>
<td></td>
<td>• Situation is emergent.</td>
</tr>
</tbody>
</table>

The claim and the client’s medical record must include documentation of medical necessity to support the need for the service. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service and any modifier used when billing the claim.

Refer to: Subsection 8.2.35, “Immunization Guidelines and Administration,” in this handbook.


8.2.39.27 Unit Calculations for Billing Drugs

Providers must calculate the number of units to be billed on the claim based on the number of units indicated in the procedure code description and the amount of the drug actually administered. Providers should refer to the procedure code description for the unit amount to calculate the number of units to be billed.

The formula to use to calculate the appropriate quantity of units to bill is:

Amount administered divided by the units indicated in the procedure code description.

For example:

<table>
<thead>
<tr>
<th>Units Indicated in the Description</th>
<th>Amount Administered by the Provider</th>
<th>Calculation</th>
<th>Quantity to Bill on the Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 mg per unit</td>
<td>100 mg</td>
<td>100 / 50 = 2</td>
<td>2 units</td>
</tr>
<tr>
<td></td>
<td>20 units</td>
<td>20 / 1 = 20</td>
<td>20 units</td>
</tr>
<tr>
<td></td>
<td>2,500 units</td>
<td>2500 / 100 = 25</td>
<td>25 units</td>
</tr>
<tr>
<td></td>
<td>250 mg</td>
<td>250 / 50 = 5</td>
<td>5 units</td>
</tr>
</tbody>
</table>

Refer to: Subsection 8.2.54, “Palivizumab Injections,” in this handbook.

Claims submitted with incorrect unit calculations may cause delayed or incorrect payment.
The specific NDC of the drug actually dispensed should be entered on the claim form. Additional information about entering NDC codes is available on the NDC page of the TMHP website at www.tmhp.com.

**8.2.40 Medications - Oral**

Oral medications that are given in the hospital or physician’s office are a benefit to Texas Medicaid clients through Texas Medicaid. Take-home and self-administered drugs are not benefits of Texas Medicaid and should not be billed to TMHP except when they are provided to eligible Texas Medicaid fee-for-service clients through the Medicaid Vendor Drug Program (VDP) with a prescription.

*Refer to:* Appendix B: Vendor Drug Program *(Vol. 1, General Information)*.

**8.2.41 Laboratory Services**

Texas Medicaid benefits are provided for professional and technical services ordered by a physician and provided under the supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the client’s medical record as medically necessary and referenced to an appropriate diagnosis. Texas Medicaid does not reimburse baseline or screening laboratory studies.

Providers may bill only for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory must not be billed on the provider’s claim. Laboratories bill Texas Medicaid directly for the tests they perform.

Unless otherwise noted, interpretation of laboratory tests is considered part of the provider’s professional services (hospital, office, or emergency room visits) and must not be billed separately. Modifier Q4 is required for laboratory, radiology, and ultrasound interpretations by any provider other than the attending physician.

Laboratory tests that are generally considered part of a laboratory panel (e.g., chemistries, CBCs, urinalyses [UAs]) and that are performed on the same day must be billed as a panel regardless of the method used to perform the tests (automated or manual).

Physician interpretations that are requested of a consulting pathologist and require professional reading and reporting of results may be billed to Texas Medicaid separately as a professional charge.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA cannot be reimbursed for laboratory services.

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

*Refer to:* The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

Subsection 2.2.5, “Automated Laboratory Tests and Laboratory Paneling,” in *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for claims processing instructions.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA),” in *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.


Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” *(Vol. 1, General Information)* for more information about reimbursement.
8.2.41.1 THSteps Laboratory Services

Refer to: Subsection 5.3.9.6, “Laboratory Test,” in Children’s Services Handbook (Vol. 2, Provider Handbooks).

8.2.41.2 Laboratory Handling Charge

The laboratory handling charge covers the expense of obtaining and packaging the specimen and sending it to a reference laboratory.

A laboratory handling charge (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The reference laboratory name and address or provider identifier must be listed in Block 32 of the CMS-1500 claim form, and Block 20 must be completed.

The provider is required to forward the client’s name, address, Medicaid ID number, and diagnosis, if appropriate, with the specimen to the reference laboratory so the laboratory may bill Texas Medicaid for its services.

A provider may bill only one laboratory handling charge per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This laboratory handling benefit does not apply to THSteps medical checkup providers who must submit specimens to the DSHS Laboratory.

8.2.41.3 Blood Counts

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBCs should be individualized and based on client history, clinical indications, or proposed therapy and will not be reimbursed for screening purposes.

Refer to: Subsection 2.2.6, “Complete Blood Count (CBC),” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about blood counts.

8.2.41.4 Clinical Lab Panel Implementation

Refer to: Subsection 2.2.5, “Automated Laboratory Tests and Laboratory Paneling,” in Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for more information about laboratory panels.

8.2.41.5 Clinical Pathology Consultations

Clinical pathology consultations (procedure code 80500 or 80502) are a benefit of Texas Medicaid for services rendered by a consultant who is either a clinical pathologist or a geneticist. In a clinical pathology consultation, the consultant may also help the ordering physician determine whether further study is appropriate, based on test results.

Providers may be reimbursed for clinical pathology consultations when the claim indicates the following information:

- The name and address or provider identifier of the physician who requested the consultation.
- A written narrative report describing the findings of the consultation, which will also be included in the client’s medical record.

Note: To submit claims for interpretation, the provider must document an interaction that clearly shows that the consultant interpreted the test results and made specific recommendations to the attending physicians.

If the claim does not include all of this information, the clinical pathology consultation will be denied.

Note: Geneticists who provide a pathology consultation must submit claims using their acute care provider identifier.
Routine conversations held between a consultant and attending physicians about test orders or results are not consultations. Information that can be furnished by a non-physician laboratory specialist does not qualify as a consultation service.

8.2.41.6 Cytogenetics Testing

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes.

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20030 20031 20032 20033 20034 20035 20036 20037 20038 20040</td>
</tr>
<tr>
<td>20041 20042 20043 20044 20045 20046 20047 20048 20050 20051</td>
</tr>
<tr>
<td>20052 20053 20054 20055 20056 20057 20058 20060 20061 20062</td>
</tr>
<tr>
<td>20063 20064 20065 20066 20067 20068 20070 20071 20072 20073</td>
</tr>
<tr>
<td>20074 20075 20076 20077 20078 20270 20271 20272 20273 20274</td>
</tr>
<tr>
<td>20275 20276 20277 20278 20280 20281 20282 20283 20284 20285</td>
</tr>
<tr>
<td>20286 20287 20288 20290 20291 20292 20293 20294 20295 20296</td>
</tr>
<tr>
<td>20297 20298 20312 20382 20400 20401 20402 20410 20411 20412</td>
</tr>
<tr>
<td>20420 20421 20422 20480 20481 20482 20490 20491 20492 20500</td>
</tr>
<tr>
<td>20501 20502 20510 20511 20512 20520 20521 20522 20530 20531</td>
</tr>
<tr>
<td>20532 20580 20581 20582 20590 20591 20592 20600 20601 20602</td>
</tr>
<tr>
<td>20610 20611 20612 20620 20621 20622 20680 20681 20682 20689</td>
</tr>
<tr>
<td>20691 20692 20700 20701 20702 20710 20711 20712 20720 20721</td>
</tr>
<tr>
<td>20722 20780 20781 20782 20800 20801 20802 20810 20811 20812</td>
</tr>
<tr>
<td>20820 20821 20822 20880 20881 20882 20890 20891 20892 23773</td>
</tr>
<tr>
<td>2533 2572 2590 2594 27501 27549 27911 29900 29901 31400</td>
</tr>
<tr>
<td>31401 31500 31501 31502 31509 3151 3152 31531 31532 31534</td>
</tr>
<tr>
<td>31539 3154 3155 3158 3159 317 3180 3181 3182 319</td>
</tr>
<tr>
<td>37641 44770 44771 44772 44773 52400 52401 52402 52403 52404</td>
</tr>
<tr>
<td>52405 52406 52407 52409 6060 6061 61182 6260 6261 6280</td>
</tr>
<tr>
<td>6289 6299 630 6318 632 65500 65501 65503 65510 65511</td>
</tr>
<tr>
<td>65513 65520 65521 65523 65550 65951 65953 65960 65961 65963</td>
</tr>
<tr>
<td>7400 7401 7402 74100 74101 74102 74103 74109 74190 74191 74192</td>
</tr>
<tr>
<td>74193 7420 7421 7422 7423 7424 7425 74251 74253 74259 7428</td>
</tr>
<tr>
<td>7429 74300 74303 74306 74310 74311 74312 74320 74321 74322</td>
</tr>
<tr>
<td>74330 74331 74332 74333 74334 74335 74336 74337 74339 74341</td>
</tr>
<tr>
<td>74342 74343 74344 74345 74346 74347 74348 74349 74351 74352</td>
</tr>
<tr>
<td>74353 74354 74355 74356 74357 74358 74359 74361 74362 74363</td>
</tr>
<tr>
<td>74364 74365 74366 74369 7437 7439 74400 74401 74402 74403</td>
</tr>
<tr>
<td>74404 74405 74409 7441 74421 74422 74423 74424 74429 7443</td>
</tr>
</tbody>
</table>
Cytogenetics testing may be reimbursed with the following procedure codes and limitations:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-88230</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88233</td>
<td>1 per day any provider</td>
</tr>
</tbody>
</table>
8.2.41.7 Maternal Serum Alpha-Fetoprotein (MSAFP)

MSAFP may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim. Procedure code 82015 should be used for MSAFP.

8.2.42 Lung Volume Reduction Surgery (LVRS)

LVRS is a benefit for clients who are not high risk but have a presence of severe, upper-lobe emphysema or who are not high risk but have a presence of severe, non-upper-lobe emphysema with low exercise capacity.

LVRS must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission of Health Care Organization
- Identified by the National Heart, Lung, and Blood Institute
- Approved by Medicare as a lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client’s potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-88235</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88237</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88239</td>
<td>1 per day any provider</td>
</tr>
</tbody>
</table>

### Chromosome Analysis Procedure Codes and Limitations

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-88245</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88248</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88249</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88261</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88262</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88263</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88264</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88280</td>
<td>5 per day any provider</td>
</tr>
<tr>
<td>5-88283</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88285</td>
<td>1 per day any provider</td>
</tr>
<tr>
<td>5-88289</td>
<td>1 per day any provider</td>
</tr>
</tbody>
</table>

### Molecular Cytogenetics Procedure Codes and Limitations

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-88271</td>
<td>50 per provider per day</td>
</tr>
<tr>
<td>5-88272</td>
<td>10 per provider per day</td>
</tr>
<tr>
<td>5-88273</td>
<td>10 per provider per day</td>
</tr>
<tr>
<td>5-88274</td>
<td>10 per provider per day</td>
</tr>
<tr>
<td>5-88275</td>
<td>10 per provider per day</td>
</tr>
</tbody>
</table>

### Interpretation and Report Procedure Code

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Quantity Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-88291</td>
<td>As medically necessary</td>
</tr>
</tbody>
</table>
- Include a 6- to 10-week series of preoperative sessions
- Include a series of postoperative sessions within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client’s medical, psychosocial, and nutritional needs
- Be consistent with the preoperative and postoperative services provided in NETT
- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place

LVRS (procedure code 32491) is limited to one per rolling year per client for any provider.

**8.2.42.1 Prior Authorization for Lung Volume Reduction Surgery**

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. The following documentation must be submitted with the request for prior authorization:

- The client’s history and physical examination is consistent with emphysema BMI less than 31.1 kg/m² (men) or less than 32.3 kg/m² (women) stable with less than 20 mg prednisone (or equivalent) per day.
- A radiographic high resolution computer tomography (HRCT) scan has been conducted that shows evidence of bilateral emphysema.
- The forced expiratory volume in one second (FEV1) (maximum of pre- and postbronchodilator values) is less than or equal to 45 percent of the predicted value. If the client is 70 years of age and older, FEV1 is 15 percent of the predicted value or more.
- The total lung capacity (TLC) greater than 100 percent predicted postbronchodilator residual volume (RV) greater than 150 percent predicted postbronchodilator found on prerehabilitation pulmonary function study.
- The postbronchodilator TLC is greater than or equal to 100 percent of the predicted value, and the RV is greater than or equal to 150 percent of the predicted value.
- A cardiologist’s approval for surgery if one or more of the following is present:
  - Unstable angina.
  - The left-ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram.
  - LVEF is less than 45 percent.
  - A dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction.
  - Arrhythmia is present (greater than 5 premature ventricular contractions per minute, cardiac rhythm other than sinus, premature ventricular contractions on electrocardiogram [EKG] at rest).
- The resting partial pressure of oxygen (PaO2) is greater than 45 mmHg.
- The resting partial pressure of carbon dioxide (PaCO2) is less than or equal to 60 mmHg on room air.
- Approval for the surgery by a pulmonary physician, thoracic surgeon, and anesthesiologist is included postrehabilitation.
- A computed tomography (CT) scan shows evidence of bilateral emphysema.
• The plasma cotinine is less than or equal to 13.7 ng/ml (if the client is not using nicotine products) or the carboxyhemoglobin is less than or equal to 2.5 percent (if the client is using nicotine products).

• The program is consistent with the care plan developed by the treating physician, and arranged, monitored, and performed under the coordination of the facility where the surgery takes place and must include:
  • A 6- to 10-week series of at least 16, and no more than 20, preoperative sessions, each lasting a minimum of 2 hours. After the preoperative rehabilitation, the client must be able to complete a 6-minute walk of more than 140 meters and successfully complete a 3-minute unloaded pedaling in an exercise tolerance test.
  • At least 6, and no more than 10, postoperative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks of the LVRS.

In addition, the client must meet all of the following conditions:
• Have a signed consent for screening and preoperative and postdischarge pulmonary surgery services associated with LVRS
• Have not smoked for 4 or more months
• Have a cardiac ejection fraction of less than 45 percent and no history of congestive heart failure or myocardial infarction within six months of consideration for surgery

Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation for LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

8.2.42.1.1 Noncovered Conditions
LVRS is not a benefit in any of the following clinical circumstances:
• A client with characteristics that carry a high risk for perioperative morbidity and/or mortality
• A disease that is unsuitable for LVRS
• A medical condition or other circumstance that makes it likely that the client will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery
• The client presents with FEV less than 20 percent of predicted value, and either a homogeneous distribution of emphysema on the CT scan or a carbon monoxide diffusing capacity of less than 20 percent of predicted value (a high-risk group identified in October 2001 by the NETT)
• The client satisfies the criteria outlined above and has severe, non-upper-lobe emphysema with a high-exercise capacity. High-exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 watts for women or 40 watts for men (under the measurement conditions for cycle ergometry)

In addition, LVRS is contraindicated for clients who meet the following criteria:
• A previous LVRS (laser or excision)
• A pleural or interstitial disease which precludes surgery
• A giant bulla (greater than 1/3 the volume of the lung in which the bulla is located)
• A clinically significant bronchiectasis
• A pulmonary nodule requiring surgery
• A previous lobectomy
• Uncontrolled hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg)
• Oxygen requirement greater than 6 liters per minute during resting to keep oxygen saturation greater than or equal to 90 percent
• A history of recurrent infections with clinically significant production of sputum
• Unplanned weight loss greater than 10 percent within 3 months before the consideration of surgery
• Pulmonary hypertension, defined as the mean pulmonary artery pressure of 35 mmHg or greater on the right heart catheterization or peak systolic pulmonary artery pressure of 45 mmHg or greater. Right heart catheterization is required to rule out pulmonary hypertension if the peak systolic pulmonary artery pressure is greater than 45 mmHg on an echocardiogram
• Resting bradycardia (less than 50 beats per minute) or frequent multifocal premature ventricular contractions (PVCs) of complex ventricular arrhythmia or sustained supraventricular tachycardia (SVT)
• Evidence of a systemic disease or neoplasia that is expected to compromise survival

All other indications for LVRS remain noncovered.

8.2.43 Mastectomy and Breast Reconstruction

Mastectomy and breast reconstruction services are benefits of Texas Medicaid for male or female clients. These procedures are to be individualized, specific, and not in excess of the client’s needs.

Mastectomy and breast reconstruction procedures may be reimbursed when the procedures are consistent with confirmed diagnosis of illness or injury under treatment or with appropriate personal history.

The following services are not benefits of Texas Medicaid:
• Mastectomy for a diagnosis of fibrocystic disease in the absence of documented risk factors.
• Cosmetic services performed primarily to improve appearance, except as outlined in this section.
• Commercial or “decorative” tattooing.
• Replacement of external breast prostheses beyond the limitations outlined in this policy, when the replacement is due to ordinary wear and tear.

8.2.43.1 Mastectomies

The following procedure codes for partial mastectomy, simple, subcutaneous, radical, and modified radical mastectomy are benefits of Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19301</td>
</tr>
</tbody>
</table>

Procedure codes 19301 and 19302 may be reimbursed for services rendered to male or female clients of any age when the services are billed with an appropriate diagnosis code.

For clients with a diagnosis of cancer, procedure codes 19301 and 19302 may be reimbursed for more than 2 services rendered per lifetime.

Procedure codes 19303, 19304, 19305, 19306, and 19307 may be reimbursed for services rendered to male or female clients who are 18 years of age and older when the services are billed with an appropriate diagnosis code. Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Procedure codes 19303, 19304, 19305, 19306, and 19307 are limited to 2 services per lifetime.
Mastectomy and breast reconstruction procedures may be reimbursed without prior authorization for services rendered to clients who are 18 years of age and older when the procedures meet the criteria outlined below and are billed with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1740</td>
</tr>
<tr>
<td>1759</td>
</tr>
</tbody>
</table>

*Diagnosis codes V103, V163, V4571, and V8401 may be billed only with breast reconstruction procedures and simple, subcutaneous, radical, and modified radical mastectomy procedures.

The physician must maintain documentation of medical necessity in the client’s medical record. Services are subject to retrospective review.

**8.2.43.2 Prophylactic Mastectomies**

Prophylactic mastectomy is the removal of the breast to prevent the development of cancer. This procedure is a benefit of Texas Medicaid for clients who are 18 years of age and older and who are at moderate-to-high risk for the development of breast cancer. Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Moderate-risk to high-risk clients are those who meet one or more of the following criteria:

- Presence of a breast cancer 1 (BRCA1) or a breast cancer 2 (BRCA2) genetic mutation
- Presence of lesions associated with an increased risk of cancer, such as atypical hyperplasia or lobular carcinoma in situ (LCIS)
- Diagnosis of breast cancer in one breast

Refer to: Subsection 8.2.14, “* BRCA Testing,” in this handbook.

Documentation that supports medical necessity for the procedure must be maintained in the client’s medical record and must include the following:

- Documentation that the client is moderate-to-high risk.
- Documentation that, as a candidate for prophylactic mastectomy, the client has undergone counseling regarding cancer risks. Counseling must include assessment of all of the following:
  - The client’s ability to understand the risks and long-term implications of the surgical procedure.
  - The client’s informed choice to proceed with the surgical procedure.

All documentation is subject to retrospective review.

**8.2.43.3 Breast Reconstruction**

Breast reconstruction following a medically necessary mastectomy is a benefit of Texas Medicaid when all of the following criteria are met:

- The client is eligible for Texas Medicaid at the time of the breast reconstruction.
- The client has a documented history of a mastectomy performed while eligible for Texas Medicaid and has one of the diagnoses listed above.

**Note:** Prior authorization is required for breast reconstruction service rendered to clients who do not have an established history of mastectomy procedure(s) reimbursed by Texas Medicaid for the client.

- The client meets age and sex criteria for the requested procedure as outlined above.
- The physician has documented a plan in the client’s chart that addresses the recommended breast reconstruction.
Breast reconstruction includes the following:

- Creation of a new mound.
- Reconstruction of the nipple or areola, which is accomplished with small flaps for the nipple and either tattooing or a skin graft for the areola. Nipple-areola pigmentation, commonly known as medical tattooing, is the final stage of breast reconstruction surgery.

Breast reconstruction may also include the following, in order to establish symmetry with the contralateral breast:

- Reduction mammoplasty
- Mastopexy
- Augmentation

Breast implants, tissue flaps, or both are surgically placed in the area where natural tissue has been removed.

Breast reconstruction is performed in order to correct or repair abnormal structures of the breast caused by any of the following:

- Tumor or disease (e.g. following a primary mastectomy procedure in order to establish symmetry with a contralateral breast or following bilateral mastectomy)
- Congenital defect
- Developmental abnormality
- Infection
- Trauma to the chest wall

Breast reconstruction may be based on the type of treatment a client receives or on the extent of surgery performed. The reconstructive surgery may be performed in a single stage or several stages and may occur during or after the initial surgical procedure.

The following breast reconstruction procedure codes may be reimbursed for services rendered to clients who are 18 years of age and older:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11920</td>
</tr>
<tr>
<td>19357*</td>
</tr>
</tbody>
</table>

* Procedure codes 19316, 19324, 19325, 19340, 19342, 19357, and 19396 may be reimbursed for services rendered to female clients only. Prior authorization is required for services rendered to male clients.

Prior authorization is required for services rendered to clients who are 17 years of age and younger. The following procedure codes may be reimbursed when performed as part of breast reconstruction:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11920</td>
</tr>
</tbody>
</table>

For clients with a diagnosis of cancer, the following procedure codes may be reimbursed for more than two services rendered per lifetime:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19340</td>
</tr>
<tr>
<td>19370</td>
</tr>
</tbody>
</table>
The following procedure codes may be reimbursed if a mastectomy (procedure code 19303, 19304, 19305, 19306, or 19307) has been reimbursed for the client by Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19340</td>
</tr>
</tbody>
</table>
| S2068

The following procedure codes may be reimbursed if a mastectomy (procedure code 19303, 19304, 19305, 19306, or 19307) has been reimbursed by Texas Medicaid within the client’s lifetime:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>19316</td>
</tr>
</tbody>
</table>

### 8.2.43.4 Tattooing to Correct Color Defects of the Skin

Tattooing to correct color defects of the skin (procedure codes 11920, 11921, and 11922) is limited to clients who have a documented history of a breast reconstruction performed within the past 12 months. The breast reconstruction must have been performed while the client was eligible for Texas Medicaid. Prior authorization is required for tattooing services for clients who do not have an established history.

Procedure codes 11920, 11921, and 11922 are limited to two services per lifetime.

Procedure code 11922 must be billed with procedure code 11920 or 11921.

### 8.2.43.5 Treatment for Complications of Breast Reconstruction

The treatment of complications related to breast reconstruction may be reimbursed using procedure codes 19370, 19371, and 19380 when all of the following criteria are met:

- The client is eligible for the Texas Medicaid breast reconstruction benefit when the complications occur.
- The client is 18 years of age or older at the time the services are rendered.
- A breast reconstruction (procedure code 19316, 19324, 19325, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, or S2068) has been reimbursed for the client by Texas Medicaid.

Procedure codes 19370 and 19371 may be reimbursed for services rendered to female clients only.

Prior authorization is required for services rendered to clients who do not have an established history of related services reimbursed for the client by Texas Medicaid or for clients who do not meet age and gender criteria.

### 8.2.43.6 External Breast Prostheses

External breast prostheses are benefits when provided by a licensed prosthetist or orthotist to clients who have a history of a medically necessary mastectomy procedure. The following procedure codes may be reimbursed for external breast prostheses services rendered to female clients of any age:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8000</td>
</tr>
<tr>
<td>L8039</td>
</tr>
</tbody>
</table>

* Modifier LT or RT required.

Procedure codes L8001, L8010, L8020, L8030, L8031, and L8032 must be submitted with modifier LT or RT indicating the location for the breast prosthesis.
The external breast prosthesis procedure codes are limited as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8000</td>
<td>4 per rolling year</td>
</tr>
</tbody>
</table>
| L8001          | 4 per rolling year

Note: If more than 4 unilateral mastectomy bras are required per rolling year, prior authorization may be requested for the additional item(s). If a second mastectomy is performed within the same year, the bilateral procedure code must be used for the necessary mastectomy bra.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8002</td>
<td>4 per rolling year</td>
</tr>
<tr>
<td>L8010</td>
<td>8 total per rolling year (regardless of modifier)</td>
</tr>
<tr>
<td>L8015</td>
<td>2 per lifetime</td>
</tr>
<tr>
<td>L8020</td>
<td>1 total per 6 rolling months (regardless of modifier)</td>
</tr>
<tr>
<td>L8030</td>
<td>1 total per 2 rolling years (regardless of modifier)</td>
</tr>
<tr>
<td>L8031</td>
<td>1 total per 2 rolling years (regardless of modifier)</td>
</tr>
<tr>
<td>L8032</td>
<td>8 total per rolling year</td>
</tr>
<tr>
<td>L8035</td>
<td>Prior authorization required</td>
</tr>
<tr>
<td>L8039</td>
<td>Prior authorization required</td>
</tr>
</tbody>
</table>

The following procedure codes may be reimbursed if a mastectomy (procedure code 19303, 19304, 19305, 19306, or 19307) has been reimbursed for the client by Texas Medicaid:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8000</td>
</tr>
</tbody>
</table>

Prior authorization is required for the initial prosthesis for clients who do not have an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.

Prior authorization is required for the replacement of external breast prosthesis as follows:

- If the external breast prosthesis is lost or irreparably damaged, prosthesis of the same type may be prior authorized at any time.
- If the external breast prosthesis is needed due to a change in the client’s medical condition, prosthesis of a different type may be prior authorized at any time.

**8.2.43.7 Prior Authorization Requirements for Mastectomy and Breast Reconstruction**

Prior authorization is not required when all of the following criteria are met:

- The procedure is a mastectomy.
- The procedure is a breast reconstruction and the client has an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.
- The client is 18 years of age or older.
- The diagnosis code is listed above.
- The client meets gender criterion.
- The request is within the limitations outlined in this section for external breast prosthesis procedure code L8000, L8001, L8002, L8010, L8015, L8020, or L8030.
Prior authorization is required when any of the following criteria is met:

- The client is 17 years of age or younger.

**Exception:** Partial mastectomy procedure codes 19301 and 19302 may be reimbursed for clients of any age and do not require prior authorization.

- The diagnosis code is not listed above.

**Note:** If it becomes medically necessary to submit a noncovered diagnosis code that differs from the noncovered diagnosis code approved in the prior authorization, the authorization may be updated before claim submission.

- The client does not meet the gender criterion for the requested procedure.

- The client does not have an established history of related services while Medicaid-eligible as follows:
  - For breast reconstruction procedures, the client does not have an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.
  - For complications related to breast reconstruction, the client does not have an established history of breast reconstruction procedure(s) reimbursed for the client by Texas Medicaid.
  - For external breast prostheses, the client does not have an established history of mastectomy procedure(s) reimbursed for the client by Texas Medicaid.
  - The request is for external breast prosthesis procedure code L8035 or L8039. The request must include documentation of medical necessity for the requested device.
  - The request is for new or replacement external breast prostheses outside of the limitations outlined above.

Prior authorization requests for fee-for-service Medicaid clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department. Documentation that supports medical necessity for the requested procedure must be included with the request. When required, the requests must include the physician’s original signature and the date signed. Stamped or computerized signatures and dates are not accepted. Without this information, requests will be considered incomplete.

### 8.2.44 Neurostimulators

Neurostimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting conductive garments are a benefit of Texas Medicaid when medically necessary.

Neurostimulator devices are considered DME, so providers must complete both the Home Health (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX Form) to prescribe the DME and the DME Certification and Receipt Form to show receipt of the DME by the client. Both forms must be maintained in the client’s medical record.

**Refer to:** Subsection 2.2.2, “Durable Medical Equipment (DME) and Supplies,” in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (Vol. 2, Provider Handbooks) for more information about DME.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

Items and/or services addressed in the sections below are either reimbursed at a maximum fee determined by HHSC or are manually priced. If an item is manually priced, the manufacturer’s suggested retail pricing (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are reimbursed at the MSRP minus a discount (18 percent) as determined by HHSC.
8.2.44.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator device require prior authorization.

Requests for prior authorization must be submitted to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the requested device. Providers may use the Special Medical Prior Authorization (SMPA) Request Form when they submit requests to the SMPA department.

To avoid unnecessary denials, the physician must provide correct and complete information including documentation for medical necessity of the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the equipment and/or supplies. Prior authorization requests for all neurostimulators and related procedures must include the provider identifiers for both the surgeon and the facility.

A neurostimulator device that has been purchased is anticipated to last a maximum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. At that time, replacement of the device will be considered. Replacement devices require prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

8.2.44.2 Neuromuscular Electrical Stimulation (NMES)

NMES application and the rental or purchase of devices and conductive garments are a benefit of Texas Medicaid when medically necessary and prior authorized. Prior authorization requests for NMES must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

NMES may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>64580</td>
</tr>
</tbody>
</table>

8.2.44.2.1 NMES Rental

The rental of a NMES device may be considered before purchase and is limited to a one-month trial period with consideration for one additional month’s trial with documentation of medical necessity. Supplies are considered to be part of the rental and will not be separately reimbursed. Garments may be considered for reimbursement during the rental period when medically necessary.

8.2.44.2.2 NMES Purchase

The purchase of a NMES device is limited to once per five years, and may be reimbursed when there is documentation of successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by the following:

- A demonstrated increase in range of motion.
- The client’s improved ability to complete activities of daily living or perform activities outside the home.

Garments may be considered for reimbursement during the purchase period when medically necessary.
8.2.44.2.3 NMES for Muscle Atrophy

NMES may be reimbursed when used to treat muscle disuse atrophy when brain, spinal cord, and peripheral nerve supply to the muscle is intact, as well as other nonneurological reasons. Examples of NMES treatment for nonneurological reasons include, but are not limited to, casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery until orthotic training begins.

8.2.44.2.4 NMES for Walking in Clients with Spinal Cord Injury (SCI)

The type of NMES that is used to enhance the ability to walk of SCI clients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence. The use of NMES/FES is limited to SCI clients for walking, who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months. The trial period of physical therapy will enable the physician treating the client for his or her spinal cord injury to properly evaluate the client’s ability to use NMES/FES devices frequently and for the long term. Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program. The goal of physical therapy must be to train SCI clients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

NMES/FES used for walking is a benefit for SCI clients who have all of the following characteristics:

- Clients with intact lower motor unit (L1 and below) (both muscle and peripheral nerve).
- Clients with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently.
- Clients who demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction.
- Clients who possess high motivation, commitment, and cognitive ability to use such devices for walking.
- Clients who can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes.
- Clients who can demonstrate hand and finger function to manipulate controls.
- Clients with at least 6-month post recovery spinal cord injury and restorative surgery.
- Clients with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.
- Clients who have demonstrated a willingness to use the device long-term.

NMES/FES used for walking is not a benefit in SCI clients with any of the following:

- Cardiac pacemakers
- Severe scoliosis or severe osteoporosis
- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dyslexia

8.2.44.3 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS involves the attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated.
TENS may be reimbursed for the treatment of acute postoperative pain or chronic pain that is refractory to conventional therapy.

TENS may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>64550</td>
</tr>
</tbody>
</table>

**8.2.44.3.1 TENS Rental**

Rental of a TENS device will be considered for prior authorization when there is documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS device is limited to one-month trial period with consideration for one additional month’s trial with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be separately reimbursed. Garments may be considered during the rental period when medically necessary.

When the TENS device is rented for a trial period rather than supplied by the provider, the combined payment made for professional services and the rental of the stimulator must not exceed the amount which would be reimbursed for the total service, including the stimulator, if furnished by the provider alone.

**8.2.44.3.2 TENS Purchase**

The purchase of a TENS device is limited to once every five years and may be reimbursed with prior authorization when there is documentation of the following:

- A condition that indicates chronic pain that is refractory to conventional therapy.
- A successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by demonstrated increase in range of motion.
- The client’s improved ability to complete activities of daily living or perform activities outside the home.

**8.2.44.4 NMES and TENS Garments**

The rental of the NMES/TENS garment is not covered during the trial rental period unless the client has a documented skin problem prior to the start of the trial period, and HHSC or its designee determines that use of such an item is medically necessary for the client based on the documentation submitted.

The purchase of conductive garments for NMES/TENS devices may be considered when:

- The garment has been prescribed by a physician for use in delivering covered NMES/TENS treatment.
- A NMES/TENS device has been purchased for the client’s use.
- The conductive garment is necessary for one of the medical indications outlined below:
  - The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  - The client cannot manage the treatment for chronic intractable pain without the conductive garment because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  - The client has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires.
Lead wires and electrodes for NMES or TENS are a benefit of Texas Medicaid only if the devices are owned by the client. Additional documentation such as the purchase date, serial number, and purchasing entity may be required.

**8.2.44.5 NMES and TENS Supplies**

Supplies for purchased devices are limited as follows:

- If additional electrodes are required, procedure code A4556 may be considered for reimbursement at a maximum of 15 per month.
- If additional lead wires are required, procedure code A4557 may be considered for reimbursement at a maximum of 2 per month.
- Procedure code A4595 is limited to 1 per month.

Supplies are included in the rental and will not be reimbursed separately.

Supply procedure codes A4556, A4557, or A4595 may be reimbursed with documentation of a client-owned device and without prior authorization. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required.

**8.2.44.6 Dorsal Column Neurostimulator (DCN)**

DCN involves the surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space. The neurostimulation system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

DCN implantation may be reimbursed using procedure codes 61783, 63650, 63655, or 63685.

Conditions that may indicate chronic intractable pain include, but are not limited to, the following:

- Amputation "ghost" pain
- Cancer with bone metastasis
- Causalgia of upper/lower limb
- Herniated disc
- Radiculitis
- Spinal stenosis
- Spinal surgery
- Tic douloureux (trigeminal neuralgia)

**8.2.44.6.1 Prior Authorization for Dorsal Column Neurostimulators**

DCN electrode implantation and the purchase of devices is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation of DCN device may be considered for prior authorization for clients who have chronic intractable pain with documentation that indicates the following:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.
- There has been demonstration of pain relief with a temporarily implanted electrode preceding the permanent implantation.
• All the facilities, equipment, and professional and support personnel required for the proper
diagnosis, treatment, training, and follow-up of the client are available.

8.2.44.7 Intracranial Neurostimulators

The surgical implantation, revision, and removal of intracranial deep brain stimulators (DBS) are a
benefit for the relief of chronic intractable pain when more conservative methods, such as TENS, PENS,
or pharmacological management have failed or were contraindicated.

Intracranial neurostimulation may be reimbursed using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>61781 61782 61850 61860 61863 61864 61867 61868 61870 61875 61885 61886</td>
</tr>
</tbody>
</table>

8.2.44.7.1 Prior Authorization for Intracranial Neurostimulators

Intracranial neurostimulation involves the stereotactic implantation of electrodes in the brain and is a
benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation and purchase of an intracranial neurostimulation device may be considered
for prior authorization for chronic intractable pain or treatment of intractable tremors.

Requests for prior authorization must include documentation of the following:

• Other treatment modalities, including pharmacological, surgical, physical, and/or psychological
  therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the
  client.
• The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team
  prior to implantation.
• There has been demonstration of pain relief with a temporarily implanted electrode preceding the
  permanent implantation.
• All the facilities, equipment, and professional and support personnel required for the proper
  diagnosis, treatment, training, and follow-up of the client are available.

Prior authorization will not be given for the treatment of motor function disorders such as multiple
sclerosis; however, the implantation, revision, and removal of deep brain stimulators may be reimbursed
for the treatment of intractable tremors due to the following:

• Idiopathic Parkinson’s disease
• Essential tremor

8.2.44.8 Percutaneous Electrical Nerve Stimulation (PENS)

PENS is a benefit of Texas Medicaid when medically necessary and prior authorized. Devices and
supplies are considered a part of the service and are not separately reimbursable.

PENS is a diagnostic procedure for the treatment of chronic pain involving the stimulation of peripheral
nerves by a needle electrode inserted through the skin.

8.2.44.8.1 Prior Authorization for PENS

PENS services may be reimbursed with prior authorization for clients who meet the following criteria:

• The client has a diagnosis that indicates chronic pain, which is refractory to conventional therapy.
• Treatment with TENS has failed or is contraindicated for the client.
PENS may be reimbursed using the following procedure codes: 64553, 64555, or 64590. The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed without prior authorization using procedure code 64595.

### 8.2.44.9 Sacral Nerve Stimulators (SNS)

SNS are a benefit of Texas Medicaid when medically necessary and prior authorized. SNS implantation may be reimbursed using procedure code 64561, 64581, or 64590.

SNS are pulse generators that transmit electrical impulses to the sacral nerves through a surgically implanted wire for treatment of urinary retention, urinary frequency, and urinary/fecal incontinence.

#### 8.2.44.9.1 Prior Authorization for SNS

The surgical implantation of SNS and purchase of a device may be considered for prior authorization with the following diagnosis codes: 59655, 78820, 78831, 78841, or 78760.

Additionally, the medical record of the client must have documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, and/or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

### 8.2.44.10 Vagal Nerve Stimulators (VNS)

VNS are a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of intractable partial onset seizures.

VNS are devices that deliver electrical pulses to the cervical portion of the vagus nerve by an implanted generator.

#### 8.2.44.10.1 Prior Authorization for VNS

The surgical implantation and purchase of VNS devices may be considered for prior authorization with the following diagnosis codes: 34541 or 34551.

The surgical implantation of VNS may be reimbursed using procedure code 61885, 61886, 64553, or 64568.

VNS are not a benefit of Texas Medicaid in the following cases:

- For the treatment of clients with an absent left vagus nerve
- For the treatment of clients with depression
- For the treatment of clients with progressive fatal or medical diseases with a poor prognosis

Disabilities due to mental retardation or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of mental retardation or cerebral palsy exists, the treating physician must document in the medical record how VNS will measurably benefit the client in spite of mental retardation or cerebral palsy.

### 8.2.44.11 Prior Authorization of Neurostimulator Devices Procedure Codes

The following device procedure codes may be reimbursed with prior authorization:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0740 L8681 L8682 L8683 L8684 L8685 L8686 L8687 L8688 L8689</td>
</tr>
</tbody>
</table>

To identify the service as a VNS device, procedure code L8686 must be submitted with modifier TG. Only one similar device code may be reimbursed per date of service for any client.
8.2.44.12 Supplies for Neurostimulators

Supply procedure codes A4290, C1883, C1897, and L8680 may be reimbursed if there is documentation of a client-owned device. Additional documentation such as the purchase date, serial number and purchasing entity may be required. Only one similar supply code may be reimbursed per day by any provider.

8.2.44.13 Electronic Analysis for Neurostimulators

The following procedure codes may be reimbursed without prior authorization for the electronic analysis of the implanted neurostimulator:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>95970 95971 95972 95973 95974 95975 95978 95979</td>
</tr>
</tbody>
</table>

8.2.44.14 Revision or Removal of Neurostimulator Devices

The revision or removal of implantable neurostimulators may be reimbursed without prior authorization for clients who have a history of neurostimulator implantation or device purchase using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>63661 63662 63663 63664 63688 61880 61888 64585 64595</td>
</tr>
</tbody>
</table>

8.2.44.15 Noncovered Neurostimulator Services

The following services are not a benefit of Texas Medicaid:

- VNS and associated equipment and supplies are not a benefit when provided for the treatment of depression.
- Gastric neurostimulation (GNS) and associated equipment and supplies.
- Neurostimulator services for indications or diagnoses other than those outlined above.

8.2.45 Newborn Services

The newborn period is defined as the time from birth through 28 days of life. This section addresses routine newborn care, attendance at delivery, newborn resuscitation, neonatal critical care, and intensive (noncritical) low birth weight services.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

Modifier 25 may be used to identify a significant separately identifiable E/M provided on the same day by the same physician as a procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Physician standby (procedure code 99360) is not a benefit.

**Note:** Some of the services addressed in this section may also be used for care beyond 28 days of life.

**Refer to:** Subsection 8.2.60, “Physician Evaluation and Management (E/M) Services,” in this handbook.

8.2.45.1 Circumcisions for Newborns

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54160.

8.2.45.2 * Hospital Visits and Routine Care

The following procedure codes may be reimbursed for neonatal care and intensive care services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code(s)</th>
<th>Benefit(s) and Limitation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial hospital E/M admission</td>
<td>99221, 99222, 99223</td>
<td>If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission. Reimbursed one per day, any provider.</td>
</tr>
<tr>
<td>Hospital discharge</td>
<td>99238, 99239</td>
<td>Reimbursed for the client’s discharge from the hospital.</td>
</tr>
<tr>
<td>Subsequent hospital and hospital consultation services</td>
<td>99251, 99252, 99253, 99254, 99255</td>
<td>Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99251, 99252, 99253, 99254, and 99255).</td>
</tr>
<tr>
<td>Initial newborn care</td>
<td>99460*</td>
<td>May be reimbursed once per lifetime, any provider. May be reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
<tr>
<td>Normal newborn care</td>
<td>99461*</td>
<td>May be reimbursed once per lifetime, any provider. Subsequent visits must be billed using an appropriate visit code based on the place of service. Reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99462</td>
<td>Reimbursable once per day in the hospital. Procedure code 99462 is not reimbursable in the birthing center. May be reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
<tr>
<td>Newborn admission and discharge, same date</td>
<td>99463**</td>
<td>May be reimbursed once per lifetime when submitted by any provider. Reimbursed for newborns who are admitted and discharged on the same day from the hospital or birthing room setting (either hospital or birthing center). May be reimbursed when billed with a well newborn diagnosis code.</td>
</tr>
<tr>
<td>Attendance at delivery</td>
<td>99464</td>
<td>May be reimbursed once, and only on the day of delivery, when billed by a physician other than the delivering physician.</td>
</tr>
<tr>
<td>Newborn resuscitation</td>
<td>99465</td>
<td>Reimbursed for the resuscitation of the newborn.</td>
</tr>
</tbody>
</table>

* Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a T11Steps periodic medical checkup when all necessary components are completed and documented in the medical record.

** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).
Note: Services for a newborn’s unsuccessful resuscitation may be billed under the mother’s Texas Medicaid number using procedure code 99499.

Refer to: Section 5, “THSteps Medical” in Children’s Services Handbook (Vol. 2 Provider Handbooks).

Subsection 5.3.7, “Newborn Examination,” in Children’s Services Handbook (Vol. 2 Provider Handbooks) for a list of the required components for an initial THSteps exam.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

Procedure codes 99460, 99461, 99462, and 99463 may be reimbursed when billed with one of the following well newborn diagnosis codes:

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V290</td>
<td></td>
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<tr>
<td>V291</td>
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<tr>
<td>V292</td>
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<td>V293</td>
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<td>V298</td>
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<td>V299</td>
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<td>V3000</td>
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<td>V3001</td>
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<td>V301</td>
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<td>V302</td>
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<td>V3000</td>
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<td>V3001</td>
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<td>V3100</td>
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<td>V3101</td>
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<td>V311</td>
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<td>V312</td>
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<td>V3200</td>
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<td>V3201</td>
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<td>V321</td>
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<td>V322</td>
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<td>V3300</td>
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<td>V3301</td>
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<td>V331</td>
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<td>V332</td>
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<td>V3400</td>
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<td>V341</td>
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<td>V342</td>
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<td>V3500</td>
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<td>V3501</td>
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<td>V351</td>
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<td>V352</td>
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<td>V362</td>
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<td>V3700</td>
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<td>V3701</td>
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<td>V371</td>
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<tr>
<td>V372</td>
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<tr>
<td>V3900</td>
<td></td>
</tr>
<tr>
<td>V3901</td>
<td></td>
</tr>
<tr>
<td>V391</td>
<td></td>
</tr>
</tbody>
</table>
In the following table, procedure codes in Column A will be denied when billed with the same date of service by the same provider as a procedure code in Column B:

<table>
<thead>
<tr>
<th>Column A (Denied)</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>99238, 99239</td>
<td>99460, 99461, 99463</td>
</tr>
<tr>
<td>99462</td>
<td>99238, 99239</td>
</tr>
<tr>
<td>99469</td>
<td>99468</td>
</tr>
<tr>
<td>99461, G0102</td>
<td>99463</td>
</tr>
<tr>
<td>36410, 96361, 99292, 99307, 99354, 99355, 99356, 99357</td>
<td>99468, 9469</td>
</tr>
<tr>
<td>36410, 96361, 99354, 99355, 99356, 99357, 99471, 99472</td>
<td>99477</td>
</tr>
<tr>
<td>36410, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478</td>
<td>99478</td>
</tr>
<tr>
<td>36410, 94761, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479</td>
<td>99479</td>
</tr>
<tr>
<td>36410, 96361, 99291, 99292, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479, 99480</td>
<td>99480</td>
</tr>
</tbody>
</table>

### 8.2.45.3 Newborn Hearing Screening

The newborn hearing screening procedure is a screening procedure, not diagnostic, and will not be reimbursed separately from the usual inpatient newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants. For more information on newborn hearing screening, providers may contact:

Texas Early Hearing Detection and Intervention  
PO Box 149347, MC-1918  
Austin, TX. 78714-9347  
(512) 458-7111, Ext. 2600  
www.dshs.state.tx.us/audio


Subsection 5.3.9.2.3, “Hearing Screening,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for additional information about hearing screenings.

### 8.2.46 * Obstetrics and Prenatal Care

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by TMHP within 95 days of the date of service.
When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity. Failure to use modifier TH may result in recoupment of payment rendered.

Providers must bill the most appropriate new or established patient prenatal or postnatal visit procedure code. New patient codes may be used when the client has not received any professional services from the same physician or a physician of the same specialty who belongs to the same group, within the past three years.

Physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 prenatal care visits per pregnancy and one postpartum care visit after discharge from the hospital. Routine pregnancies are anticipated to require around 11 visits per pregnancy, and high-risk pregnancies are anticipated to require around 20 visits per pregnancy.

More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. The provider can appeal with documentation supporting a complication of pregnancy. Documentation reflecting the need for increased visits must be maintained in the physician’s files and is subject to retrospective review.

Prenatal and postpartum care visits billed in an inpatient hospital (POS 3) are denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or Cesarean section and should not be billed separately.

One postpartum care procedure code may be reimbursed per pregnancy. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy regardless of the number of postpartum visits provided.

Procedure code 59430 may be reimbursed once per pregnancy following a delivery if the delivery procedure code does not include postpartum care. Since delivery procedure codes 59410, 59515, 59614, and 59622 include postpartum care, procedure code 59430 will be denied if procedure codes 59410, 59515, 59614, or 59622 were submitted by any provider for the same pregnancy.

Any other E/M office visit will not be reimbursed when billed with the same date of service, by the same provider, as any antenatal or postpartum office visit. Modifier 25 may be used to identify a significant, separately identifiable E/M service performed by the same physician on the same date of service as the procedure or other service. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except as outlined under subsection 8.2.6.3, “Anesthesia for Labor and Delivery” in this handbook. Medicaid may reimburse only one delivery or Cesarean section procedure code per client in a seven-month period; reimbursement includes multiple births.

Procedure code 99140 is not considered for reimbursement when submitted with diagnosis code 650 for a normal delivery or with diagnosis code 66970 or 66971 for a Cesarean delivery when one of these diagnosis codes is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition. An emergency is defined as a situation when delay in treatment of the client poses a significant health threat to a client’s life, bodily organ, or body part.

Hospital admissions resulting from conditions or comorbidities complicating labor should be billed using the appropriate E/M procedure codes. These codes are not subject to the three-day pre-care period but are not payable on the date of delivery or the following six-week post-care period.
Refer to: Subsection 8.2.6, “Anesthesia,” in this handbook for complete information about anesthesia for obstetrical procedures.

8.2.46.1 Amniocentesis, Cordocentesis, and Ultrasonic Guidance

Procedure code 59001 is restricted to diagnosis codes 65700, 65701, and 65703.

Cordocentesis and ultrasonic guidance procedure code 76941 are benefits of Texas Medicaid when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>64190 64191 64193 65530 65531 65533 65610 65613 65620 65623 67800 67801 67803</td>
</tr>
</tbody>
</table>

The Medical Director reviews cordocentesis requests on a case-by-case basis for diagnosis codes other than those listed above.

Cordocentesis or umbilical blood sampling is included in the global fee for procedure code 36460.

8.2.46.2 Deliveries

Texas Medicaid restricts any cesarean section, labor induction, or any delivery following labor induction to one of the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary will be denied.

Claims that are submitted for obstetric delivery procedure codes 59409, 59410, 59514, 59515, 59612, 59614, 59620, or 59622 require one of the following modifiers:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>To Indicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
<tr>
<td>U2</td>
<td>Delivery at 39 weeks of gestation or later</td>
</tr>
<tr>
<td>U3</td>
<td>Non-medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
</tbody>
</table>

Note: Claims for deliveries that are submitted without one of the required modifiers will be denied.

Records are subject to retrospective review. Payments made for a Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria (as determined by review of medical documentation), will be recouped. Recoupment will apply to the obstetric delivery procedure code and the associated hospital claim.

8.2.46.3 External Cephalic Version

External cephalic version is the external manipulation of a fetus to alter its position in the uterus to make it more favorable for delivery.

Procedure code 59412 is payable in the inpatient hospital (POS 3) or outpatient hospital (POS 5) setting when billed as an independent procedure performed by a physician at least one day before delivery.

Emergency room and subsequent hospital care visit procedure codes billed the same day as external cephalic version by the same provider are denied.
8.2.46.4 Fetal Fibronectin

Procedure code 82731 is a benefit of Texas Medicaid and may be considered for reimbursement when the fetal gestational age is 23 weeks through 34 weeks on the date the service was provided.

Fetal fibronectin is limited to threatened preterm labor using diagnosis code 64400 or 64403.

8.2.46.5 Fetal Intrauterine Transfusion (FIUT)

FIUT (procedure code 36460) is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>64190</td>
</tr>
<tr>
<td>67800</td>
</tr>
</tbody>
</table>

FIUT is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis.

In addition to the physician performing the FIUT, another physician may assist with echography control. Procedure code 76941 may be reimbursed separately when billed by a different physician.

8.2.46.6 Doppler Studies

Umbilical artery Doppler (procedure code 76820) is limited to the following indications, as supported by the American College of Obstetricians and Gynecologists (ACOG):

- Suspected intrauterine growth restriction (IUGR)
- Post-term gestation
- Diabetes mellitus
- Systemic lupus erythematosus or antiphospholipid antibody syndrome

Middle cerebral artery Doppler (procedure code 76821) is indicated, but not limited to, fetuses who are alloimmunized.

8.2.46.7 Fetal Echocardiography

Fetal echocardiography (procedure codes 76825, 76826, 76827, and 76828) may be reimbursed for the following risk factors and syndromes:

Fetal Risk Factors

- Extracardiac anomalies (including chromosomal and anatomic)
- Fetal cardiac dysrhythmia (including irregular rhythm, tachycardia, and bradycardia)
- Nonimmune hydrops fetalis
- Suspected cardiac anomaly on ultrasound
- Abnormal fetal situs

Maternal Risk Factors

- Congenital heart disease
- Cardiac teratogen exposure (including lithium, alcohol, phenytoin, trimethadione, and isoretinoin)
- Maternal metabolic disorders (including diabetes mellitus and phenylketonuria)

Familial Risk Factors

- Congenital heart disease (including previous sibling and paternal)
Syndromes

- Marfan’s
- Noonan’s
- Tuberous sclerosis

8.2.46.8 Obstetric Ultrasound

Ultrasound of the pregnant uterus is a benefit of Texas Medicaid when medically indicated. Ultrasound may be indicated for suspected genetic defects, high risk pregnancy, and fetal growth retardation.

The following procedure codes for ultrasound of the pregnant uterus are limited to a total of three per pregnancy:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>76801</td>
</tr>
<tr>
<td>76817</td>
</tr>
</tbody>
</table>

The limit of three obstetric ultrasounds per pregnancy does not apply to obstetric ultrasound procedures that are rendered in the emergency room, outpatient observation, or inpatient hospital setting. Obstetric ultrasounds provided in the emergency department must be submitted with modifier U6 when submitted on the professional claim form in order to be considered for payment. Obstetric ultrasounds provided in the emergency department or during a hospital observation stay must be submitted with the appropriate corresponding emergency services or hospital observation revenue code in order to be considered for payment.

The initial three claims paid for obstetric ultrasounds do not require prior authorization. Any obstetric ultrasound claims submitted with or without prior authorization for the initial three will count toward the three-per-pregnancy limit. If it is medically necessary to perform more than three obstetrical ultrasounds on a client during one pregnancy, the provider must request prior authorization with documentation of medical necessity using the Form MD.8, “Obstetric Ultrasound Prior Authorization Request Form” in this handbook.

Documentation is required to substantiate the need to perform a transvaginal obstetric ultrasound in addition to a transabdominal examination on the same date of service. Texas Medicaid follows the ACOG indications for sonography. First trimester ultrasounds may be medically necessary for, but are not limited to, the following reasons:

- To confirm the presence of an intrauterine pregnancy
- To evaluate a suspected ectopic pregnancy
- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose or evaluate multiple gestation
- To confirm cardiac activity
- As an adjunct to chorionic villus sampling or localization and removal of an intrauterine device
- To assess certain fetal anomalies, such as anencephaly, in clients at high risk
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy
- To evaluate a suspected hydatidiform mole
Second and third trimester ultrasounds may be medically necessary for the following reasons:

- To estimate fetal age
- To evaluate fetal growth
- To evaluate vaginal bleeding
- To evaluate cervical insufficiency
- To evaluate abdominal and pelvic pain
- To determine fetal presentation
- As an adjunct to amniocentesis or other procedure
- To evaluate suspected multiple gestation
- To evaluate a significant discrepancy between uterine size and clinical dates
- To evaluate a pelvic mass
- To evaluate a suspected hydatidiform mole
- As an adjunct to cervical cerclage placement
- To evaluate a suspected ectopic pregnancy
- To evaluate suspected fetal death
- To evaluate suspected uterine abnormality
- To evaluate fetal well-being
- To evaluate suspected amniotic fluid abnormalities
- To evaluate suspected placental abruption
- As an adjunct to external cephalic version
- To evaluate premature rupture of membranes or premature labor
- To evaluate abnormal biochemical markers
- As a follow-up evaluation of a fetal anomaly
- As a follow-up evaluation of placental location for suspected placenta previa
- To evaluate clients who have a history of previous congenital anomaly
- To evaluate fetal condition in late registrants for prenatal care
- To assess findings that may increase the risk of aneuploidy
- To screen for fetal anomalies

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, dated, and maintained in the client’s medical record by the provider ordering the test, regardless of the method of request for authorization. A physician, nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse midwife (CNM), or physician assistant (PA) may sign the Obstetric Ultrasound Prior Authorization Request Form. Residents may order obstetric ultrasounds; however, the attending physician must sign the authorization form and include the group or supervising provider identifier on the form.

The provider’s signature must be current, unaltered, original, and handwritten. A computerized or stamped signature or date will not be accepted.

The form must include information related to medical necessity of the test including all of the following:

- Procedure code requested (CPT code) and quantity requested
• The trimesters during which the requested ultrasounds will be performed
• The date range during which the procedures will be performed
• Client’s estimated date of confinement (EDC) at the time the request is submitted
• Diagnosis

Additional documentation to support medical necessity may include any of the following:
• Treatment history
• Treatment plan
• Medications
• Previous imaging results

When requesting retroactive authorization, providers must submit the request no later than 14 calendar
days beginning the day after the study is completed.

Providers can submit requests for prior authorization or retroactive authorization by phone, by fax,
online, or by mailing to:

Texas Medicaid & Healthcare Partnership
Inpatient/Outpatient Prior Authorization
12357-B Riata Trace Parkway Ste. 150
Austin, TX 78727

Reimbursement for obstetric ultrasounds may be considered on appeal when submitted with documen-
tation that indicates any one of the following:
• Ultrasound was performed for a different pregnancy.
• The provider was unable to obtain the previous ultrasound records from a different provider.
• The provider was new to treating the client and was not aware the client had already had three
  obstetric ultrasounds.

Only one appeal will be considered per client for the same provider. Providers must obtain prior autho-
rization for any additional obstetric ultrasounds performed after the appealed service. Claims for add-
on codes for multiple fetuses should be billed with modifier 76 if there is more than one additional fetus.
Claims will be considered on appeal with documentation indicating the number of fetuses.

The following procedure codes must be billed together:
• Procedure code 76802 must be billed in conjunction with primary procedure code 76801.
• Procedure code 76810 must be billed in conjunction with primary procedure code 76805.
• Procedure code 76812 must be billed in conjunction with primary procedure code 76811.
• Procedure code 76814 must be billed in conjunction with primary procedure code 76813.

Note: Add-on procedure codes (76802, 76810, 76812, and 76814) do not count toward the three-
per-pregnancy limitation.
8.2.46.9 Prenatal Surveillance

Prenatal surveillance includes fetal contraction stress test (procedure code 59020), fetal nonstress test (procedure code 59025), and fetal biophysical profile with or without nonstress testing (procedure code 76818 or 76819). According to guidelines established by ACOG, some of the conditions under which testing may be appropriate include, but are not limited to, the following maternal and pregnancy related conditions:

**Maternal Conditions**
- Antiphospholipid syndrome
- Hyperthyroidism (poorly controlled)
- Hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
- Cyanotic heart disease
- Systemic lupus erythematosus
- Chronic renal disease
- Type I diabetes mellitus
- Hypertensive disorders

**Pregnancy Related Conditions**
- Pregnancy-induced hypertension
- Decreased fetal movement
- Oligohydramnios
- Polyhydramnios
- Intrauterine growth restriction
- Post-term pregnancy
- Isoimmunization (moderate to severe)
- Previous fetal demise (unexplained or recurrent risk)
- Multiple gestations (with significant growth discrepancy)

Procedure code 59025 is payable in the office setting only and procedure code 59020 is payable in the inpatient and outpatient hospital settings only.

Procedure codes 59020 and 59025, when billed with revenue code 729 for outpatient facilities, may be reimbursed on the same day by a different provider without appeal. However, procedure codes 59020 and 59025, billed with revenue code 729 more than once per day by the same provider, will be denied. The provider may appeal with documentation supporting the performance of the test more than once on the same day by the same provider.

Fetal biophysical profile (procedure codes 76818 and 76819) may be reimbursed separately when billed with one of the following procedure codes on the same day:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76805</td>
</tr>
</tbody>
</table>
To prevent repeat unintended or unwanted pregnancies, physicians are urged to include family planning services or referrals in the maternity care of the client. Genetic diagnosis and counseling is also available through Texas Medicaid for clients suspected of having a genetic disorder for informed reproductive decision making.

Refer to: Section 2, “Medicaid Title XIX family planning services” in *Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).*

8.2.46.10 Tobacco Use Cessation Counseling

Tobacco use cessation counseling (procedure codes 99406 and 99407) is a benefit of Texas Medicaid for pregnant clients who are 10 through 55 years of age. Both procedure codes are restricted to diagnosis codes 64900, 64901, 64902, 64903, and 64904.

Only one procedure code, either 99406 or 99407, will be reimbursed per day, any provider. Procedure codes 99406 and 99407 will be limited to a combined total of 8 visits per rolling year, any provider.

8.2.46.11 Transabdominal Amnioinfusion

Procedure codes 59070, 59074, and 59076 are restricted to diagnosis codes 65610, 65613, 65620, and 65623.

8.2.46.12 Documentation Requirements for Diagnostic Studies

Texas Medicaid requires providers to follow the documentation requirements as set forth in the Diagnostic Ultrasound section of the *Current Procedural Terminology* (CPT) manual for the diagnostic studies of the fetus, including when ultrasound is used to guide a procedure.

Documentation requirements set forth in the CPT manual include, but are not limited to, the following:

- Permanently recorded images with measurements, when measurements are clinically indicated.
- Final written report included in the client’s medical record (includes written interpretation).
- Report must include description of elements that comprised a “complete” or “limited” exam, and the reasons an element could not be visualized.
- Permanently recorded images are also required for ultrasound guidance procedures of the site to be localized. In addition, description of the localization process, either separately or within the report of the procedure, when the guidance is used.

Permanently recorded images must be made available on request by HHSC.

Medical record documentation must include assessment findings that substantiate the medical necessity for each diagnostic test.

8.2.46.13 Required Screening of Pregnant Women for Syphilis, HIV, and Hepatitis B

Providers are required to perform serologic testing during pregnancy for syphilis, HIV, and hepatitis B (*Health and Safety Code* §81.090).

8.2.46.13.1 HIV Testing

An HIV test must be performed at the first prenatal care visit and during the third trimester of pregnancy.

If there is no record of a third-trimester test when a woman arrives at labor and delivery, a test must be immediately performed. The laboratory must provide the results of the test to the provider within six hours of the submission of the sample. If there is no record of a third-trimester test and no test was performed during labor and delivery, the infant must be tested within two hours of birth, and those test results must be provided to the provider within six hours of the submission of the sample.
If a pregnant woman refuses HIV testing, the attending health care provider must make a note in the client’s record of the following:

- The HIV test was offered.
- The patient declined testing.
- A referral to an anonymous testing site was made.
- The patient was provided with appropriate literature.

8.2.46.13.2 Hepatitis B and Syphilis Screening

Providers and hospitals are required to screen all pregnant women for hepatitis B surface antigen (HBsAg) and syphilis at their first prenatal visit and at delivery. Pregnant women who test positive for HBsAg must be reported to DSHS (25 TAC §97.3) and appropriate prophylaxis must be administered to the infant born to that pregnant woman per DSHS and the ACIP. The Perinatal Hepatitis B Prevention Program manual, reporting forms, and information brochures are available at www.texas-perinatalhepb.org. Providers may also contact the Perinatal Hepatitis B Prevention Program Coordinator at (512) 776-7447.

Pregnant women who are identified as being chronically infected with HBsAg should receive appropriate follow-up services.

8.2.47 Occupational Therapy (OT) Services

Occupational therapy (OT) is a payable benefit to physicians.

Refer to: Section 4, “Therapists, Independent Practitioners, and Physicians” in Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for information about occupational therapy services provided by a physician.

8.2.48 Ophthalmology

When an ophthalmologist sees a client for a minor condition that does not require a complete eye exam, such as conjunctivitis, providers are to use the appropriate office E/M code.

Providers are to use the eye exam procedure codes with a diagnosis of ophthalmological disease or injury.


8.2.48.1 Corneal Transplants

Corneal transplants are benefits of Texas Medicaid. Corneal transplants are subject to global surgery fee guidelines. Procedure codes 65710, 65730, 65750, 65755, 65756, and 65757 are used for this surgery.

Bioengineered cornea transplants remain investigational at this time and are not considered for reimbursement under Texas Medicaid.

Procurement of the cornea is not reimbursed separately.

8.2.48.2 Eye Surgery by Laser

Eye surgery by laser is a benefit of Texas Medicaid when medically necessary and meets the conditions and limitations stated in this section.

Authorization is not required for eye surgery by laser.

All procedure codes in this section are subject to multiple surgery guidelines. For bilateral procedures, the following modifiers must be added to the claim to indicate that the procedures were performed on the right and left eyes:

- Modifier RT to indicate the right eye
• Modifier LT to indicate the left eye

All procedures may be reimbursed only to physicians and are limited to reimbursement once every 90 days for the same eye with the exception of infants from birth through 23 months of age. Procedures performed on infants from birth through 23 months of age are not subject to any frequency restrictions.

8.2.48.2.1 Other Eye Surgery Procedures

Anterior Segment of the Eye–The Cornea
Laser surgery to the cornea by Laser-Assisted in Situ Keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of Texas Medicaid.

Reimbursement for laser surgery to the cornea, procedure codes 65450, 65855, and 65860 is limited to once every 90 days for the same eye.

Anterior Segment of the Eye–The Iris, Ciliary Body
Laser surgery to the anterior segment of the eye–the iris, ciliary body may be reimbursed only when billed with one of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>66600</td>
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<tr>
<td>66605</td>
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<tr>
<td>66710</td>
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<td>66711</td>
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<td>66761</td>
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<tr>
<td>66762</td>
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<tr>
<td>66770</td>
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</tbody>
</table>

Reimbursement for procedure codes 66600, 66605, 66710, 66711, 66761, 66762, and 66770 is limited to once every 90 days for the same eye.

Claims for iridectomy (66600, 66605, 66625, 66630, or 66635) or iridotomy (66500 or 66505) are not reimbursed when billed for the same date of service as a trabeculectomy (66170 or 66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends for review.

An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (66600 or 66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>65920</td>
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<tr>
<td>66840</td>
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<tr>
<td>66850</td>
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<tr>
<td>66852</td>
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<td>66920</td>
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<td>66930</td>
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<td>66940</td>
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<td>66983</td>
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<tr>
<td>66984</td>
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<tr>
<td>66985</td>
</tr>
<tr>
<td>66986</td>
</tr>
</tbody>
</table>

Posterior Segment of the Eye–Retina or Choroid
Laser surgery to the retina or choroid may be reimbursed only when billed with one of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67105</td>
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<tr>
<td>67107</td>
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<tr>
<td>67108</td>
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<tr>
<td>67110</td>
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<td>67112</td>
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<td>67113</td>
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<td>67145</td>
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<td>67210</td>
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<td>67221</td>
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<tr>
<td>67225</td>
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<tr>
<td>67228</td>
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<tr>
<td>67229</td>
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<tr>
<td>G0186</td>
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</tbody>
</table>

Procedure code 67229 is restricted to clients who are birth through 1 year of age.
When billed for the same date of service, same eye, any provider, procedure code 67031 will be denied as part of any of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67036</td>
</tr>
<tr>
<td>67227</td>
</tr>
</tbody>
</table>

When billed for the same date of service, same eye, any provider, only one of the following procedure codes may be reimbursed: 67220, 67221, 67225, or G0186.

When billed for the same date of service, same eye, by any provider, procedure codes 67025, 67028, 67031, 67036, 67039, 67040, and 67105 will be denied as part of 67108.

**Posterior Segment of the Eye, Vitreous–Vitrectomy**

Laser surgery to the vitreous may be reimbursed only when billed with one of the following procedure codes: 67031, 67039, 67040, and 67043.

Reimbursement for procedure codes 67031, 67039, 67040, and 67043 is limited to once every 90 days for the same eye.

When billed for the same date of service, same eye, any provider procedure codes 67500 and 69990 are denied as part of 66821.

Procedures 66821, 67005, 67010, and 69990 will be denied as part of 67031.

When billed for the same date of service, same eye, any provider procedure code 67031 will be denied as part of any of the following procedure codes: 67036, 67108, 67110, 67120, 67121, 67208, 67218, 67227, and 67228.

### 8.2.48.3 Eye Surgery by Incision

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 66500, 66505, 66605, 66625, 66630, and 66635 are denied as part of another procedure when billed with the following cataract surgeries: 65920, 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984, 66985, and 66986. Claims may be appealed with additional documentation to demonstrate the medical necessity.
- Procedure code 66020 is denied as part of another procedure when billed with any related eye surgery procedure code.
- Procedure code 67036 may be reimbursed when billed alone.
- Procedure code 67036 is denied as part of another procedure when billed with procedure codes 67039, 67040, 67041, 67042, 67043, and/or 67108.
- Procedure codes 67039 and 67040 are combined and reimbursed as procedure code 67108 when billed by the same provider for the same date of service.
• For clients who are 8 years of age and younger, the following cataract extraction and vitrectomy procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>66840</td>
</tr>
<tr>
<td>67015</td>
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<tr>
<td>67042</td>
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</tbody>
</table>

• For clients who are 9 years of age and older, the following procedure codes will be paid when performed on the same eye as a cataract extraction:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>67005</td>
</tr>
<tr>
<td>67040</td>
</tr>
</tbody>
</table>

• For clients who are 9 years of age and older, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>66840</td>
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</tbody>
</table>

Reimbursement for procedure codes 67041, 67042, and 67043 is limited to once every 90 days for the same eye.

8.2.48.4 Intraocular Lens (IOL)

An IOL (V2630, V2631, and V2632) may be reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer’s invoice for procedure code V2631 to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed 5 percent of the acquisition cost.

Medicaid does not reimburse physicians who supply IOLs to ASCs/HASCs.

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

8.2.48.5 Intravitreal Drug Delivery System

Procedure codes 67027 and 67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to deny when billed concurrently.

8.2.48.6 Other Eye Surgery Limitations

The following procedure codes require modifier LT or RT to identify the eye for which the surgery is being performed:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>65205</td>
</tr>
<tr>
<td>67345</td>
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</tbody>
</table>
In the following table, the procedure codes in Column A may be reimbursed only when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

<table>
<thead>
<tr>
<th>Column A Procedure Codes</th>
<th>Column B Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>66990</td>
<td>65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, or 67112</td>
</tr>
<tr>
<td>67320, 67331, 67332, 67334</td>
<td>67311, 67312, 67314, 67316, or 67318</td>
</tr>
<tr>
<td>67335, 67340</td>
<td>67311, 67312, 67314, 67316, or 67318</td>
</tr>
<tr>
<td>V2790</td>
<td>65780</td>
</tr>
</tbody>
</table>

### 8.2.49 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, intestinal, lung, liver, kidney, pancreas/simultaneous kidney-pancreas, or combined heart/lung are a benefit of Texas Medicaid. Organ/tissue transplants require prior authorization and may be reimbursed only when performed in a facility that is a designated children’s hospital, or certified for the procedure by the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).

Refer to: Subsection 3.2.5, “Organ and Tissue Transplant Services,” in *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information about the transplant facility approval criteria.

Subsection 3.2.5.2, “Transplant Benefits and Limitations,” in *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information about organ/tissue transplant program limitations.

### 8.2.49.1 Heart Transplants

#### 8.2.49.1.1 Prior Authorization for Heart Transplants

A heart transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a heart transplant facility by Texas Medicaid.

A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered individually.

#### 8.2.49.1.2 Guidelines for Coverage of a Heart Transplant

Heart transplant candidates are limited to those clients who, based on sound patient selection criteria, would most likely benefit from the heart transplant procedure on a long-term basis. To be reimbursed by Texas Medicaid, the facility must document the following considerations:

- One of the following:
  - New York Heart Association (NYHA) Class Stage III or IV cardiac disease
  - Congenital heart disease
  - Valvular heart disease
  - Viral cardiomyopathies
  - Familial and restrictive cardiomyopathies
- A heart transplant will result in a return to improved functional independence.
• An absence of comorbidities such as:
  • Severe pulmonary hypertension.
  • End-stage renal, hepatic or other organ dysfunction unrelated to primary disorder.
  • Active, uncontrolled HIV infection or AIDS-defining illness.
  • Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.

Documented compliance with other medical treatments, regimen, and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

8.2.49.2 Intestinal Transplants

8.2.49.2.1 Prior Authorization for Intestinal Transplants
Intestinal transplants and related services must meet criteria for authorization, and all transplants must be performed in transplant facilities approved by the CMS.

8.2.49.2.2 Guidelines for Coverage of an Intestinal Transplant
All intestinal transplant services must be prior authorized.

Small bowel transplantation from a cadaveric or living donor is considered medically necessary in clients with irreversible intestinal failure who have experienced total parenteral nutrition (TPN) failure. The client has experienced TPN failure if any one of the following criteria is met:

• Impending or overt liver failure due to TPN-induced liver injury. Clinical indictors include the following:
  • Increased serum bilirubin levels
  • Increased liver enzyme levels
  • Splenomegaly
  • Thrombocytopenia
  • Gastroesophageal varices
  • Coagulopathy
  • Stomal bleeding
  • Hepatic fibrosis
  • Cirrhosis

• Thrombosis of major central venous channels (subclavian, jugular, or femoral veins). Thrombosis of two or more of these vessels is considered a life-threatening complication and TPN failure.

• Frequent central line-related sepsis. Two or more episodes of central-line-induced systemic sepsis per year that require hospitalization are considered TPN failure. A single episode of central-line-related fungemia, septic shock, or acute respiratory distress syndrome is considered TPN failure.

• Frequent episodes of severe dehydration despite TPN and intravenous fluid supplement. Under medical conditions, such as secretory diarrhea and nonconstructable gastrointestinal tract, the loss of combined gastrointestinal and pancreatobiliary secretions exceed the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system.
Diagnoses that indicate intestinal failure include, but are not limited to, the following:

- Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment
- Small bowel syndrome resulting from postsurgical conditions due to resections
- Intestinal cysts
- Mesenteric cysts
- Small bowel or other tumors involving small bowel
- Crohn’s disease
- Mesenteric thrombosis
- Volvulus
- Short-gut syndrome in which there is liver function impairment (usually secondary to TPN)

The prior authorization request must include the following documentation:

- A recent and complete history and physical
- A copy of the multidisciplinary client care team’s evaluation summary
- Statement of the client’s status, including why the transplant is being recommended at this time (Each client’s condition is evaluated on an individual basis.)

Requests for intestinal transplants should include all procedures, such as backbench work, that will be provided and billed in addition to the intestinal transplant.

8.2.49.2.3 Other Limitations for Intestinal Transplants

Backbench procedure codes 44715, 44720, and 44721 are payable under the client.

8.2.49.3 Kidney Transplants

8.2.49.3.1 Prior Authorization for Kidney Transplants

A kidney transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a kidney transplant facility by Texas Medicaid.

A kidney transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

8.2.49.3.2 Guidelines for Coverage of a Kidney Transplant

Kidney transplants must be prior authorized. The following documentation is required:

- A recent and complete history and physical.
- A copy of the Transplant Committee’s evaluation summary.
- A statement of the client’s status including why a transplant is being recommended at this time. Each client’s condition is evaluated on an individual basis. Approved indications for a kidney transplant may include the following:
  - Hemodialysis or continuous ambulatory peritoneal dialysis (CAPD).
  - Chronic renal failure with anticipated deterioration to end-stage renal disease.
  - End-stage renal disease, evidenced by a creatinine clearance below 20 ml/min or development of symptoms of uremia.
  - End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12-month period.
Requests for kidney transplants should include all procedures, such as backbench work, that will be provided and billed in addition to the kidney transplant. Backbench procedure codes 50323, 50325, 50327, 50328, and 50329 are payable under the client.

8.2.49.3.3 Cytogam

Procedure code J0850 is reimbursable by Texas Medicaid. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code V420, status post kidney transplant. Cytogam is payable only in the office or outpatient setting.

Refer to: Subsection 3.2.5, “Organ and Tissue Transplant Services,” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for more information about the transplant facility approval criteria.

8.2.49.4 Liver Transplants

8.2.49.4.1 Prior Authorization for Liver Transplants

A liver transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a liver transplant facility by Texas Medicaid.

For a client to be considered for coverage of a liver transplant, the medical records for the client must include documentation showing the client is unresponsive to more conventional and/or standard therapies.

8.2.49.4.2 Guidelines for Coverage

Authorization of liver transplantation requires documentation of life threatening complications of acute liver failure or chronic end-stage liver disease.

Liver transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the liver transplant procedure on a long-term basis. To be reimbursed by Texas Medicaid, the facility must document the following considerations:

- A critical medical need with a likelihood of a successful clinical outcome
- Liver disease in one of the following categories:
  - Primary cholestatic liver disease
  - Other cirrhosis:
    - Alcoholic
    - Hepatitis C, non-A, non-B, and Hepatitis B
  - Fulminant hepatic failure
  - Metabolic diseases
  - Malignant neoplasms
  - Benign neoplasms
  - Biliary atresia
- An absence of comorbidities such as:
  - End-stage cardiac, pulmonary, or renal disease unrelated to primary disorder.
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.
• Documented compliance with other medical treatments, regimen, and plan of care. (Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.)

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

Payment for liver transplant professional services is made under procedure code 47135 or 47136. These procedures include six months of professional postoperative care. Separate charges for procedure code 47780 are denied as part of the liver transplant. Parenteral immunosuppressant therapy is approved for a period of 12 months following the date of discharge from the hospital, conditional upon the client’s Medicaid eligibility.

Services unrelated to the liver transplant surgery are paid separately.

Two assistant surgeons are allowed for liver transplant surgery using the appropriate assistant surgery modifier with procedure codes 47135 or 47136.

8.2.49.5 Lung Transplants

8.2.49.5.1 Prior Authorization for Lung Transplants

A lung transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a lung transplant facility by Texas Medicaid.

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a heart/lung transplant and must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant are considered on an individual basis.

8.2.49.5.2 Guidelines for Coverage of a Lung Transplant

Lung transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the lung (single or double) transplant procedure on a long-term basis. To be reimbursed by Texas Medicaid, the facility must document the following considerations:

• A critical medical need with a likelihood of a successful clinical outcome
• Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation
• Lung transplantation may be authorized with documentation of end-stage pulmonary diseases in these categories:
  • Obstructive lung disease
  • Restrictive lung disease
  • Cystic Fibrosis
  • Pulmonary hypertension
• An absence of comorbidities such as:
  • End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder.
  • Multiple organ compromise secondary to infection, malignancy, or condition with no known cure.
• Documented compliance with other medical treatments, regimen, and plan of care. (Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.)
Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen.

8.2.49.6 Pancreas Transplant and Simultaneous Kidney-Pancreas Transplant

8.2.49.6.1 Prior Authorization for Pancreas Transplant/Simultaneous Kidney-Pancreas Transplant

A pancreas/simultaneous kidney-pancreas transplant for individual Medicaid clients is subject to prior authorization and must be performed in an institution approved as a pancreas/simultaneous kidney-pancreas transplant facility by Texas Medicaid.

**Note:** Islet cell transplant is considered experimental and investigational and is not a benefit of Texas Medicaid.

A pancreas/simultaneous kidney-pancreas transplant must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization is required for a pancreas/simultaneous kidney-pancreas transplant and must follow criteria for both pancreas and simultaneous kidney-pancreas transplant.

8.2.49.6.2 Guidelines for Coverage of a Pancreas/Simultaneous Kidney-Pancreas Transplant

Pancreas/simultaneous kidney-pancreas transplant candidates must be limited to those clients who, based on sound patient selection criteria, would most likely benefit from the transplant procedure on a long-term basis. Documentation at the time of authorization is required in order to be considered for reimbursement by Texas Medicaid.

8.2.49.6.3 Pancreas Transplant Alone

For a transplant of the pancreas alone, documentation must be submitted that shows all of the following:

- A satisfactory kidney function (creatinine clearance greater than 40 mL/min)
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management and meet at least one of the following below:
  - Secondary complications, which must include at least two of the following:
    - Diabetic neuropathy
    - Retinopathy
    - Gastroparesis
    - Autonomic neuropathy
  - Extremely labile (brittle) insulin-dependent diabetes mellitus
  - Recurrent, acute and severe metabolic and potentially life-threatening complications requiring medical attention, which include:
    - Hypoglycemia
    - Hyperglycemia
    - Ketacidosis
    - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
    - Insensibility to hypoglycemia
8.2.49.6.4 Simultaneous Kidney-Pancreas Transplant

For a simultaneous kidney-pancreas transplant, documentation must be submitted that shows that the client has type 1 diabetes mellitus with secondary diabetic complications that are progressive despite the best medical management. Additionally, the documentation must show at least one of the following:

- Secondary complications, which must include at least two of the following:
  - Diabetic neuropathy
  - Retinopathy
  - Gastroparesis
  - Autonomic neuropathy
  - Extremely labile (brittle) insulin-dependent diabetes mellitus
- Recurrent, acute and severe metabolic and potentially life-threatening complications requiring medical attention, which include:
  - Hypoglycemia
  - Hyperglycemia
  - Ketacidosis
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
  - Insensibility to hypoglycemia
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months

The following contraindications for the transplant applies to both pancreas and simultaneous kidney-pancreas transplant and are as follows:

- Inadequate cardiac status, pulmonary or liver function.
- Ongoing or recurrent active infections that are not effectively treated.
- Uncontrolled HIV/AIDS infection.
- Malignancy (except nonmelanoma skin cancers).
- Documented psychiatric instability if severe enough to jeopardize incentive for adherence to medical regimen.

Documentation of compliance with medical treatments regimen and plan of care includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen.

8.2.49.7 Nonsolid Organ Transplants

Nonsolid organ transplants covered by Texas Medicaid include allogeneic and autologous stem cell transplantation, allogeneic and autologous bone marrow transplantation, and autologous islet cell transplantation.

8.2.49.7.1 Allogeneic and Autologous Bone Marrow and Stem Cell Transplantation

Stem cell transplantation is a process in which stem cells are obtained from either a client’s or donor’s bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.

Benefits are not available for any experimental or investigational services, supplies, or procedures.
Coverage of bone marrow and stem cell transplantation is limited to the following procedure codes: 38206, 38230, 38232, 38240, 38241, 38242, and S2142.

**Allogeneic** stem cell transplantation may be authorized for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>20008 20010 20011 20012 20013 20014 20015 20016 20017 20018</td>
</tr>
<tr>
<td>20020 20021 20022 20023 20024 20025 20026 20027 20028 20030</td>
</tr>
<tr>
<td>20031 20032 20033 20034 20035 20036 20037 20038 20040 20041</td>
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</tr>
<tr>
<td>28401 28409 2842 28481 28489 2849 74259 75652</td>
</tr>
</tbody>
</table>

See ICD-9-CM: Neoplasm by site, malignant

**Autologous** stem cell transplantation may be authorized for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1860 1869 1890 1916 19882 20000 20001 20002 20003 20004</td>
</tr>
<tr>
<td>20005 20006 20007 20008 20010 20011 20012 20013 20014 20015</td>
</tr>
<tr>
<td>20016 20017 20018 20020 20021 20022 20023 20024 20025 20026</td>
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<td>20038 20040 20041 20042 20043 20044 20045 20046 20047 20048</td>
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<tr>
<td>20050 20051 20052 20053 20054 20055 20056 20057 20058 20060</td>
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<td>20061 20062 20063 20064 20065 20066 20067 20068 20070 20071</td>
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<td>20104 20105 20106 20107 20108 20110 20111 20112 20113 20114</td>
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See ICD-9-CM: Neoplasm by site, malignant
8.2.49.7.2 Autologous Islet Cell Transplantation

Autologous islet cell transplantation associated with the complete or partial removal of the pancreas (procedure code 48160) is a benefit of Texas Medicaid only for clients with a diagnosis of chronic pancreatitis (diagnosis code 5771).

Allogeneic islet cell transplantation is not a benefit.

8.2.49.7.3 Prior Authorization for Nonsolid Organ Transplants

All nonsolid organ transplants require mandatory prior authorization and must be performed in a Texas facility that is a designated children’s hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization is effective for the date span specified on the prior authorization approval letter. If the transplant has not been performed by the end of the authorization period, the physician must apply for an extension.

Documentation supplied with the prior authorization request must include the following:

- A complete history and physical.
- A statement of the client’s current medical condition and the expected long-term prognosis for the client from the proposed procedure.

Each subsequent transplant must be prior authorized separately.

Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but will not be approved when performed simultaneously.

If a stem cell transplant has been prior authorized for a client who is 21 years of age or older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Bone marrow harvesting (38230) or peripheral stem cell harvesting (38206) for autologous bone marrow or stem cell transplants are a benefit of Texas Medicaid and require prior authorization.

Autologous harvesting of stem cells (single or multiple sessions) may be reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.

Physician services for the storage of stem cells are not a benefit of Texas Medicaid.
Donor expenses are included in the global fee for the transplant recipient and are not reimbursed separately. Therefore, allogeneic bone marrow or stem cell harvesting procedures are not a benefit of Texas Medicaid.

Stem cell transplants for other diagnoses may be considered on a case by case basis. Documentation for prior authorization must be submitted to determine whether the transplant is medically necessary and appropriate.

8.2.49.8 Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records.

Physician services for the procurement of peripheral stem cells are not reimbursable.

8.2.49.9 Prior Authorization for All Transplants

It is the requesting physician and facility’s responsibility to receive prior authorization through TMHP Special Medical Prior Authorization.

HHSC or its designee must prior authorize all transplant services provided by facilities and professionals. Documentation supplied with the prior authorization request must address the criteria listed for each type of transplant above, and must be medically necessary, reasonable, and federally allowable.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g., laboratory services, status post visits, radiology services). Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent transplant because of organ rejection. A subsequent transplant is not included in the prior authorization for the initial transplant; therefore, it must be prior authorized separately.

A transplant request signed by a physician associated with one of Texas Medicaid-approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution’s transplant protocol. Additional documentation may be required, which is addressed in the previous specific organ/tissue information.

Texas Medicaid does not pay for transplants or post-transplant services in a nonqualifying facility, nor are physician charges reimbursed for transplants in a nonqualifying facility.

Benefits are not available for any experimental or investigational services, supplies, or procedures. Expenses incurred by a living donor for transplants will not be reimbursed.

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213
8.2.50 Orthognathic Surgery

Orthognathic surgery is a benefit of Texas Medicaid only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery is administered and may be reimbursed as part of the medical/surgical benefit of Texas Medicaid and not as part of the Texas Medicaid Dental Program.

Treatment of malocclusion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is a benefit when it is necessary as part of the approved dental benefit.

Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:

- Producing signs or symptoms of masticatory dysfunction
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies
- Facial skeletal discrepancies associated with documented speech impairments
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies

Orthognathic surgery may be considered for reimbursement when required for the client to access a dental service. Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of Texas Medicaid.

8.2.50.1 Prior Authorization for Orthognathic Surgery

The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons with prior authorization. A narrative explaining medical necessity must be provided with the authorization request.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>21010 21031 21032 21050 21060 21073 21100 21110 21120 21121</td>
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<td>21122 21123 21125 21127 21137 21138 21139 21145 21146 21147</td>
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<tr>
<td>29804 40840 40842 40843 40844 40845 S8262</td>
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8.2.51 Osteogenic Stimulation

Professional services for osteogenic stimulation (procedure codes 20974, 20975, and 20979) are a benefit for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>73381 73382 73396 73397 73398 9052 9053 9054 9055 99640</td>
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<td>V454</td>
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Procedure codes 20974, 20975, and 20979 are limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the criteria for an osteogenic stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

Prior authorization is required for an osteogenic bone stimulator device (procedure codes E0747, E0748, E0749, and E0760).

Refer to: Subsection 2.2.16, “Osteogenic Stimulation,” in Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks) for prior authorization criteria.

8.2.52 Osteopathic Manipulative Treatment (OMT)

OMT, when performed by a physician (MD or DO), is a benefit of Texas Medicaid for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component.

OMT is covered when it is performed with the expectation of restoring the patient’s level of function, which has been lost or reduced by injury or illness. Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. A model of documentation that supports medical necessity for the treatment plan includes the following:

- Specific modalities/procedures to be used in treatment
- Diagnosis
- Region treated
- Degree of severity
- Impairment characteristics
- Physical examination findings (X-ray or other pertinent findings)
- Specific statements of long- and short-term goals
- Reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and techniques used

The treatment plan must be updated as the client’s condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made. Paper claims submitted without modifier AT will be denied; electronic claims will be rejected. The AT modifier is described as representing treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 98925, 98926, 98927, 98928, and 98929.
OMT will be denied when billed on the same date of service by the same provider as any of the following procedure codes:

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<thead>
<tr>
<th>Procedure Codes</th>
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<td>00640 51701 51702 51703 62310 62311 62318 62319 64400 64402</td>
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<td>99478 99479 99480</td>
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When multiples of procedure codes 98925, 98926, 98927, 98928, and 98929 are billed on the same day by the same provider, the most inclusive code is paid and the others are denied.

An E/M or initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day if the client’s condition requires a visit for a significant and separately identifiable service above and beyond the usual pre- and post-care associated with the OMT procedure, even if the visit and OMT are related to the same symptom or condition. Modifier 25 must be submitted with the E/M procedure code to identify a separate and distinct service rendered on the same day as OMT.

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Procedure code 97140 will be denied as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

**8.2.53 Pain Management**

Pain management is a benefit of Texas Medicaid.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.
Use the following procedure codes when billing for the implantation/revision/replacement of the pump/catheter:

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<th>Procedure Codes</th>
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Procedure codes 62367 and 62368 do not require prior authorization and are payable as a medical service only.

Refer to: Subsection 8.2.39.22, “Implantable Infusion Pumps,” in this handbook for more information about implanted pumps.

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent, often lasting more than six months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

**8.2.53.1 Epidural and Subarachnoid Infusion (Not Including Labor and Delivery)**

Epidural and subarachnoid infusion for pain management is payable for acute, chronic, and postoperative pain management.

Procedure code 01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure. Procedure code 01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30-day limitation.

Procedure code 01996 is payable to CRNAs and physicians.

**8.2.54 Palivizumab Injections**

Texas Medicaid considers the AAP criteria as the most useful single reference describing the evidence basis for RSV prophylaxis medical necessity. RSV immune globulin, intramuscular palivizumab (Synagis) is a benefit of CCP when medically necessary.

Based upon RSV surveillance data and the expert opinion of Texas-based specialists, the beginning of RSV season in Texas starts on different dates based on the region. The RSV season is expected to start no earlier than October 1 for all regions, except regions 1, 9, and 10. For regions 1, 9, and 10, the RSV season is expected to start no earlier than November 1 of each calendar year.

During the RSV season, hospitalized infants determined to be at risk of severe RSV disease in September should receive their first dose of RSV prophylaxis 48–72 hours before being discharged. Clients will continue with five more doses. Discharge planning should arrange outpatient follow-up for continued administration of RSV prophylaxis if medically indicated.

Beginning at 6 months of age, all high-risk infants, including those who qualify for RSV prophylaxis and their contacts should be immunized against influenza, unless influenza immunization is medically contraindicated in the case of a specific individual.

**8.2.54.1 Benefits and Limitations**

RSV prophylaxis is not reimbursed for dates of service outside the RSV season.

**Exception:** RSV prophylaxis may be reimbursed for two weeks preceding the start of the RSV season for hospitalized infants determined to be at risk of severe RSV disease in September.

RSV prophylaxis injections given during an inpatient hospital stay are considered included in the hospital DRG and are not separately reimbursed.
RSV prophylaxis is not reimbursed for Medicaid clients who are 24 months of age and older at the start of the RSV season in Texas.

CCP may consider reimbursement for the intramuscular version of the RSV prophylaxis when billed with procedure code 90378. RSV prophylaxis is provided in single use vials and must be billed per milligram (mg). If different size vials (e.g., 50 mg vial and 100 mg vial) are required for the appropriate dosage on the same date of service, providers must bill each vial separately on the same claim and include the appropriate NDC for each detail.

Providers are required to maintain accurate records of the total number of units given and the total number of units purchased, administered, and wasted for each client. If billing waste, the total number of units billed must include the number of units wasted. Texas Medicaid reimburses providers for waste only if a partial vial is actually wasted and not if the partial vial is used for another patient.

**Example:** If 180 mg is administered to a client and 20 mg is wasted, 200 services/units must be billed, not 4 services/units.

Providers may not bill Texas Medicaid if the RSV prophylaxis was obtained through the VDP; however, providers may be reimbursed for administering the drug.

RSV prophylaxis medications are covered in the office or outpatient setting.

### 8.2.54.2 Prior Authorization Requirements

All RSV prophylaxis injections require prior authorization through CCP. All requests for RSV prophylaxis must be submitted to CCP on a completed Texas Medicaid Palivizumab (*Synagis*) Prior Authorization Request Form. The form must be signed and dated by the ordering physician. The physician’s original, handwritten signature and date are required on the form and must be maintained in the client’s medical record.

Providers may submit prior authorization requests beginning September 1 for an administration date starting on or after October 1, and beginning October 1 for an administration date starting on or after November 1. Subsequent doses of RSV prophylaxis should be given approximately every 30 days. Clients continue with 4 more doses, with the last dose given by February 28 for those starting in October. Clients starting in November should continue approximately every 30 days until a stop date of March 31.

RSV prophylaxis may be prior authorized for Medicaid clients who are birth through 23 months of age who have congenital heart disease. For Medicaid clients who are birth through 23 months of age who have congenital heart disease, documentation submitted must demonstrate at least one of the following:

- The presence of moderate to severe pulmonary hypertension
- Active treatment for and diagnosis of hemodynamically significant heart disease, including both of the following documentation requirements:
  - Active treatment for hemodynamically significant heart disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of digitalis, diuretics, or supplemental oxygen
  - A diagnosis code consistent with hemodynamically significant congenital heart disease (i.e., congenital anatomical cardiac defects or cardiomyopathies of any etiology)

RSV prophylaxis may be prior authorized for Medicaid clients who are birth through 23 months of age who have underlying lung disease when the documentation submitted demonstrates the following:

- Active treatment for lung disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of one of the following:
  - Corticosteroids (systemic or inhaled), bronchodilators, diuretics, or supplemental oxygen therapy
  - Mechanical ventilation
• One of the following diagnoses of significant lung disease:
  • Chronic respiratory failure
  • Chronic respiratory disease arising in the perinatal period
  • Congenital bronchiectasis
  • Diaphragmatic defects
  • Congenital cystic lung disease
  • Congenital agenesis, hypoplasia and dysplasia of lung
  • Other respiratory diagnoses with supportive documentation of medical necessity

Palivizumab may be prior authorized for clients who are birth through 11 months of age when documentation includes one of the following:
• A diagnosis code that indicates the infant was born at 28 weeks, 6 days estimated gestational age or earlier
• A diagnosis code that indicates the infant was born at less than 35 weeks gestational age and documentation of one of the following:
  • Neuromuscular disease (including chronic respiratory failure)
  • Significant congenital anomalies of the airway expected to compromise respiratory reserve

Palivizumab may be prior authorized for clients who are birth through 5 months of age when documentation includes one of the following:
• A diagnosis code that indicates the infant was born at 29 weeks through 31 weeks, 6 days estimated gestational age
• A diagnosis code that indicates the infant was born at 32 weeks through 34 weeks, 6 days gestational age and documentation of two of the following in the client’s medical record:
  • Direct exposure to tobacco smoke or documented environmental air pollutants
  • Regular childcare attendance
  • Siblings who attend childcare or school outside of the home
• A diagnosis code that indicates the infant was born at any gestational age with documentation of cystic fibrosis

Palivizumab may be prior authorized for Medicaid clients who are birth through 1 year of age who have had a stem cell or solid organ transplant.

Providers may request prior authorization for RSV prophylaxis through CCP for clients with medical conditions not otherwise noted. All such requests must provide documentation to support the determination of medical necessity for this service.

8.2.54.3 Obtaining Palivizumab

Providers have two options for obtaining palivizumab for Medicaid clients: purchase and bill for palivizumab; or to obtain the drug through the VDP.

Option 1–Texas Medicaid reimbursement for palivizumab:
1) The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with palivizumab.
2) The provider purchases palivizumab for administration to the client in the office.
3) The provider adheres to Texas Medicaid benefits policy for RSV prophylaxis. Prior authorization is required.
4) The injection provider bills for the drug, an injection administration fee, and any medically necessary office-based E/M service provided at the time of injection.
5) The provider is reimbursed through the Texas Medicaid claims payment system.

**Option 2– Obtaining palivizumab through the VDP**

1) The treating provider identifies a Medicaid-enrolled client with indications for RSV prophylaxis with palivizumab.
2) The provider obtains palivizumab through the VDP.
3) The provider adheres to Texas Medicaid benefits policy for RSV prophylaxis, except that prior authorization is required for all clients as noted below.
4) The provider or provider’s agent sends a prescription for palivizumab with supporting clinical information on the Texas Medicaid Vendor Drug Program Palivizumab (Synagis) Prescription Form to a Texas Medicaid-enrolled pharmacy that is a member of the Synagis Distribution Network. The administering provider does not purchase the drug. Not all pharmacies participate in VDP for the palivizumab distribution program.

**Refer to:** HHSC’s Vendor Drug Program website at www.txvendordrug.com/dur/Synagis.shtml to find participating pharmacies.

5) The pharmacy contacts VDP’s Prior Authorization Call Center. Prior authorization is required for all clients.
6) If the information submitted does not demonstrate medical necessity, the request is denied. Both the pharmacy and provider are notified of the denial.
7) If the information submitted demonstrates medical necessity, the request is approved and both pharmacy and provider are notified.
8) The selected pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the Medicaid client, directly to the provider. An initiation packet is mailed to the client’s family, informing them of RSV and palivizumab’s benefits and side effects.
9) The treating provider administers the palivizumab injection to the Medicaid client in the office setting.
10) The injection provider bills for an injection administration fee and any medically necessary office-based E/M service provided at time of injection. The provider does not bill Texas Medicaid for the drug.
11) The pharmacy contacts the provider each month after initial injection to obtain updated client information to ensure the proper amount for the next dose.

The following client demographic information is required:
- The client’s date of birth
- The client’s age in months, as of October 1
- The client’s estimated gestational age (in weeks) at birth
- The client’s body weight (in pounds or kilograms)
- The monthly dose required

### 8.2.55 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits of Texas Medicaid when prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation establishing medical necessity of the service requested. This documentation must remain in the client’s medical record and is subject to retrospective review.
8.2.55.1 Panniculectomy

A panniculectomy (procedure code 15830) may be reimbursed with prior authorization for one of the following conditions when the panniculus hangs to or below the level of the pubis:

- A panniculus has recurrent non-healing ulcers.
- Client is insulin dependent with recurring infection and causing the prolapse of a ventral hernia.
- Panniculus directly causes significant clinical functional impairment.

Panniculectomy is not a benefit when one of following is the primary purpose:

- To remove excess skin and fat from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To minimize the risk of ventral hernia formation of recurrence.
- For the sole purpose of treating neck or back pain.

Panniculectomy may be prior authorized when the client meets one of the following:

- Panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery.
- Panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis.
- Panniculectomy is planned with history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery.

If a panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery, or a panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis, one of the following must be met:

- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

If a panniculectomy is planned with a history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery, the following must be met:

- Documentation that the panniculus hangs to or below the level of the pubis and the client has maintained a significant (100 pounds or more), stable weight loss for at least six months. Documentation must include the weight loss history, prior and current height, prior and current weight, and the history and physical including all previous surgeries.
- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription. The 12-month post-gastric bypass requirement may be waived.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia. The 12-month post-gastric bypass requirement may be waived.
• Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. The 12-month post-gastric bypass requirement may be waived. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

All medical record documentation pertinent to the client’s evaluation and treatment must support medical necessity of the panniculectomy. Documentation may include the following:

• Office records
• Consultation reports
• Operative reports
• Other hospital records (examples: pathology report, history and physical)

Documentation to support the panniculectomy must be submitted with the request for prior authorization. In addition to medical record documentation, the provider may also submit a letter of support or an explanation to substantiate medical necessity.

This service is typically expected to be limited to once per lifetime; however, repeat panniculectomies may be considered for prior authorization upon submission of supporting documentation as outlined above.

A panniculectomy provided as a secondary surgery may be considered for prior authorization when the panniculus interferes with a medically necessary intra-abdominal surgery (e.g., abdominal hernia repair or hysterectomy) or to facilitate an improved anatomical field in order to provide radiation treatment to the abdomen. Documentation of medical necessity must include:

• The comorbidity for the diagnosis of the primary surgery or for the nature of the condition undergoing radiation treatment.
• Documentation supporting the need for the panniculectomy as the panniculus hangs below the level of the pubis and will significantly interfere with a planned surgical procedure, or the abdominal structures identified as requiring radiation therapy will not be adequately treated due to the size of the panniculus.

A panniculectomy provided as a secondary surgery may be considered when the primary surgery was performed for an urgent condition defined as a symptom or condition that is not an emergency, but requires further diagnostic workup or treatment within 24 hours to avoid a subsequent emergent situation.

The need for the panniculectomy as a secondary surgery in conjunction with a primary urgent surgery must be supported by retrospective review of submission of all of the following documentation:

• History and physical and the operative report.
• The panniculus hangs below the level of the pubis and would have significantly interfered with the urgent primary surgical procedure.

8.2.55.2 Abdominoplasty

An abdominoplasty (procedure code 15847) is a benefit for clients who are birth through 20 years of age and may be reimbursed with prior authorization for one of the following conditions:

• Prune belly
• Diastasis recti in the presence of a true midline hernia (ventral or umbilical)
Abdominoplasty is not a benefit when one of the following is the primary purpose:

- To remove excess skin and fat and tighten abdominal wall from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To repair diastases recti (unless prior authorization criteria has been met).

Abdominoplasty may be prior authorized when the client meets all of the following criteria:

- Documented diagnosis of prune belly (i.e., Eagle Barret syndrome) or repair of diastasis recti in the presence of a true midline hernia (ventral or umbilical).
- Documentation for reconstructive surgery that must include appropriate historical medical record documentation and may include any of the following:
  - Consultation reports
  - Operative reports or other applicable hospital records (examples: pathology report, history and physical)
  - Office records
  - Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)
- For repair of diastasis recti with a true midline hernia, documentation must also include all of the following:
  - The size of the hernia
  - Whether it is reducible, painful, or other symptoms
  - Whether there is a defect rather than just thinning of the abdominal fascia

Consideration of other abdominal diagnoses may be considered for prior authorization with the submission of additional supporting documentation that may include the following:

- Consultation reports
- Operative reports or other applicable hospital records (examples: pathology report, history and physical)
- Office records
- Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

8.2.56 Penile and Testicular Prostheses

The following services are a benefit of Texas Medicaid for male clients:

- Removal of a penile prosthesis without replacement (procedure codes 54406 and 54415).
- Insertion of testicular prosthesis for the replacement of congenitally absent testes or testes lost due to disease, injury, or surgery (procedure code 54660)—prior authorization is required.

Procedure code 54660 is a benefit for clients who are birth through 20 years of age. Insertion of a testicular prosthesis may be prior authorized with the following criteria:

- The client has lost a testicle as a result of cancer or trauma or has congenital absence of a testicle.
- The loss of the testicle has resulted in detrimental psycho-social sequelae, as evidenced by a psychiatric evaluation.
Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The request must be submitted with documentation that supports medical necessity.

8.2.57 Pentamidine Aerosol
Payment for aerosol pentamidine medication (procedure code J2545) and treatments (procedure code 94642) is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>042 07951 07952 07953 1363 48284 5186</td>
</tr>
</tbody>
</table>

Aerosol pentamidine treatments are limited to one treatment every 28 days.

8.2.58 Percutaneous Transluminal Coronary Interventions
Percutaneous transluminal coronary interventions are a therapeutic option for clients who have arteriosclerotic heart disease.

When any of the following procedure codes are performed on the same date of service and on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure code will be considered for reimbursement: 92973, 92982, 92984, 92995, and 92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels may be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

8.2.59 Physical Therapy (PT) Services
Physical therapy (PT) is a payable benefit to physicians.

Refer to: Section 4, “Therapists, Independent Practitioners, and Physicians” in Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for information about physical therapy services provided by a physician.

8.2.60 Physician Evaluation and Management (E/M) Services
E/M is a benefit of Texas Medicaid. E/M is divided into categories and subcategories. Medical documentation for E/M must consist of the appropriate components as designated in the 1995 and 1997 Physician Evaluation and Management guidelines published by CMS and in the CPT manual.

The following E/M services are benefits of Texas Medicaid:
- Domiciliary, rest home, or custodial care services
- Emergency department services
- Group clinical visits
- Home services
- Hospital services including inpatient, observation, critical care, discharge, and concurrent care services (includes consultation and prolonged services)
- Nursing facility services
- Office or other outpatient services for new and established patients (includes consultation and prolonged services)
- Preventive care visits
- Services outside of business hours
Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days of each date of service, not 95 days of the discharge date.

Inpatient claims must indicate the facility’s provider identifier in Block 32 or in the appropriate field of electronic software.

### 8.2.60.1 Office or Other Outpatient Hospital Services

#### 8.2.60.1.1 * New and Established Patient Services

A new patient is one who has not received any professional services from a physician or from another physician of the same specialty who belongs to the same group practice, within the past three years. Providers must use procedure codes 99201, 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office or an outpatient or other ambulatory facility. New patient visits are limited to one every three years, per client, per provider.

An established patient is one who has received professional services from a physician or from another physician of the same specialty within the same group practice, within the last three years. Providers must use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office or an outpatient or other ambulatory facility.

New or established office or outpatient care visits are limited to once per day, same provider. When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Modifier 25 may be used to identify a significant, separately identifiable E/M service performed by the same physician on the same day as another procedure or service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded.

The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

An established patient visit that is billed with the same date of service as a new patient visit by the same provider will be denied as part of another procedure except when the established patient visit is billed with a new THSteps medical checkup.

Office visits (procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.

Office visit procedure code 99211, 99212, 99213, 99214, or 99215 must be billed by the same provider with the same date of service as a group clinical visit.

Refer to: Subsection 8.2.60.4, “Group Clinical Visits,” in this handbook.

Procedures that are included in the E/M service (e.g., noninvasive ear or pulse oximetry for oxygen saturation, etc.) are denied as part of another procedure when billed by the same provider with the same date of service as one of the following office or outpatient consultation visit procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 99202 99203 99204 99205 99211 99212 99213 99214 99215</td>
</tr>
<tr>
<td>99241 99242 99243 99244 99245</td>
</tr>
</tbody>
</table>
Emergency department-based physicians or emergency department-based groups may not bill charges for inconvenience or after hours services (procedure code 99050, 99056, or 99060).

8.2.60.1.2 Preventive Care Visits

Preventive care services are comprehensive visits that may include counseling, anticipatory guidance, and risk-factor-reduction interventions. Documentation must indicate the anticipatory guidance rendered.

Preventive health visits for clients who are birth through 20 years of age are available through THSteps medical checkups.

Refer to: Section 5, “THSteps Medical” in Children’s Services Handbook (Vol. 2, Provider Handbooks).

Subsection 5.3.9.2.3, “Hearing Screening,” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for additional information about hearing screenings.

Adult preventive services (procedure codes 99385, 99386, 99387, 99395, 99396, and 99397) are a benefit of Texas Medicaid for clients who are 21 years of age and older. Procedure codes 99385 and 99395 are restricted to clients who are 21 through 39 years of age. Adult preventive services are limited to one service per rolling year, any provider, and must be billed with diagnosis code V700.

Adult preventive services must be provided in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations with grades A or B. USPSTF recommendations, with specific age and frequency guidelines, are located on the Agency for Healthcare Research and Quality website at www.ahrq.gov/clinic/uspstfix.htm.

Laboratory, immunization, and diagnostic procedures recommended by USPSTF are covered benefits and may be billed separately, as clinically indicated, using the most appropriate diagnosis code that represents the client’s condition.

The following USPSTF recommendations are not reimbursed separately but must be provided, when applicable, as part of the routine preventive exam:

- Counseling to prevent tobacco use and tobacco-caused disease
- Behavioral counseling in primary care to promote a healthy diet
- Behavioral interventions to promote breast feeding
- Screening for obesity in adults (with intensive counseling and interventions)
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
- Screening for depression

The following USPSTF recommendations are not a benefit of Texas Medicaid:

- Chemoprevention of breast cancer
- Varicella immunization

The following screenings are covered benefits in addition to USPSTF recommendations:

- Tuberculosis screening
- Prostate cancer screening; prostate specific antigen (PSA) for men who are 50 through 64 years of age

Services that exceed USPSTF recommendations are not considered part of a screening and require medical documentation to justify medical necessity of the services performed.
For clients who are 21 years of age and older, breast exams and Pap smears are available through programs related to women’s health, including Texas Medicaid family planning services and Women’s Health Program.

Refer to: Section 2, “Medicaid Title XIX family planning services” in Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).


8.2.60.1.3 Consultation Services
A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. The consultation must meet the following requirement:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.
- There must be correspondence from the consulting provider back to the referring provider indicating the consulting provider’s medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary.

The visit is not considered a consultation if any of the following applies:

- If diagnostic or therapeutic treatment is initiated during a consultation and the patient returns for follow-up care, the follow-up visit is considered an established patient visit, and must be billed as an established patient visit.
- If the purpose of the referral is to transfer care.

The medical records maintained by both the referring and consulting providers must identify the other provider and the reason for consultation.

Providers must use procedure code 99241, 99242, 99243, 99244, or 99245 when billing new or established patient consultations in the office, or in an outpatient or other ambulatory facility.

Office or outpatient consultations are limited to one consultation every six months by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this six-month period will be denied.

8.2.60.1.4 Services Outside of Business Hours
Texas Medicaid limits reimbursement for after-hours charges (procedure codes 99050, 99056, and 99060) to office-based providers rendering services after routine office hours.

An office-based provider may bill an after-hours charge in addition to a visit when providing medically necessary services for the care of a client with an emergent condition after the provider’s posted, routine office hours. Office-based physicians may be reimbursed an inconvenience charge when either of the following exists and the reason is documented in the client’s medical record:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician’s routine office hours.
- The physician is interrupted from routine office hours to attend to another client’s emergency outside of the office.
8.2.60.1.5 * Observation Services

Hospital observation (procedure codes 99217, 99218, 99219, and 99220) are professional services provided for a period of more than 6 hours but fewer than 24 hours regardless of the hour of the initial contact, even if the client remains under physician care past midnight. Subsequent observation care, per day (procedure codes 99224, 99225, and 99226) is also a benefit of Texas Medicaid.

Inpatient hospital observation services must be submitted using the procedure code 99234, 99235, or 99236.

Observation care discharge day management procedure code 99217 must be billed to report services provided to a client upon discharge from observation status if the discharge is on a date other than the initial date of admission. The following procedure codes are denied if submitted with the same date of service as procedure code 99217:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>99211</td>
</tr>
</tbody>
</table>

If an E/M service is billed by the same provider with the same date of service as a physician observation visit, the E/M service is denied if provided in any place of service other than inpatient hospital.

If a physician observation visit (procedure code 99217, 99218, 99219, 99220, 99234, 99235, or 99236) is billed by the same provider with the same date of service as prolonged services (procedure code 99354, 99355, 99356, or 99357), the prolonged services will be denied as part of another procedure on the same day.

If dialysis treatment and a physician observation visit are billed by the same provider (and same specialty other than an internist or nephrologist) with the same date of service, the dialysis treatment may be reimbursed and the physician observation visit will be denied.

8.2.60.2 Domiciliary, Rest Home, or Custodial Care Services

The following procedure codes are used to report E/M in a facility that provides room, board, and other personal assistance services:

<table>
<thead>
<tr>
<th>New Patient Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99324</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Established Patient Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99334</td>
</tr>
</tbody>
</table>

Established patient visits billed on the same date of service as a new patient visit, by the same provider, will be denied as part of another procedure. Established patient visits are limited to one per day regardless of diagnosis.

8.2.60.3 * Physician Services Provided in the Emergency Department

Providers must use procedure codes 99281, 99282, 99283, 99284, and 99285 when billing emergency department services.

If an emergency department visit is billed by the same provider with the same date of service as any of the following office, outpatient consultation, or nursing facility service procedure codes, the emergency department visit may be reimbursed and the office, consultation, or nursing facility visit is denied:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>
Emergency department visits are denied when billed with the same date of service as an observation service (procedure code 99217) by the same provider.

Multiple emergency department visits provided by the same provider for the same client on the same day must have the times for each visit documented on the claim form. Also, more than one visit billed with the same date of service can be indicated by adding the modifier 76 to the claim form. Medical documentation is required to support this service.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for nonemergent and nonurgent physicians’ services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The emergency department procedure code that is submitted on the claim is used to determine the appropriate reimbursement for these services. The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered by the physician in the hospital’s emergency department. The reimbursement for each service is determined by multiplying the base allowable fee by 60 percent.

Refer to: Section 4, “Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)” in Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for information on emergency department services by facilities (room and ancillary).

### 8.2.60.4 Group Clinical Visits

Texas Medicaid may reimburse physicians for group clinical visits (procedure code 99078) providing clinical services and educational counseling to a group of clients with the same condition.

To be considered for reimbursement, procedure code 99078 must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215.

Group clinical visits may be reimbursed for established patients only. The client’s plan of care must be determined and documented in the medical record by the physician before attending group clinical visits.

Participation of established patients in a group clinical visit is optional. Informed consent must be obtained from the client and maintained in the medical record before rendering group clinical visit services.

Clients who participate in group clinical visits and who have diseases covered under the Texas Medicaid Enhanced Care Program (congestive heart failure, chronic obstructive pulmonary disease, diabetes, coronary artery disease, and asthma) must receive a referral to the disease management program. Clinical providers are encouraged to coordinate care with the Texas Medicaid Enhanced Care Program for clients who are eligible for the disease management program and choose to participate in the program.

The physician leading the group clinical visit is responsible for the effectiveness and content of the information provided during the group clinical visit.

Nationally-approved curriculum on asthma and diabetes, such as that available through the American Association of Diabetic Educators and Asthma Education and Prevention Programs approved by the CDC must be incorporated into the educational portion of group clinical visits.
Group clinical visits must last at least 1 hour, but no longer than 2 hours, with a minimum of 2 clients and a maximum of 20 and must include:

- An informational and instructional presentation. In order to promote self-management of the chronic disease, the group visit must include a presentation instructing and informing the client about clinical issues including how to prevent exacerbation or complications, proper use of medications and other therapeutic techniques, and living with chronic illness.
- A question and answer period. Allow time for the clients to ask questions.
- An encounter with the physician. A short (approximately 5 to 15 minutes per client), one-on-one, private, face-to-face encounter with the physician is required. This visit consists of a physical examination; the gathering, monitoring, and reviewing of laboratory and diagnostic tests; and medical decision-making, including an individual treatment plan. Documentation in the client’s medical record must support the level of E/M as approved by CMS guidelines.

The documentation of the individual treatment plan retained in the client’s medical record must include data collected (physical exam and lab findings), educational services provided, patient participation, referrals to the HHSC disease management program, and the beginning and ending time of the visit.

Group visits for conditions of diabetes or asthma are limited to a maximum of four per year for any provider.

### 8.2.60.4.1 Group Clinical Visits for Diabetes

Group clinical visits are benefits of Texas Medicaid for the management of the condition of diabetes when submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>25000</td>
</tr>
<tr>
<td>25022</td>
</tr>
<tr>
<td>25050</td>
</tr>
<tr>
<td>25072</td>
</tr>
</tbody>
</table>

Diabetic education must explain the following:

- What diabetes is
- Nutrition
- Exercise and physical activity
- Prevention of acute complications
- Prevention of chronic complications
- Monitoring
- Medication

### 8.2.60.4.2 Group Clinical Visits for Asthma

Group clinical visits are benefits of Texas Medicaid for the management of the condition of asthma when submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>49300</td>
</tr>
<tr>
<td>49382</td>
</tr>
</tbody>
</table>
Asthma education must consist of the following:

- What is asthma?
- What are symptoms of asthma?
- What happens during an episode of asthma?
- What exacerbates asthma?
- How is asthma controlled?
- What physical activities can people with asthma do?

8.2.60.4.3 Group Clinical Visits for Pregnancy

Group clinical visits are benefits of Texas Medicaid for the management of the condition of pregnancy when submitted with procedure code 99078 and modifier TH, along with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V220</td>
</tr>
<tr>
<td>V235</td>
</tr>
</tbody>
</table>

Providers are encouraged to provide a comprehensive curriculum or use materials from the Centering Pregnancy Program that will be incorporated into the educational portion of the group clinical visit.

Comprehensive curriculums will allow clinical issues to be identified to promote a healthy pregnancy. The education material may include screenings and preparations, health maintenance, counseling, and birth plans:

- Screenings and preparations may consist of the following:
  - Expected course of the pregnancy
  - Anticipated outline of the scheduled visits
  - Signs and symptoms, which should be reported to the physician as soon as possible
  - Laboratory services
  - Appropriate use of medications
  - Proper weight monitoring
  - Immunizations (e.g., hepatitis, varicella, or RhoGAM)
  - Complications of pregnancy that may occur (e.g., preeclampsia, diabetes, or edema)

- Health maintenance may consist of the following:
  - Hygiene (e.g., hot tubs or baths)
  - Sexual activity
  - Exercise
  - Nutrition and dietary needs

- Counseling may consist of the following:
  - Use of seat belts
  - Job activity
  - Air travel
• Dental care appointments
• Domestic abuse or violence
• Tobacco or drug use
• Birth planning may consist of the following:
  • What to expect during labor and delivery
  • Pain control during labor
  • Complications during delivery that may occur (e.g., Caesarean section or episiotomy)
  • Breast feeding
  • Newborn care
  • Postpartum adjustments

Group clinical visits for the management of pregnancy are restricted to female clients who are 10 through 55 years of age and are limited to a maximum of 10 visits per 270 days for any provider.

To be considered for reimbursement, procedure code 99078 with modifier TH must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215 with modifier TH.

8.2.60.5 Home Services

Home services are provided in a private residence. New patient visits will be limited to once every three years. Providers must utilize procedure codes 99341, 99342, 99343, 99344, and 99345 when billing for new patient services provided in the home setting. New patient visits are limited to one every three years. Providers must use procedure codes 99347, 99348, 99349, and 99350 when billing established patient services provided in the home setting.

A subsequent home visit (procedure codes 99347, 99348, 99349, and 99350) billed with the same date of service as a new patient home visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure, regardless of the diagnosis.

Subsequent home E/M codes are limited to one per day, regardless of diagnosis.

8.2.60.6 Inpatient Hospital Services

Hospital visits are limited to one per day for the same provider.

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A hospital care visit submitted by the same provider for the same client within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or for a similar diagnosis must be submitted as a subsequent care visit.

Refer to: Subsection 8.2.72.6, “Global Fees,” in this handbook for more information about global services.

8.2.60.6.1 * Hospital Admissions, Initial Visits, and Subsequent Visits

Inpatient hospital visits must be submitted using procedure codes 99221, 99222, 99223, 99231, 99232, and 99233.
If a subsequent hospital visit (procedure code 99231, 99232, or 99233) following admission is billed by the same provider with the same date of service as any of the following emergency department visits, office visits, or outpatient consultations, the subsequent hospital visit may be reimbursed and the other visits will be denied:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
</tr>
<tr>
<td>99211</td>
</tr>
</tbody>
</table>

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A subsequent hospital visit (procedure code 99231, 99232, or 99233) may be reimbursed to the same provider when performed on the same day as critical care services (procedure codes 99291 and 99292).

E/M services provided in a hospital setting following a major procedure and provided by the same provider or in direct follow-up for postsurgical care are included in the surgeon’s global surgical fee and are denied as included in another procedure.

Refer to: Subsection 8.2.45, “Newborn Services,” in this handbook for information about newborn services.

8.2.60.6.2 Concurrent Care

Concurrent care exists when services are provided to a patient by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the patient in accordance with accepted standards of good medical practice. Concurrent care may be reimbursed to providers of different specialties when the services are for unrelated diagnoses involving different organ systems.

Concurrent care will be denied when billed for providers of the same specialty for the same or related diagnoses (i.e., diagnosis codes containing the same first three digits). Denied concurrent care may be appealed when accompanied by documentation of medical necessity.

Each appeal submitted for concurrent care must contain the following information:

- Documentation of the medical necessity for the physician’s services (care and treatment)
- Diagnosis and indication of the severity of the client’s condition (acute or critical)
- Role of the physician in the care of the client, including the name of the admitting physician
- Specialty and subspecialty of each physician and any limitations of practice

Claims appealed without clear documentation of medical necessity as described above will be denied.

Important: If the attending physician requests only a consultation, the request must be clearly stated in the orders.

All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and must include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician.
- The name of the requesting physician by the physician rendering concurrent care.
8.2.60.6.3 Consultations

Consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting must be billed using procedure codes 99251, 99252, 99253, 99254, and 99255.

One initial inpatient consultation (procedure code 99251, 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period. Subsequent consultations billed as initial consultations during this time period will be denied.

Refer to: Subsection 8.2.60.1.3, “Consultation Services,” in this handbook for additional criteria information.

8.2.60.6.4 Critical Care

Critical care includes the care of critically ill clients that require the constant attention of the physician. The physician must either be at bedside or immediately available to the client. The physician’s full attention must be devoted to the client so that the physician cannot render E/M to any other client during the same period of time. Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit, or the emergency department care facility. The following procedure codes are used to bill critical care services:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291</td>
<td>A per day charge for the first 30 to 74 minutes of critical care (time spent by the physician does not have to be continuous on that day).</td>
</tr>
<tr>
<td>99292</td>
<td>A per day charge for each additional 30 minutes beyond the first 74 minutes of critical care for up to 6 units or 3 hours per day.*</td>
</tr>
<tr>
<td>99471</td>
<td>A per day charge for initial inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.</td>
</tr>
<tr>
<td>99472</td>
<td>A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.</td>
</tr>
<tr>
<td>99475</td>
<td>A per day charge for initial inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.</td>
</tr>
<tr>
<td>99476</td>
<td>A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.</td>
</tr>
</tbody>
</table>

* If the number of units is not stated on the claim, a quantity of one is allowed.

Services for a client who is not critically ill and unstable but who was treated in a critical care unit must be reported using subsequent hospital visit codes or hospital consultation codes.

If the same provider who performed a major surgery must also perform critical care on the same day for the same client, the provider must bill the critical care with documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure.

Critical care (procedure codes 99291, 99292, 99471, 99472, 99475, and 99476) may be reimbursed only to the provider rendering the critical care service at the time of crisis. Critical care involves high-complexity decision-making to access, manipulate, and support vital system functions. While providers from various specialties may be consulted to render an opinion and assist in the management of a particular portion of the care, only the provider managing the care of the critically ill patient during a life threatening crisis may bill the critical care procedure codes.

Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous.
Actual time spent with the individual client must be recorded in the client’s record and reflect the time billed on the claim. The time that can be reported as critical care is the time spent engaged in work directly related to the individual client’s care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

Time spent under the following circumstances may not be reported as critical care:

- Activities that occur outside of the unit or off the floor
- Activities that do not directly contribute to the treatment of the client
- While performing separately reportable procedures or services

Critical care of less than 30 minutes total duration per day must be reported with the appropriate E/M procedure code.

If critical care that meets the initial 30-minute time requirement is provided to the same client by different physicians, the initial provider’s claim may be reimbursed. The second provider’s claim will be denied but may be appealed. The time spent by each physician cannot overlap; two physicians cannot bill critical care for care delivered at the same time. Supporting medical record documentation that includes the time in which the critical care was rendered must be provided by the second physician. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill patient during the life threatening crisis.

If the provider’s time exceeds the 74-minute threshold for procedure code 99291, procedure code 99292 may be billed for each additional 30 minutes. Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider’s group practice and is limited to 6 units per day for any provider.

Inpatient critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care procedure codes 99471 and 99472. The pediatric critical care procedure codes are reported as long as the infant or young child qualifies for critical care services during the hospital stay through 24 months of age.

Pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge. Only one physician can bill pediatric critical care per day. If an inpatient or outpatient E/M service is billed by the same provider with the same date of service as pediatric critical care, the E/M service is denied.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room), which does not result in admission must be billed using procedure codes 99291 and 99292. Critical care provided to a neonatal or pediatric client in both the outpatient and inpatient settings on the same day must be billed using the appropriate neonatal or pediatric critical care procedure code.

If critical care (procedure code 99291 or 99292) is provided to a patient at a distinctly separate time from another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

Prolonged physician services (procedure codes 99354, 99355, 99356, and 99357) will be denied when billed by the same provider with the same date of service as critical care (procedure code 99291, 99292, 99471, 99472, 99475, or 99476).

Claims may be subject to retrospective review to ensure documentation supports the medical necessity of the service when billing the claim.

Critical care procedure codes 99291 and 99292 will be denied when submitted with the same date of service by the same provider as neonatal intensive care procedure code 99468, 99469, 99478, 99479, or 99480.

8.2.60.6.5 * Hospital Discharge

Hospital discharge must be submitted using procedure code 99238 or 99239.
Discharge management billed by the same provider with the same date of service as the admission will be denied.

Discharge management billed by the same provider with the same date of service as an emergency room visit will be denied but may be reimbursed upon appeal if provided at a separate time.

Subsequent hospital visits billed by the same provider with the same date of service as discharge management will be denied.

Initial hospital visit procedure codes 99221, 99222, and 99223 billed with the same date of service as hospital discharge day management procedure code 99238 will be denied as part of another procedure billed on the same day. Initial hospital visit procedure code 99221 billed with the same date of service as hospital discharge day management procedure code 99239 will be denied as part of another procedure billed on the same day.

8.2.60.6.6 * Nursing Facility Services

Providers must use the following when billing initial nursing facility assessments, subsequent nursing facility care, and annual nursing facility assessments in a nursing facility:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304*</td>
</tr>
</tbody>
</table>

* Initial nursing facility assessments include all services related to an admission to the nursing facility.

Comprehensive initial nursing facility assessments performed by the same provider for the same diagnosis are limited to one every six months. The second initial nursing facility assessment within the six-month period will be denied.

Prolonged services in the nursing facility involving direct (face-to-face) patient contact that is beyond the usual service may be reimbursed on the same day as a nursing facility visit (procedure code 99304, 99305, 99306, 99307, 99308, 99309, or 99310).

Procedure code 99356 must be used to report the first hour of prolonged service and is limited to one per day.

Procedure code 99357 must be used to report each additional 30 minutes and is limited to a quantity of three units or one and one-half hours per day.

Prolonged physician services will not be reimbursed in addition to an emergency room visit billed on the same day.

All E/M services, regardless of setting, are considered part of the initial nursing facility care when performed by the same provider on the same day as the admission.

Subsequent nursing facility care E/M procedure codes 99307, 99308, 99309, and 99310 are limited to one per day regardless of diagnosis.

8.2.60.6.7 * Observation

When a patient is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This is an acceptable billing practice under Texas Medicaid when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement.

Refer to: Subsection 8.2.60.1.5, “* Observation Services,” in this handbook for more information about hospital observation.
8.2.60.7 Prolonged Physician Services

Prolonged services involve face-to-face patient contact and may be provided in the office, outpatient hospital, or inpatient hospital settings. The face-to-face patient contact must exceed the time threshold of the following E/M procedure codes submitted for the date of service and be beyond the usual service.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 99202 99203 99204 99205 99211 99212 99213 99214 99215</td>
<td>Used in conjunction with the E/M procedure code to report the first hour of prolonged service and are limited to one per day.</td>
</tr>
<tr>
<td>99221 99222 99223 99231 99232 99233 99241 99242 99243 99244</td>
<td>Used to report each additional 30 minutes and are limited to a quantity of 3 units or 1.5 hours per day.</td>
</tr>
<tr>
<td>99245 99251 99252 99253 99254 99255 99341 99342 99343 99344</td>
<td>Note: Prolonged services that are less than 30 minutes in duration cannot not be reported separately.</td>
</tr>
<tr>
<td>99345 99347 99348 99349 99350</td>
<td></td>
</tr>
</tbody>
</table>

The following procedure codes must be used for prolonged physician services:

Prolonged services in the inpatient setting involving face-to-face client contact that is beyond the usual service may be reimbursed when provided on the same day as an initial hospital visit (procedure codes 99221, 99222, 99223, 99251, 99252, 99253, 99254, and 99255) or a subsequent hospital visit (99231, 99232, 99233).

Prolonged physician services are denied when billed with critical care or emergency room visits billed with the same date of service.

Prolonged physician services and physician standby services without a face-to-face contact (procedure codes 99358, 99359, and 99360) are not a benefit of Texas Medicaid.

8.2.60.8 Referrals

A referral is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services must be billed using the appropriate E/M visit code.

When a Texas Medicaid provider refers a Texas Medicaid client to another provider for additional treatment or services, the referring provider must forward notification of the client’s eligibility and his provider identifier. The client must be made aware that the provider he/she is referred to does or does not participate in Texas Medicaid. Some clients not eligible for Medicaid are eligible for family planning through the DSHS Family Planning Program. These clients should be referred to contracted agency providers for family planning services.

8.2.60.8.1 Referral Requirements for Children with Disabilities

All health-care professionals are required by state and federal legislation to refer children who are younger than 3 years of age with developmental delays to early childhood intervention services provided under the authority of the Department of Assistive and Rehabilitative Services (DARS).

8.2.61 Physician Services in a Long Term Care (LTC) Nursing Facility

The Department of Aging and Disability Services (DADS) requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician’s office or the nursing facility.

Additional information is available on the DADS website at www.dads.state.tx.us.

8.2.62 Podiatry and Related Services

Podiatry and related services are a benefit of Texas Medicaid.

8.2.62.1 Clubfoot Casting

Procedure code 29450 is limited to clients who are birth through 3 years of age and is payable to a physician in the management of clubfoot when a previous surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. Procedure code 29750 is limited to clients who are birth through 2 years of age and is payable to a physician in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting and wedging are benefits if the client has one of the following conditions:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>73671</td>
</tr>
</tbody>
</table>

8.2.62.2 Flat Foot Treatment

Reimbursement for treatment of deformities of the foot and lower extremity that includes flat foot as a component of the deformity may be considered when the client presents with significant pain in the foot, leg, or knee, resulting in a loss of or decrease in function, along with a secondary condition such as valgus deformity or plantar fasciitis.

Treatment of flat foot (flexible pes planus) that is solely cosmetic in nature is not a benefit of Texas Medicaid.

8.2.62.3 Routine Foot Care

Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to one service every six months per client, regardless of provider specialty: 11055, 11056, 11057, 11719, and G0127.

8.2.63 Prostate Surgery

A transurethral resection of the prostate (TURP) is the most common procedure performed to treat benign prostatic hyperplasia (BPH). A TURP may be billed with procedure code 52601, 52630, or 52640.

If a provider submits separate charges for any of the TURP procedure codes listed above and procedure code 52351 or 52354, the charges for procedure codes 52351 and 52354 will be denied as part of the TURP procedure.

8.2.64 Radiation Therapy

Radiation treatment management may be reimbursed by Texas Medicaid as defined in the Current Procedure Terminology (CPT) manual under the “Radiation Treatment Management” section.
The following radiation therapy services are limited to once per day unless documentation submitted with an appeal supports the need for the service to be provided more frequently:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavitary radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization
- Radioisotope therapy

Laboratory and diagnostic radiological services provided in the office setting may be reimbursed to physicians as a total component. Radiation treatment centers may also be reimbursed for the total component for these services in the outpatient hospital setting. Injectable medications given during the course of therapy in any setting may be reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be reimbursed on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

The professional component and the technical component will be denied when billed with the total component. The total component includes the professional and the technical components.

The professional component may be reimbursed for services rendered in the inpatient hospital setting, radiation treatment center setting, or outpatient hospital setting. Physicians billing client services rendered in the office setting or in a facility recognized by Medicaid as a radiation treatment center may be reimbursed for total components.

The following procedure codes will be denied when billed with the same date of service as radiation therapy by the same provider:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90804 90805 90806 90807 90808 90809 90816 90817 90818 90819</td>
</tr>
<tr>
<td>90821 90822 90862 97802 97803 99201 99202 99203 99204 99205</td>
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<tr>
<td>99217 99218 99219 99220 99221 99223 99231 99232 99233 99238</td>
</tr>
<tr>
<td>M0064</td>
</tr>
</tbody>
</table>

**8.2.64.1 Brachytherapy**

**8.2.64.1.1 Prior Authorization for Brachytherapy**

Prior authorization is not required for brachytherapy.
8.2.64.1.2 Other Limitations on Brachytherapy

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied as part of another service when billed with the same date of service as clinical brachytherapy services.

An office visit will be denied as part of another service when billed with the same date of service by the same provider as clinical treatment planning and clinical brachytherapy.

Normal follow-up care by the same physician will be denied as part of another service when billed with the same dates of service as any therapeutic radiology service. Any other E/M office visit will be denied as part of another service when billed with the same date of service by the same provider as the radiation treatment or radiation treatment complication.

Providers may use modifier 25 to indicate that the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available upon request.

8.2.64.2 Procedure Code Limitations

The following table summarizes the procedure code limitations for radiation therapy. The right column are denied as part of another service when submitted with the same date of service by the same provider as any of the procedure codes in the left column.

<table>
<thead>
<tr>
<th>Procedures May Be Reimbursed</th>
<th>Procedure Codes Will Be Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>11100, 36000, 96360, 96365, 97022</td>
<td>16000, 16020, 16025, 16030</td>
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<td>16000, 16020, 16025, 16030, 36425</td>
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<td>11719</td>
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</tr>
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<tr>
<td>99471</td>
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<tr>
<td>Procedures May Be Reimbursed</td>
<td>Procedure Codes Will Be Denied</td>
</tr>
<tr>
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<td>-------------------------------</td>
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</tbody>
</table>
8.2.64.3 Stereotactic Radiosurgery

8.2.64.3.1 Prior Authorization for Stereotactic Radiosurgery

The following procedure codes are a benefit of Texas Medicaid with prior authorization and documentation of medical necessity:

<table>
<thead>
<tr>
<th>Procedures May Be Reimbursed</th>
<th>Procedure Codes Will Be Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>76376, 76377, 77401, 77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411</td>
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<td>G0339, G0340, 76506, 76511, 76512, 76513, 76516, 76519, 76529, 76536, 76604, 76645, 76700, 76705, 76770, 76775, 76800, 76805, 76810, 76815, 76816, 76818, 76819, 76825, 76826, 76827, 76828, 76830, 76831, 76836, 76857, 76870, 76872, 76873, 76885, 76886, 76930, 76932, 76936, 76941, 76942, 76945, 76946, 76965, 76970, 76975, 76977</td>
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<td>77421, 77427, 77431, 77432, 99183, 99355, 99357</td>
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</tr>
</tbody>
</table>

Prior authorization requirements for stereotactic radiosurgery may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in chest, abdomen, and pelvis
- Trigeminal neuralgia refractory to medical management

Other diagnoses may be considered after reviewing the documentation of medical necessity. Stereotactic radiosurgery is considered investigational and not a benefit of Texas Medicaid for all other indications including, but not limited to, epilepsy and chronic pain.

Prior authorization requirements for proton beam (procedure codes 77520, 77522, 77523, 77525, and S8030) and helium ion radiosurgery (procedure codes 77422 and 77423) may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low-grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
• Pituitary neoplasms
• Other central nervous system tumors located near vital structures

Prior authorization for neutron beam radiosurgery may be considered for malignant neoplasms of the salivary gland.

Prior authorization requirements for procedure code 77399 include, but are not limited to, diagnosis, documentation of medical necessity, a specific description of the procedure to be performed, and an indication that the procedure would not be covered by a more specific procedure code.

Stereotactic radiosurgery will not be prior authorized for clients with metastatic disease and a projected life span of less than six months or for clients with widespread cerebral or extracranial metastasis that is not responsive to systemic therapy.

**8.2.64.3.2 Other Limitations on Stereotactic Radiosurgery**

In the following table, the procedure codes in Column A may be reimbursed when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

<table>
<thead>
<tr>
<th>Column A Procedure Code</th>
<th>Column B Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>61797</td>
<td>61796, 61798</td>
</tr>
<tr>
<td>61799</td>
<td>61796</td>
</tr>
<tr>
<td>61800</td>
<td>61796, 61798</td>
</tr>
<tr>
<td>63621</td>
<td>61796</td>
</tr>
</tbody>
</table>

Procedure codes 61796 and 63620 must not be billed more than once per course of treatment.

Procedure codes 61797 and 61799 must not be billed more than once per lesion, and may only be billed up to four times for the entire course of treatment, regardless of the number of lesions treated.

Procedure code 63621 may only be billed up to two times for the entire course of treatment, regardless of the number of lesions treated.

**8.2.65 Radiology Services**

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to Texas Medicaid. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation of procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist’s office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.
A separate charge for an X-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician’s overall work-up and treatment of the patient.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.

Abdominal flat plates (AFP) or kidneys, ureters, bladder (KUB) codes 74000, 74010, and 74020 are frequently done as preliminary X-rays before other, more complicated X-ray procedures. If a physician bills separately for an AFP or KUB and more complicated procedures, the charges are combined and the more complex procedure may be paid. If, however, the claim specifically states the AFP or KUB was done first and the results required additional X-rays, each procedure may be paid separately.

Oral preparations for X-rays are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

**8.2.65.1 Diagnosis Requirements**

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms
- Venography
- Chest X-rays
- Cardiac blood pool imaging
- Echography

Radiologists are required to identify the referring provider by full name and address or provider identifier in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to Texas Medicaid, baseline screening and/or comparison studies are not a benefit.

**8.2.65.2 Cardiac Blood Pool Imaging**

Cardiac blood pool imaging may be reimbursed with procedure codes 78472, 78473, 78481, 78483, 78494, and 78496. Prior authorization is required for outpatient diagnostic services.

Refer to: Subsection 8.2.27.10, “Myocardial Perfusion Imaging,” in this handbook for more information about myocardial perfusion imaging.

Section 3, “Radiological and physiological laboratory services” in *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for additional information and authorization requirements.

**8.2.65.3 Chest X-Rays**

All providers including radiologists billing for chest X-rays must supply a diagnosis code.
TEXAS MEDICAID PROVIDER PROCEDURES MANUAL: VOL. 2 - DECEMBER 2012

Screening, baseline, or rule-out studies do not qualify for reimbursement; however, the following
diagnosis codes are payable:
Diagnosis Codes
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*Claims for clients who are 12 years of age and older may be appealed with documentation of medical necessity.

MD-204
CPT ONLY - COPYRIGHT 2011 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.


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*Claims for clients who are 12 years of age and older may be appealed with documentation of medical necessity.
8.2.65.4 Magnetic Resonance Angiography (MRA)

MRA is an effective diagnostic tool used to detect, diagnose, and aid the treatment of heart disorders, stroke, and blood vessel diseases.

Refer to: Section 3, "Radiological and physiological laboratory services" in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for additional information and authorization requirements.

8.2.65.5 Magnetic Resonance Imaging (MRI)

MRIs may be an effective diagnostic tool for detecting defects, diseases, and trauma.

Refer to: Section 3, “Radiological and physiological laboratory services” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks) for additional information and authorization requirements.

8.2.65.6 Technetium TC 99M

Procedure codes A9500 (Sestamibi) and A9502 (Tetrofosmin) are limited to three per day when billed by the same provider.

8.2.66 Reduction Mammoplasties

8.2.66.1 Prior Authorization for Reduction Mammaplasty

Procedure code 19318 is the removal of breast tissue and is a benefit of Texas Medicaid when prior authorized.

For prior authorization of reduction mammoplasty, a completed “Medicaid Certificate of Medical Necessity for Reduction Mammaplasty” form signed and dated by the physician, must be submitted and include at least one of the following criteria:

- Evidence of severe neck and/or back pain with incapacitation from the pain.
- Evidence of ulnar pain or paresthesia from thoracic nerve root compression.
- Submammary dermatological conditions such as intertrigo and acne that are refractory to conventional medication.
• Shoulder grooving with ulceration due to breast size.

In addition to the above criteria, documentation must indicate:

• The minimum weight of tissue expected to be removed from each breast with consideration to height and weight is as follows:

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<th>Under 5’</th>
<th>&lt;140 lb</th>
<th>300 grams per breast</th>
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<td>5’-5’.4”</td>
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<td>5’.4”-5’.7”</td>
<td>up to 220 lb</td>
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<td>5’.7”- and up</td>
<td>211 lb and up</td>
<td>500 grams per breast</td>
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• The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer.

The following services are not a benefit of Texas Medicaid:

• Reduction mammaplasty for cosmetic purposes (such as the equalization of breast size)
• Reduction mammaplasty for gynecomastia (enlargement of breast tissue in the male)
• Augmentation mammaplasty to increase breast size

The physician is required to maintain the following documentation in the client’s clinical records:

• A complete history and physical
• Pulmonary function studies results
• Past treatments, therapies, and outcomes for pain control and weight reduction

The physician is required to maintain preoperative photographs (frontal and lateral views) in the client’s clinical records and must be made available to Texas Medicaid upon request.

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

When submitting for prior authorization, requests must be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammaplasty to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax 1-512-514-4213

8.2.67 Renal Disease

8.2.67.1 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all POSs except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.
8.2.67.1.1 Physician Supervision of Dialysis Patients

Physician supervision of outpatient ESRD services includes services provided in the course of office visits where any of the following occur:

- The routine monitoring of dialysis.
- The treatment or follow-up of complications of dialysis, including:
  - The evaluation of related diagnostic tests and procedures.
  - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts.

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90951</td>
</tr>
<tr>
<td>90961</td>
</tr>
</tbody>
</table>

The procedure codes must be billed as described below:

- In the circumstances where the client is not on home dialysis and has had a complete assessment visit during the calendar month and ESRD-related services are provided for a full month, procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be used, determined by the number of face-to-face visits the physician has had with the client during the month, and the client’s age.

- When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure codes 90963, 90964, 90965, or 90966 must be used, determined by the client’s age.

- Report procedure codes 90967, 90968, 90969, and 90970 when ESRD related services are provided for less than a full month, per day, under the following conditions:
  - The client is seen for a partial month and is not on home dialysis and received one or more face-to-face visits but did not receive a complete assessment.
  - The client is on home dialysis and received less than a full month of services.
  - The client is a transient client.
  - The client was hospitalized during a month of services before a complete assessment could be performed.
  - Dialysis was stopped due to recovery or death of client.
  - The client received a kidney transplant.

- Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing procedure code 90967, 90968, 90969, or 90970, the date of service must indicate each day that supervision was provided.

- Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed within the same calendar month by any provider as procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966.

- Procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966 are limited to once per calendar month by any provider, and only one service may be reimbursed per calendar month by any provider.
The following services may be provided in conjunction with physician supervision of ESRD dialysis but are considered non-routine and may be billed separately:

- Declotting of shunts when performed by the physician.
- Physician services to inpatient clients. If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician must bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days. If a client has a complete assessment during a month in which the client is hospitalized, procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month, and the client’s age. The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.
- Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP. The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the patient’s renal condition that cause the number of physician-patient contacts to increase. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

Use procedure codes 90935, 90937, 90945, and 90947 for inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis. These codes are not payable for a cursory visit by the physician; hospital visit codes must be used for a cursory visit.

The hospital procedure codes 90935, 90937, 90945, and 90947 are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician must bill the appropriate hospital visit code. The inpatient dialysis code must not be submitted for payment.

Only one of procedure code 90935, 90937, 90945, or 90947 may be reimbursed per day, any provider.

Procedure codes 90935, 90937, 90945, and 90947 may also be used for outpatient dialysis services for non-ESRD clients.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly, may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.
- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.
- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client’s renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.
Payment is made for physician training services in addition to the monthly capitation payment for physician supervision rendered to maintenance facility clients.

**8.2.67.2 Laboratory Services for Dialysis Patients**

Texas Medicaid may reimburse for laboratory services performed for dialysis patients. Charges for *routine laboratory services* performed according to established frequencies are included in the facility’s composite rate billed to Texas Medicaid regardless of where the tests were performed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by a renal dialysis facility, unless they are inclusive tests.

*Nonroutine laboratory services* for people dialyzing in a facility and all laboratory work for people on CAPD may be billed separately from the dialysis charge.

*Refer to:* Subsection 6.2.9, “Laboratory and Radiology Services,” in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for more information on laboratory services.

**8.2.67.3 Self-Dialysis Patients**

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient’s training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 90989 and 90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, bill procedure code 90989. Providers are to use modifier AT when using this procedure code. The date of service indicates the date training was completed, and the quantity is 1.
- When dialysis training is not completed, bill procedure code 90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided.

The amount of reimbursement of subsequent training is determined by prorating the physician’s payment for initial training sessions. The amount of payment for each additional training session does not exceed $20.

**8.2.67.3.1 Physician Supervision**

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients.
- Review of family and home status and environment, and counseling and training of family members.
- Review of training progress.

**8.2.67.3.2 Initial Training**

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings.
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
• Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications.

• General support services (for example, arranging for supplies).

8.2.67.3.3 Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

• A change from the client’s treatment machine to one the client had not been trained to use in the initial training course

• A change in setting

• A change in dialysis partner

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of Texas Medicaid, including the lease or purchase of dialysis machines and disposable supply kits.

8.2.68 Sign Language Interpreting Services

Sign language interpreting services are benefits of Texas Medicaid. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and T1013 with modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, same provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day, same provider.

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a Medicaid client if the parent or guardian is deaf or hard of hearing.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from Texas Medicaid for providing this service.

Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A through H) issued by either the DARS, Office for Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI) or the National Registry of Interpreters for the Deaf (RID).

Certification Levels:

• BEI Level I/II and BEI OC: B (Oral Certificate: Basic)

• BEI Basic and RID NIC (National Interpreter Certificate) Certified

• BEI Level II/III, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate)

• BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter)

• BEI Advanced and RID NIC Advanced
- BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal)
- BEI V/VI
- BEI Master; and RID NIC Master

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client’s medical record and must include the name of the sign language interpreter and the interpreter’s certification level. Documentation must be made available if requested by HHSC or its designee.

### 8.2.69 Skin Therapy

Skin therapy is a benefit of Texas Medicaid and may be reimbursed with the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>15782</td>
</tr>
<tr>
<td>17110</td>
</tr>
<tr>
<td>17271</td>
</tr>
<tr>
<td>17286</td>
</tr>
<tr>
<td>96900</td>
</tr>
</tbody>
</table>

Claims for incision and drainage of acne when the diagnosis states there is infection or pustules may be paid.

Procedure codes 96900, 96910, 96912, 96913, 96920, 96921, and 96922 are covered benefits for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>0780</td>
</tr>
<tr>
<td>20210</td>
</tr>
<tr>
<td>69010</td>
</tr>
<tr>
<td>6923</td>
</tr>
<tr>
<td>69284</td>
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<tr>
<td>6943</td>
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<tr>
<td>6962</td>
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</tbody>
</table>

Intralesional injection(s) may be considered for reimbursement in addition to an office visit.

Procedure codes 11900 and 11901 are covered benefits for intralesional injections for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0780</td>
</tr>
<tr>
<td>6953</td>
</tr>
<tr>
<td>70583</td>
</tr>
<tr>
<td>94100</td>
</tr>
</tbody>
</table>
Procedure codes 15782, 15783, 15792, 15793, and 17999 require prior authorization. Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the anticipated procedure. This documentation must remain in the client’s medical record and is subject to retrospective review. To avoid unnecessary denials, the physician must provide correct and complete information.

Dermabrasion procedures (procedure codes 15782 and 15783) and chemical peel procedures (procedure codes 15792 and 15793) may be prior authorized with documentation that the client meets all of the following criteria:

- A diagnosis of actinic keratosis with more than three lesions.

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>94110 94111 94112 94113 94114 94115 94116 94117 94118 94119</td>
</tr>
<tr>
<td>94120 94121 94122 94123 94124 94125 94126 94127 94128 94129</td>
</tr>
<tr>
<td>94130 94131 94132 94133 94134 94135 94136 94137 94138 94139</td>
</tr>
<tr>
<td>94140 94141 94142 94143 94144 94145 94146 94147 94148 94149</td>
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<tr>
<td>94150 94151 94152 94153 94154 94155 94156 94157 94158 94159</td>
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<tr>
<td>94160 94161 94162 94163 94164 94165 94166 94167 94168 94169</td>
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<tr>
<td>94170 94171 94172 94173 94174 94175 94176 94177 94178 94179</td>
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<tr>
<td>94180 94181 94182 94183 94184 94185 94186 94187 94188 94189</td>
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<tr>
<td>94190 94191 94192 94193 94194 94195 94196 94197 94198 94199</td>
</tr>
</tbody>
</table>
• Failed conservative treatment or documentation that conservative treatment is contraindicated.

Prior authorization requests for procedure code 17999 must include the following documentation:

• A clear, concise description of the procedure to be performed.
• Reason for recommending the particular procedure.
• Documentation that a specific procedure code is not available for the procedure requested.
• The client’s diagnosis.
• Medical records indicating prior treatment for the diagnosis and the medical necessity of the requested procedure.
• Place of service the procedure is to be performed.
• Documentation that the procedure is not investigational or experimental.
• The physician’s intended fee for the procedure including a comparable procedure code.

8.2.70  Sleep Studies

Sleep study procedure code 95806 is not a benefit of Texas Medicaid.

8.2.70.1  Actigraphy

Actigraphy (procedure code 95803) may be reimbursed in the office or outpatient hospital setting with a limit of one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Actigraphy can be performed as a stand-alone procedure or as an adjunct to polysomnography or multiple sleep latency test (MSLT).

Actigraphy (procedure code 95803) must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>32700</td>
</tr>
<tr>
<td>32719</td>
</tr>
<tr>
<td>32751</td>
</tr>
</tbody>
</table>

If the primary care physician performs the actigraphy, the technical component must be billed (procedure code 95803 with modifier TC).

Documentation of actigraphy must include a hard-copy printout or electronic file. Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s professional interpretation and report must include inspection of the entire recording and integration of the information gathered from other professionals’ analysis and observations. Documentation of the interpretation must be maintained by the interpreting physician.

Under the following conditions, actigraphy may be a useful adjunct to a detailed history, examination, and subjective sleep diary for the diagnosis and treatment of insomnia, circadian-rhythm disorders, and excessive sleepiness:

• When demonstration of multiday rest-activity patterns is necessary to diagnose, document severity, and guide the proper treatment.
• When more objective information regarding the day-to-day timing or the amount or patterns of a client’s sleep is necessary for optimal clinical decision-making.
• When the severity of a sleep disturbance reported by the client or caretaker seems inconsistent with clinical impressions or laboratory findings.
• To clarify the effects of, and under some instances, compliance with pharmacologic, behavioral, phototherapeutic, or chronotherapeutic treatment.

• In symptomatic clients for whom an accurate history cannot be obtained and at least one of the following is true:
  • A polysomnographic study has already been conducted.
  • A polysomnographic study is considered unlikely to be of much diagnostic benefit.
  • A polysomnographic study is not yet clearly indicated (because of the absence of accurate historical data).
  • A polysomnographic study is not immediately available.

Actigraphy may be useful in the assessment of specific aspects of the following disorders:

• Insomnia. Assessment of sleep variability, measurement of treatment effects, and detection of sleep phase alterations in insomnia secondary to circadian rhythm disturbance.

• Restless legs syndrome or periodic limb movement disorder. Assessment of treatment effects.

8.2.70.2 Pneumocardiograms

Pneumocardiograms (procedure code 95807) are limited to clients who are birth through 12 months of age.

Pneumocardiograms are limited to one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Procedure code 95807 must be billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>32721 32723 32724 32725 32726 32727 77081 77082 77083 77084</td>
</tr>
<tr>
<td>77981 77982 7825 78603 78604 79902 79982</td>
</tr>
</tbody>
</table>

Documentation of the complete readings associated with the pneumocardiogram and the physician’s interpretation must be maintained in the client’s medical record in a hard-copy printout or electronic file at the facility where the procedure is performed.

The physician’s interpretation and report must include inspection and integration of the information gathered from all physiological systems and other professionals’ analysis and observations.

8.2.70.3 Polysomnography

Polysomnography (procedure codes 95808, 95810, and 95811) is a benefit of Texas Medicaid.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1-to 4-lead electroencephalogram (EEG), electro-oculogram (EOG), and a limb or submental electromyogram (EMG).

Additional parameters of sleep that are evaluated in polysomnography include, but are not limited to, the following:

• ECG
• Airflow (by thermistor or intra-nasal pressure monitoring)
• Respiratory effort
• Adequacy of oxygenation by oximetry or transcutaneous monitoring
• Extremity movement or motor activity
- EEG monitoring for sleep staging
- Nocturnal penile tumescence
- Esophageal pH or intraluminal pressure monitoring
- Continuous blood pressure monitoring
- Snoring
- Body positions
- Adequacy of ventilation by end-tidal or transcutaneous CO2 monitoring

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 95808, 95810, and 95811.

Polysomnography (procedure codes 95808, 95810, and 95811) is limited to one per day and two per rolling year by any provider and is allowed for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>27801 27803 29182 29285 30740 30741 30742 30743 30744 30745</td>
</tr>
<tr>
<td>30746 30747 30748 32700 32701 32702 32710 32711 32712 32713</td>
</tr>
<tr>
<td>32715 32719 32720 32721 32722 32723 32724 32725 32726 32727</td>
</tr>
<tr>
<td>32729 32730 32731 32732 32733 32734 32735 32736 32737 32739</td>
</tr>
<tr>
<td>32740 32741 32742 32743 32744 32749 32751 32752 32753 32759</td>
</tr>
<tr>
<td>3278 33394 3350 33511 33519 33520 34120 3439 34400 34700</td>
</tr>
<tr>
<td>34701 34710 34711 3481 3590 3591 47410 51883 60784 7428</td>
</tr>
<tr>
<td>7483 7560 7564 78050 78051 78052 78053 78054 78055 78056</td>
</tr>
<tr>
<td>78057 78058 78059 78603 79902</td>
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</tbody>
</table>

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of the polysomnography testing must be maintained in the client’s medical record at the sleep facility and include approximately 1,000 pages or the electronically-stored equivalent of data during a single nighttime recording. Each record must be for sleep-wake states and stages, cardiac arrhythmias, respiratory events, motor activity, oxygen desaturations, and behavioral observations.

Documentation must also include the technologist’s analysis and report, the patient’s subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s professional interpretation and report must include inspection of the entire recording, examination of the technologist’s analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

8.2.70.4 Multiple Sleep Latency Test (MSLT)

Multiple sleep latency test (procedure code 95805) is limited to one per day and two per rolling year by any provider, and is restricted to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
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<tbody>
<tr>
<td>27803 32700 32701 32702 32709 32743 32751 33394 34700 34701</td>
</tr>
<tr>
<td>34710 34711 78053</td>
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</tbody>
</table>
Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client’s medical record at the sleep facility and include a hard copy or electronic copy of four to five 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist’s analysis and report, the client’s subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s interpretation and report must include inspection of the entire recording, examination of the technologist’s analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

### 8.2.70.5 Sleep Facility Restrictions for Polysomnography and Multiple Sleep Latency Testing

Sleep facilities that perform services for Medicaid clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Sleep facilities must maintain documentation with proof that the facility is accredited. Documentation is subject to retrospective review. Sleep facilities that perform services for Texas Medicaid clients must also follow current AASM practice parameters and clinical guidelines.

Physicians who provide supervision in sleep facilities must be board-certified or board-eligible, as outlined in the AASM guidelines.

Sleep facility technicians, technologists, and trainees must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist, or a physician.

  **Note:** Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is provided.

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (MD or DO).
• A polysomnographic technician provides comprehensive polysomnographic testing and analysis and associated interventions under the general supervision of a polysomnographic technologist or clinical director (MD or DO).

• The supervising physician must be readily available to the performing technologist throughout the duration of the study, but is not required to be in the building.

The sleep facility must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of the nonphysician staff who use the equipment.

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client’s medical record at the sleep facility and include a hard copy or electronic copy of four to five, 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

• EEG
• Electro-oculogram (EOG)
• EMG
• EKG
• Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist’s analysis and report, the client’s subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician’s interpretation and report must include inspection of the entire recording, examination of the technologist’s analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

8.2.71 Speech Therapy (ST) Services
Speech therapy (ST) is a payable benefit to physicians.

Refer to: Section 4, “Therapists, Independent Practitioners, and Physicians” in the Nursing and Therapy Services Handbook (Vol. 2, Provider Handbooks) for information about speech therapy services provided by a physician.

8.2.72 Surgery Billing Guidelines

8.2.72.1 Primary Surgeon
A primary surgeon may be reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.
A surgeon billing for a surgery and an assistant surgery fee on the same day may be reimbursed if two separate procedures are performed.

**Refer to:** Subsection 8.2.72.7, “Multiple Surgeries,” in this handbook.

### 8.2.72.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. The exception to this policy is an epidural during labor and delivery.

**Refer to:** Subsection 8.2.6, “Anesthesia,” in this handbook.

### 8.2.72.3 Assistant Surgeon

Assistant surgeons may be reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician’s specialty. Medicaid may consider reimbursement for an assistant surgeon at a teaching hospital classified by Medicare as a teaching facility with approved graduate training program if one of the following situations is present and documented on the claim:

- No qualified resident was available. (Modifier 82 may be used to document this exception.)
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).
- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

Use of these modifiers is not required but expedites claims processing. Therefore, it is recommended that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 paper claim form the name and address or provider identifier of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

> “I understand that section 1842(b)(6)(D) of the Social Security Act generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP.”

Surgical procedures that do not ordinarily require the services of an assistant, as identified by Medicare, are denied when billed as an assistant surgery. One assistant surgeon is reimbursed for surgical procedures when appropriate.

Use modifier AS when the physician assistant is not enrolled as an individual provider and provides assistance at surgery. The claim must include the PA’s name and license number. Only procedures currently allowed for assistant surgeons are payable.

PAs actively enrolled as a Medicaid provider with an assigned provider identifier may bill assistant surgery services on a separate claim form using the PA’s individual provider identifier and modifiers U7 and 80.
8.2.72.4 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>29405</td>
<td>LT</td>
</tr>
<tr>
<td>29405</td>
<td>RT</td>
</tr>
</tbody>
</table>

8.2.72.5 Cosurgery

Cosurgery (two surgeons) may be reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons’ separate contributions to the successful outcome of the procedure are considered to be of equal importance.

Note: No additional reimbursement will be made for an assistant surgeon.

Cosurgeons may be reimbursed for surgical procedure codes that are billed with modifier 62 if the CMS fee schedule indicates that the procedure allows for cosurgeons. Claims will not suspend for manual review of the documentation of medical necessity. Reimbursement will be calculated at 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure’s fee.

No cosurgery payment is made for claims submitted without modifier 62. In instances where the surgeons do not use modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

8.2.72.6 Global Fees

Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

Texas Medicaid adheres to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period-Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period-Reimbursement includes the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days following the date of the surgical procedure.
- 90-day Global Period-Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days following the date of the surgical procedure.
Procedure codes that are designated as “Carrier Discretion” will have their global periods determined by HHSC.

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

**Modifiers**
For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

<table>
<thead>
<tr>
<th>Modifiers Related to Surgical Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
</tr>
<tr>
<td>58</td>
</tr>
</tbody>
</table>

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the physician who provides preoperative or postoperative care. Reimbursement for claims associated with modifier 54, 55, or 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

**Documentation Requirements**
For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client’s medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

**Note:** Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.

**Preoperative Services**
Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a significant, separately identifiable service may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with the identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.
E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when billed with modifier 57. The client’s medical record must clearly indicate when the initial decision to perform the procedure was made.

Intraoperative Services
Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Modifier 54 indicates that the surgeon provided the surgical care only. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

Postoperative services
Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Postoperative follow-up visits (any place of service)
- Postoperative pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care
  - Platelet gel
  - Removal of operative packs
  - Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
  - Replacement of vascular access lines
  - Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
  - Changes or removal of tracheostomy tubes

  **Note:** Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of the surgery, and modifier 54, which indicates that he or she was the surgeon.
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care.

  **Note:** Providers must not submit a claim for the postoperative care until after the client has been seen during a face-to-face follow-up visit.

When a transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider assuming in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- When the transfer of care occurs after hospital discharge, the surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
• Documentation in the medical record must include all of the following:
  • A copy of the written transfer agreement.
  • The dates the care was assumed and relinquished.
• The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication and any of the following:
  • It was planned at the time of the initial surgical procedure.
  • It is more extensive than the initial surgical procedure.
  • It is for therapy following an invasive diagnostic surgical procedure.

  **Note:** Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).

Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and, as a result, not separately billable; however, separate payment for such visits can be allowed if any of the following conditions apply:
  • Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy following transplant surgery is covered separately from other postoperative services, so postoperative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery. This coverage applies regardless of the setting.
  • Critical care is provided by the surgeon for a burn or trauma patient.
  • The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. The submitted documentation must substantiate the reasons for providing E/M services.
  • Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
  • Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

**Return Trips to the Operating Room**
Return trips to the operating room for a repeat surgical procedure on the same part of the body may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifier 76 or 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure must be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.
Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period only the intraoperative portion will be reimbursed.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis.
- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier.
- When a different procedure is performed with the same diagnosis.
- When a different procedure is performed with a different diagnosis.

Billing with modifier 79 initiates a new global surgical period.

8.2.72.7 Multiple Surgeries

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.
- Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).
- Procedure code 58611 performed in conjunction with a Cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.
- When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

8.2.72.8 Office Procedures

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician’s office). The medical necessity and/or special
circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment. This list is not all inclusive.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Excision benign lesions</th>
<th>Excision malignant lesions</th>
<th>Manipulation (urethral)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11400</td>
<td>11600</td>
<td>53600</td>
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<td>11403</td>
<td>11603</td>
<td>53621</td>
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<td>11604</td>
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<td>11420</td>
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<tr>
<td>11444</td>
<td>11643</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple repairs</td>
<td>Endoscopy</td>
<td>Biopsy (tongue)</td>
<td></td>
</tr>
<tr>
<td>28010</td>
<td>31505</td>
<td>41100</td>
<td></td>
</tr>
<tr>
<td>28011</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesions (penile)</td>
<td>Lesions (eyelid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>54060</td>
<td>67801</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.2.72.9 Orthopedic Hardware

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon’s global fee or the facility’s payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post operative care period.

8.2.72.10 Second Opinions

Texas Medicaid benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim must be coded with the appropriate office or hospital visit codes, and the notation “Client Initiated Second Opinion” should be identified in Block 24D of the CMS-1500 paper claim form.

Refer to: Subsection 8.2.60.1.3, “Consultation Services,” in this handbook.
8.2.72.11 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under Texas Medicaid. All supplies, including anesthetizing agents, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If any of these items are submitted separately, they are denied as included in the surgical fee. If the supplies are submitted with a place of service (POS) other than the office, these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a benefit for home use.

8.2.73 Telemedicine Services

Telemedicine is defined as the practice of health-care delivery by a provider who is located at a site other than the site where the client is located. Telemedicine requires the use of advanced telecommunications technology and is used for the purposes of evaluation, diagnosis, consultation, or treatment.

Only those services that involve direct face-to-face interactive video communication between the client and the distant-site provider constitute a telemedicine interactive video consultation. The audio and visual fidelity and clarity of all telemedicine services must be functionally equivalent to a face-to-face visit. Telephone conversations, chart reviews, electronic mail messages, and facsimile transmissions alone do not constitute a telemedicine interactive video consultation and will not be reimbursed as telemedicine services.

Use of telemedicine services within ICF-MR State Schools is subject to the policy established by DSHS and the Texas Department of Aging and Disability Services (DADS) established policies.

The provider requesting the telemedicine service must maintain medical record documentation indicating the medical necessity for the service. The referring provider is responsible for contacting the distant-site provider and arranging for the telemedicine service. In the absence of a referring provider, the distant-site provider is responsible for arranging the telemedicine service.

More than one medically necessary telemedicine service may be reimbursed for the same date of service and place of service, if the services are billed by physicians of different specialties. Documentation for a service provided via telemedicine must be the same as for a comparable in-person service.

Providers may not disclose any medical information revealed by the client or discovered by the physician in connection with the treatment of the client via telemedicine without proper authorization from the patient.

8.2.73.1 Distant Site

A distant site is the location of the provider rendering the service. The distant-site provider must be a physician enrolled as a Texas Medicaid provider.

The distant-site provider must maintain medical record documentation that:

- Indicates the reason for the telemedicine service.
- Includes the name of the referring provider, if any, and the name of the client’s primary care physician, if any.
- Includes a copy of the distant-site provider’s findings, diagnosis, plan of care, and treatment recommendations.
The following procedure codes, when billed with the GT modifier, are a benefit for distant-site providers:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>90801</td>
</tr>
<tr>
<td>90952</td>
</tr>
<tr>
<td>99204</td>
</tr>
<tr>
<td>99244</td>
</tr>
</tbody>
</table>

### 8.2.73.2 Patient Site

A patient site is where the client is physically located while the service is rendered. Patient-site providers must be located in a rural or underserved area.

- A rural area is defined as a county that is not included in a metropolitan statistical area as defined by the U.S. Office of Management and Budget (OMB) according to the most recent United States Census Bureau population estimates.
- An underserved area is an area that meets the U.S. Department of Health and Human Services (DHHS) Index Primary Care Underservice criteria.

Board-eligible or board-certified specialists and subspecialists, who provide care to clients who are 20 years of age and younger, are exempt from the rural and underserved geographic limitation. The specialist or subspecialist cannot be designated as the client’s primary care provider.

Patient-site services may only be provided by one of the following Texas Medicaid enrolled providers: physicians, physician assistants, nurse practitioner, clinical nurse specialist, and outpatient hospitals.

Patient-site providers must use procedure code Q3014 for the facility fee.

A telepresenter who meets one of the qualifications listed below must be at the patient site when the service is provided via telemedicine:

- An individual who is licensed or certified in Texas to perform health-care services and who presents or is delegated tasks and activities only within the scope of the individual’s licensure or certification
- A qualified mental health professional (QMHP) as defined in 25 TAC §412.303(48)

All patient sites must maintain documentation for each service, including the following:

- Date of the service
- Name of the client
- Name of the distant-site provider

The patient site that bills for the service must maintain records that document the following:

- Name of the referring or requesting provider
- Name of the telepresenter

A patient site that does not bill for the patient-site service must still capture this information if it is available.

### 8.2.74 Therapeutic Apheresis

The following conditions must be met for therapeutic apheresis:

- To perform the medical services, including all nonphysician services, and to respond to medical emergencies at all times during client care, direct supervision by a physician is required.
• Each client must be under the care of a physician.

Procedure codes 36511, 36512, 36513, 36514, 36515, and 36516 are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20300 20302 20310 20311 20312 20380 20381 20382 20400 20401</td>
</tr>
<tr>
<td>20402 20410 20411 20412 20420 20421 20422 20480 20481 20482</td>
</tr>
<tr>
<td>20490 20491 20492 20500 20501 20502 20510 20511 20512 20520</td>
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<td>20521 20522 20530 20531 20532 20580 20581 20582 20590 20591</td>
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<tr>
<td>20592 20600 20601 20602 20610 20611 20612 20620 20621 20622</td>
</tr>
<tr>
<td>20680 20681 20682 20690 20691 20692 20700 20701 20702 20710</td>
</tr>
<tr>
<td>20711 20712 20720 20721 20722 20780 20781 20782 20800 20801</td>
</tr>
<tr>
<td>20802 20810 20811 20812 20820 20821 20822 20880 20881 20882</td>
</tr>
<tr>
<td>20890 20891 20892 2384 23871 23891 23892 2730 2731 2733 2735</td>
</tr>
<tr>
<td>2736 2737 2738 2780 2781 2782 27830 27831 27832 99680</td>
</tr>
</tbody>
</table>

Procedure codes 36515 and 36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber LA 15) or the protein A immunoadsorption (such as Prosorba) columns.

The protein A immunoadsorption column is indicated for use in either of the following cases:

• Clients who have a platelet count of less than 100,000 mm3.
• Adult clients who have signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, DMARDs.

The LDL apheresis column is indicated for use in clients who have severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or untolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:

• Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
• Functional hypercholesterolemia heterozygotes with LDL-C > 300 mg/dL.
• Functional hypercholesterolemia heterozygotes with LDL-C > 200 mg/dL and documented coronary heart disease.
Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an
American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination
drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four-
week period and should be within 10 percent of each other, indicating a stable condition.

Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code 2720.
Apheresis services represents one 30-minute time interval of personal physician involvement in the
apheresis. Apheresis is limited to three 30-minute time intervals per procedure. The actual time must be
reflected on the claim, or a unit of 1, 2, or 3 must be indicated. If the time (or unit) is not indicated,
payment is based on one 30-minute time interval.

Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP
Medical Director or designee on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in
the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the
inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

8.2.75 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical
reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body
to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of Texas Medicaid and may be billed using procedure code 99195.
This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic
reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2384</td>
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</table>

Therapeutic phlebotomy will autodeny for all other diagnosis codes.

8.2.76 Therapeutic Radiopharmaceuticals

Therapeutic radiopharmaceuticals, when used for therapeutic treatment, are a benefit of Texas
Medicaid.

The following procedure codes may be submitted for therapeutic radiopharmaceuticals:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tr>
<td>79403</td>
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</table>

8.2.76.1 Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is not required for therapeutic radiopharmaceuticals except for tositumomab or
ibritumomab tiuxetan.

Tositumomab or ibritumomab tiuxetan may be prior authorized when all of the following criteria are
met:
- Client has a diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin’s
  lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy and the following is
documented:
  - Marrow involvement is less than 26 percent.
• Platelet count is 100,000 cell/mm³ or greater.
• Neutrophil count is 1,500 cell/mm³ or greater.
• Client has failed a trial of rituximab.

Prior authorization must be submitted through Special Medical Prior Authorization department.

Only one tositumomab or ibritumomab tiuxetan (procedure codes A9542, A9543, A9544, and A9545) may be prior authorized and reimbursed once per lifetime, any provider with diagnosis code 20280.

### 8.2.76.2 Other Limitations on Therapeutic Radiopharmaceuticals

Strontium-89 chloride (procedure code A9600) may be reimbursed when submitted with diagnosis code 1985.

Strontium-89 chloride is limited to a total of 10 mci intravenously injected every 90 days, any provider, and may be reimbursed one per day same provider.

Sodium phosphate P-32, therapeutic (procedure code A9563) may be reimbursed when submitted with the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985 20410 20412 20422 20492 20510 20512 20522 20582 20592</td>
</tr>
<tr>
<td>20812 20822 20882 20892 2384</td>
</tr>
</tbody>
</table>

Chromic phosphate P-32 suspension (procedure code A9564) may be reimbursed when submitted with diagnosis codes 1972 and 1976.

Modifier 76 must be used when billing for services more than once per day, same provider.

### 8.2.77 Urethral Dilation

If urethral dilation (procedure code 53600, 53601, 53605, 53620, 53621, 53660, 53661, or 53665) is billed on the same date of service by the same provider as procedure code 52000, the charges will be combined and processed as procedure code 52281.

Urethral dilation will be denied when billed on the same date of service by the same provider as any other cystoscopy.

### 8.2.78 Ventilation Assist and Management for the Inpatient

Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 94002 and 94003. Procedure codes 94002 and 94003 may be reimbursed only when the client is in observation or inpatient status. Respiratory care billed in any other POS will be denied.

Use the ventilation assist and management subsequent code (procedure code 94003) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

When the use of a ventilator is required as part of a major surgery, initial ventilation assist and management will be denied. It should be billed as ventilation assist and management subsequent procedure code 94003.

Procedure codes 94002 and 94003 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, arterial or venous punctures; interpretations of arterial blood gases; or pulmonary function tests and management of the hemodynamic functions of the patient).
Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing—first day (procedure code 94002) when respiratory support must be established for a patient. It is a one-time charge per hospitalization that may be paid when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (procedure code 94003).

8.2.79 Wearable Cardiac Defibrillator (WCD)
A WCD (procedure codes 93292, 93745, and K0606) are a benefit of Texas Medicaid.

The rental of a WCD (procedure code K0606) is limited to once per month and must be submitted with modifier RR.

Modifier 25 may be used to identify a significant separately identifiable evaluation and management service performed (for example, different diagnosis) on the same day as the initial set up of a WCD by the same provider for the same client. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Procedure code 93292 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

Procedure codes 93000, 93005, 93010, 93040, 93041, and 93042 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

8.2.79.1 Prior Authorization for WCD
Prior authorization is required for the rental of WCD (procedure code K0606).

The WCD may be prior authorized for clients at high-risk of sudden cardiac arrest who meets one of the following criteria:

- Has completed electrophysiologic studies to determine the type of arrhythmia present and confirm that a wearable cardiac defibrillator is the best course of treatment.
- Is contraindicated for an implantable cardiac defibrillator (ICD) at the current time, such as with a systemic infection.
- Is waiting for ICD implantation.
- Is waiting for ICD implantation and is undergoing treatment for a systemic infection.
- Has had an ICD explantation due to pocket infection.
- Is waiting for heart transplantation.
- Has self-limiting arrhythmias from iatrogenic (drug loading with potentially pro-arrhythmic medications) or other causes.
- Has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy.
- Has had either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction (LVEF) less than or equal to 35 percent.
- Has received a documented diagnosis of any one of the following conditions:
  - Clinically inducible hemodynamically significant ventricular tachycardia (HSVT) or ventricular fibrillation (VF), where drug treatment has been ineffective, or the side effects of the medication used to treat the arrhythmia are intolerable.
  - Inducible VT or VF despite endocardial ablation or surgical excision when drug therapy has failed.
• VF or syncopal ventricular tachycardia.
• Specific ST-T wave changes, borderline CPK-MB isoenzymes, and dangerous ventricular arrhythmias are exhibited in a postmyocardial infarction patient.
• VT caused by ischemic heart disease not associated with an acute myocardial infarction, and where drug therapy or surgical therapy has failed.
• Recurrent syncope of undetermined etiology in a patient with HSVT or VF induced by EPS in whom no effective or tolerated drug is available or appropriate. Symptoms must be linked to HSVT or VF.
• Recurrent syncope of undetermined etiology with positive EPS studies where ventricular arrhythmia is documented as the cause.
• Palliative treatment for VT or VF in clients awaiting heart transplant.

The WCD is contraindicated in clients with an active ICD and should not be used in clients who meet the following criteria:
• Have a vision or hearing problem that may interfere with the perception of alarms or messages from the WCD.
• Is taking medications that would interfere with responding to the alarms or message from the WCD by depressing buttons.
• Is unwilling or unable to wear the device continuously, except when bathing or showering.
• Is pregnant or breastfeeding.
• Is of childbearing age and is not attempting to prevent pregnancy.

The WCD is considered investigational and not medically necessary for all other indications, including but not limited to, the following:
• Clients with drug-refractory class IV congestive heart failure who is not candidates for heart transplantation.
• Clients who have a history of psychiatric disorders that interfere with the necessary care and follow-up.
• Clients in whom a reversible triggering factor for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities.
• Clients with terminal illnesses.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form (Title XIX Form) prescribing the DME and/or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization.
• All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted.
• The completed Title XIX Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician’s medical record for the client.
• The completed Title XIX Form must include the procedure codes and quantities requested for the services.
To complete the prior authorization process the provider must submit the completed Title XIX Form by fax to the Home Health Unit at 1-512-514-4209 or in writing to the following address:

Texas Medicaid & Healthcare Partnership  
Home Health Services  
PO Box 202977  
Austin, TX 78720-2977

When a WCD is not covered as a home health service, it may be considered for reimbursement through the CCP for clients who are 20 years of age and younger. All of the following criteria must be met for CCP reimbursement for a WCD:

- The client is eligible for CCP benefits.
- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed in the policy.
- Federal financial participation is available.
- The client’s cardiac status would be compromised without the requested equipment.
- The requested equipment is safe in the home setting.

Rental of an automatic external defibrillator, with integrated electrocardiogram analysis, garment type (procedure code K0606) may be prior authorized (initially for up to three months) with documentation supporting the medical necessity and appropriateness of the device.

The provider may be reimbursed only for the length of time the device is used even though the authorization for the rental may be for a longer period of time.

The rental of the device includes the monitor, electrode belt (four sensors or electrodes and three treatment pads), garment, two rechargeable batteries, a battery charger and modem.

The purchase of a replacement battery (procedure code K0607), the purchase of a garment (procedure code K0608), and electrodes (procedure code K0609) will be considered part of the rental.

Prior authorization extensions for WCDs beyond the initial three-month rental may be considered by the medical director when documentation supports continued medical necessity for the device. Providers must submit new documentation to support continued medical necessity for an extension of the rental to be considered.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the device. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the WCD.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim.

### 8.2.80 Wound Care Management

Wound care management includes the care of acute and chronic wounds, which include, but are not limited to, open ulcers (venous pressure or diabetic ulcers), fistulas, or erosion of skin related to cancer. Acute and chronic wounds are defined as the following:

- **Acute wounds:** Wounds taking less than 30 days for complete healing
- **Chronic wounds:** Wounds taking more than 30 days for complete healing

Wound care includes the following:

- **Optimization of nutritional status**
- **Debridement by any means to remove devitalized tissue**
• Maintenance of a clean, moist bed of granulation tissue
• Necessary treatment to resolve any infection that may be present

For clients with an ulcer, wound care may include the following:
• Frequent repositioning of a client who has a pressure ulcer
• Off-loading pressure and good glucose control for a client who has a diabetic ulcer
• Establishment of adequate circulation for a client who has an arterial ulcer
• Use of a compression system for clients who have a venous ulcer

Wound care management includes first- and second-line therapies. First-line wound care is used for acute wounds. If the wound does not improve with first-line treatment, adjunctive second-line therapy may be used. Measurable signs of improved healing include the following:
• A decrease in wound size, either in surface area or volume
• A decrease in amount of exudate
• A decrease in amount of necrotic tissue

Wound care must be performed by a licensed health professional who is qualified to safely and effectively provide the medically necessary care. Providers are expected to exercise their clinical judgment to render the most appropriate care in accordance with their scope of practice as designated by their regulatory and governing boards.

The following services are not a benefit of Texas Medicaid:
• Infrared therapy
• Ultraviolet therapy
• Topical hyperbaric oxygen therapy
• Low-energy ultrasound wound cleanser (MIST therapy)
• Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
• Electrical stimulation and electromagnetic therapy
• Whirlpool therapy for wound care (procedure code 97602)

8.2.80.1 First-Line Wound Care Therapy
First-line wound care therapy includes the following:
• Cleansing, antibiotics, and pressure off-loading
• Compression
• Debridement
• Dressing
• Whirlpool for burns

8.2.80.1.1 Cleansing, Antibiotics, and Pressure Off-loading
Wound cleansing helps to create an optimal healing environment and decreases the potential for infection by loosening and removing cellular debris and residual topical agents from previous dressings.
Wound cleansing agents may include normal saline, commercial wound cleansers, providone iodine, hydrogen peroxide, or sodium hydrochlorite. Cleansing solutions and methods vary based on effectiveness and individual client needs.

Systemic or topical antibiotics may be used to prevent or treat wound infections and to aid in the healing of wounds.

Pressure off-loading devices, such as pillows, boots, mattresses, and protectors, may also be used as part of first-line wound care therapy to prevent or relieve pressure on the wound.

### 8.2.80.1.2 Compression

Compression performed as a part of wound care management is a benefit and may be reimbursed when billed with procedure code 29580.

### 8.2.80.1.3 Debridement

Wound debridement includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the client on the date of service.

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion
- Mechanical debridement

The following procedure codes are a benefit for wound debridement:

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<tr>
<th>Procedure Codes</th>
<th>11000</th>
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<th>11042</th>
<th>11043</th>
<th>11044</th>
<th>11045</th>
<th>11046</th>
<th>11047</th>
<th>16020</th>
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<td>16030</td>
<td>97597</td>
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The procedure code submitted on the claim (and authorization request, if applicable) must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

Prior authorization is required for non-emergent wound debridement procedure codes 11042, 11043, and 11044. A request for prior authorization must be submitted to TMHP with the Special Medical Prior Authorization (SMPA) Request Form before the procedure is performed. Providers must retain a copy of the signed and dated form in the client’s medical record at the provider’s place of business. The requesting provider may be asked for additional information to clarify or complete a request for the equipment/supply requested.

Requests for prior authorization for wound debridement procedure codes 11042, 11043, and 11044 must include the following documentation:

- Location of the wound
- Characteristics of the wound, including:
  - Dimensions (diameter and depth)
- Drainage (amount and type)
- Related signs and symptoms (swelling, pain, inflammation)
- Presence of necrotic tissue/slough
- Wound care treatment plan

For procedure codes 11043 and 11044, at least one of the following conditions must be present and documented:
- Stage III or IV wounds
- Venous or arterial insufficiency ulcers
- Dehisced wounds or wounds with exposed hardware or bone
- Neuropathic ulcers
- Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment

Wound debridement procedure codes 11042, 11043, and 11044 are not appropriate and will not be approved for the following:
- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates
- Acne surgery
- Destruction of warts
- Burn debridement

Retroactive authorization is required for wound debridement procedure codes 11042, 11043, and 11044 that are performed on an urgent or emergent basis. The provider must submit a request for retroactive authorization within 14 calendar days, beginning the day after the procedure is performed.

8.2.80.1.4 Dressings and Metabolically Active Skin Equivalents

Wound dressings may include wet and dry dressings.

Dressings applied to the wound are considered part of the service for wound debridement. Metabolically active skin equivalents used in wound care may be considered separate benefits, in addition to the wound debridement procedure. The following procedure codes are a benefit for metabolically active skin equivalents provided in the office setting:

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<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>C9250</td>
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<tr>
<td>Q4110</td>
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<tr>
<td>Q4122</td>
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</tbody>
</table>

The client’s medical record must include documentation that wound treatments with metabolically active skin equivalents or skins substitutes are accompanied by appropriate adjunctive measures, and must identify the adjunctive therapies being provided to the client as part of the wound treatment regimen.
Prior authorization is required for unspecified skin substitute procedure code Q4100. When requesting prior authorization for procedure code Q4100, providers must submit the Special Medical Prior Authorization (SMPA) Request Form and the following information with the request:

- The client’s diagnosis
- Characteristics of the wound, including:
  - Location
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough
- Medical records that indicate prior treatment for the diagnosis, the medical necessity of the requested skin substitute, and the wound care treatment plan
- A clear, concise description of the skin substitute to be applied and the reason for recommending this particular item
- A CPT or HCPCS procedure code that is comparable to the requested procedure
- Documentation that demonstrates that the requested procedure is not investigational or experimental
- The place of service in which the requested procedure will be performed
- The physician’s intended fee for the requested procedure

8.2.80.1.5 Whirlpool for Burns
Whirlpool may be a benefit when used as first-line wound care therapy for the treatment of burn wounds.

8.2.80.2 Second-Line Wound Care Therapy
Second-line wound care therapy is limited to chronic Stage III or IV wounds and may be covered only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second line wound care measures as indicated by the client’s medical condition.

Second-line wound care therapy includes the following:
- Whirlpool
- Irrigation, including pulsatile jet irrigation

8.2.80.2.1 Whirlpool
Whirlpool is a nonselective hydrotherapy used in the second-line treatment of chronic wounds that may be used in combination with other therapeutic treatments. Whirlpool generates water movement, which produces massage of body areas that impacts surface circulation and loosens nonviable tissue.

8.2.80.2.2 Pulsatile-Jet Irrigation
Pulsatile-jet irrigation is a benefit for the treatment of Stage III or IV wounds when other forms of treatment have failed. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.
8.2.80.3 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client’s medical records, including the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client’s overall health status.
- Appropriate medical history related to the current wound, including the following:
  - Wound measurements, which includes length, width, and depth, any tunneling and/or undermining
  - Wound color, drainage (type and amount), and odor, if present
  - The prescribed wound care regimen, which includes frequency, duration, and supplies needed
  - Treatment for infection, if present
  - All previous wound care therapy regimens, if appropriate
  - The client’s use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client’s medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

8.3 Doctor of Dentistry Practicing as a Limited Physician

This section outlines the guidelines for the Doctor of Dentistry practicing as a limited physician. The THSteps dental program is not addressed in these guidelines.

Services by a dentist (DDS or DMD) are covered by Texas Medicaid in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1987 (public law 100-203), if the services are furnished within the dentist’s scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

Dentist (DDS or DMD) who want to participate as a dentist-physician in Texas Medicaid must be separately enrolled as a Doctor of Dentistry practicing as a limited physician even if they are enrolled in the THSteps Dental Program.

Dual licensure (MD, DO, and DDS) is not required for a dentist to enroll as a limited physician. Medicare enrollment is required for a dentist to enroll as a limited physician.

8.3.1 Prior Authorization for General Dental Services Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients who are 21 years of age and older (who do not reside in an ICF-MR facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. Mandatory prior authorization is required and the dental diagnoses must be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a general dentist who is enrolled as a limited physician are:

- Extractions.
• Alveolectomies (in limited situations).
• Incision and drainage.
• Curettement.

Examples of dental procedures that may be authorized for an oral and maxillofacial surgeon who is enrolled as a limited physician are:

• Extractions.
• Alveolectomies (in limited situations).
• Incision and drainage.
• Curettement maxillofacial surgeries to correct defects caused by accident or trauma.
• Surgical corrections of craniofacial dysostosis.

Note: Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.

8.3.1.1 Guidelines for Requesting Mandatory Prior Authorization

The limited physician dentist must request the mandatory prior authorization, and the request must include:

• A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition.
• Narrative describing the current medical problem, client status, and medical need for requested services.
• The client name and Medicaid number.
• The limited physician dentist’s provider identifier.
• The name and address of the facility.
• CPT procedure codes.
• The history and physical.
• The limited physician dentist’s signature.

Note: The “limited physician” dentist who will perform the procedure(s) must submit the request for prior authorization.

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

8.3.2 Benefits and Limitations

Dental procedure codes and their corresponding CPT procedures may not be billed on the same date of service by any provider.

Cosmetic procedures are not a benefit of Texas Medicaid. Certain procedure codes, including, but not limited to, the procedure codes in the following table, may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury for the purpose of:

• Reconstructing tissues/body structures.
• Repairing damaged tissues.

### 8.3.2.1 Diagnosis Codes

The following table lists diagnosis codes (ICD-9-CM) that may be billed by a Doctor of Dentistry practicing as a limited physician:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>11950</th>
<th>11951</th>
<th>11952</th>
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8.3.2.2 Evaluation and Management Procedure Codes

Patient evaluation and management services, and consultation procedure codes must be used with the appropriate diagnosis codes listed in Subsection 8.3.2.1, “Diagnosis Codes,” in this handbook.

8.3.2.3 Additional Payable Procedure Codes

The following procedure codes are a benefit when prior authorized and:

- Accompanied by the appropriate diagnosis code.
- The dentist is qualified and licensed to perform the procedures.

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<table>
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<tr>
<th>Procedure Codes</th>
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8.3.2.4 Immune Globulin by a Doctor of Dentistry as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician may be reimbursed for immune globulin injection procedure code J1571 when billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>90284 96360 96361 96369 96370 96372 96374 J0120 J0171 J0280</td>
</tr>
<tr>
<td>J0290 J0295 J0330 J0360 J0475 J0558 J0561 J0670 J0690 J0692</td>
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<td>J0694 J0696 J0697 J0698 J0702 J0710 J0715 J0720 J0744 J0780</td>
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<td>J0945 J1020 J1030 J1094 J1100 J1165 J1170 J1200 J1364</td>
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<td>J1459 J1557 J1559 J1561 J1566 J1568 J1569 J1572 J1599 J1630</td>
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<td>J2400 J2410 J2460 J2510 J2515 J2540 J2550 J2560 J2650 J2690</td>
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<td>J3260 J3301 J3302 J3303 J3310 J3320 J3360 J3370 J3410 J3430</td>
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<td>J3480 J3485 J3490 J3520 S0021</td>
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</table>

8.3.2.5 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement when accompanied by an appropriate diagnosis:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
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<tbody>
<tr>
<td>27902 27905 27906 27941 27949 28489 35800 586 V0179</td>
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</table>

8.3.2.6 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§110.1 through 110.9, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.
The following anesthesia services are payable to dentists as physician services when accompanied by a payable diagnosis:

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<th>Procedure Codes</th>
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<td>00100</td>
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### 8.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including physician services. Physician services are subject to retrospective review and recoupment if documentation does not support the service billed.

### 8.5 Claims Filing and Reimbursement

#### 8.5.1 Claims Information

Claims for physician and doctor services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills and itemized statements are not accepted as claim supplements.

Refer to:
- Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
- Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.
- Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

#### 8.5.2 National Drug Codes (NDC)

Refer to:

#### 8.5.3 * Reimbursement

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.
Reimbursement for these services will be 60 percent of the Texas Medicaid rate for the service furnished in the physician’s office. The following table identifies the services applicable to the 60-percent limitation when furnished in outpatient hospital settings:

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These procedures are designated with note code “1” in the current physician fee schedule, which is available at www.tmhp.com. The following list shows the services excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs).
- Surgical services that are covered ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC) services.
- Anesthesiology and radiology services.
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client’s health.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.

Because of TEFRA, Texas Medicaid reimbursement for a payable nonemergency office service that is performed in the outpatient department of a hospital is limited to 60 percent of Texas Medicaid rate for that service. If the condition qualifies as an emergency or if the client is critically ill or critically injured, the 60 percent professional service reimbursement limit does not apply.

Refer to: Subsection 2.2, “Fee-for-Service Reimbursement Methodology,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about reimbursement.

Subsection 2.2.1.1, “Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits,” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information) for more information about conditions that are excluded from the 60-percent limitation.

Subsection 8.2.6, “Anesthesia,” in this handbook for information on anesthesia services that are reimbursed according to relative value units (RVUs).

9. PHYSICIAN ASSISTANT

9.1 Enrollment

To enroll in Texas Medicaid, a PA must be licensed and recognized as a PA by the Texas Physician Assistant Board. Texas Medicaid accepts a signed letter of certification from the Texas Physician Assistant Board as acceptable documentation of appropriate licensure and certification for enrollment. The PA must identify their supervising physician in the appropriate field of the enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days.
Enrollment as an individual provider is optional. PAs currently treating clients and billing under the supervising physician’s provider identifier may continue this billing arrangement.

All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

PAs may enroll as providers of THSteps medical checkups. PAs should have expertise or additional education in the areas of comprehensive pediatric assessment.

Refer to: Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).


Subsection 5.2, “Enrollment,” in the Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about enrolling as a THSteps provider.

9.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law
- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

Services provided to Medicaid clients must be documented in the client’s medical record to include the following:

- Services provided
- Date of service
- Pertinent information about the client’s condition supporting the need for service
- The individual practitioner of the service

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and claims must be received within 95 days from the date of service.

Note: Payment to providers for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Refer to: Section 2, “Medicaid Title XIX family planning services” in the Gynecological and Reproductive Health and Family Planning Services Handbook (Vol. 2, Provider Handbooks).

Section 8, “Physician” in this handbook.

Section 5, “THSteps Medical” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).
9.2.1 Prior Authorization
Services performed by a PA are subject to the same prior authorization guidelines as services performed by other provider types.

9.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including PA services. PA services are subject to retrospective review and recoupment if documentation does not support the service billed.

9.4 Claims Filing and Reimbursement

9.4.1 Claims Information
Claims for PA services must include modifier U7 on the claim details to indicate that the client was treated by a PA.

PA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to:
Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions,” in Section 6, “Claims Filing” (Vol. 1, General Information) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.4.2 Reimbursement
According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

PAs who bill Medicaid directly for services they perform must use their individual provider identifier. If the services were performed by the PA but billed by a physician or physician group, the billing provider is the physician or physician group. Services performed by a PA and billed under a physician’s or rural health clinic’s (RHC’s) provider identifier are reimbursed according to the TMRM for physician services.

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

Refer to:
Subsection 1.1, “Provider Enrollment,” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1, General Information).

Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on how to obtain electronic fee schedules from the TMHP website.
## 10. CLAIMS RESOURCES

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<td>Abortion Certification Statements Form</td>
<td>Form MD.1, Section 12 of this handbook</td>
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<td>Appendix D: * Acronym Dictionary</td>
<td>Appendix D (Vol. 1, General Information)</td>
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<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
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<td>Chiropractic Services Claim Form Example</td>
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<td>CMS-1500 Paper Claim Filing Instructions</td>
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<td>Appendix A (Vol. 1, General Information)</td>
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<td>Sterilization Consent Form Instructions (2 pages)</td>
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<td>Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form</td>
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<td>Texas Medicaid Vendor Drug Program for Outpatient Pharmacies Synagis (Palivizumab) Prior Authorization Request &amp; Prescription Form for 2012</td>
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<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Section 3: TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>
11. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.
12. FORMS
MD.1 Abortion Certification Statements Form

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client’s full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.”

Signature ______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.”

Signature ______________________________________________

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.”

Signature ______________________________________________
MD.2 DME Certification and Receipt Form (3 pages)

DME Certification and Receipt Form
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 1 of 4—Required)

This certification is required by section 32.024 of the Human Resources Code and must be completed before the DME provider can be paid for durable medical equipment provided to a Medicaid client.

Esta certificación es necesaria bajo la Sección 32.024 del Código de Recursos Humanos y se debe llenar antes de poder rembolsar al proveedor del equipo médico duradero por cualquier equipo médico proporcionado al cliente de Medicaid.

<table>
<thead>
<tr>
<th>Section A: Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Telephone Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B: Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section C: Product Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D: Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) __________ the client received the __________________________ equipment as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client’s needs.</td>
</tr>
<tr>
<td>The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment’s proper use and maintenance.</td>
</tr>
<tr>
<td>Printed name of DME Supplier</td>
</tr>
<tr>
<td>Signature of DME Supplier</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D (Optional) : Certification (Spanish)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) ________________________ el cliente recibió [el] [la] [los] [las] __________________________ equipo que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.</td>
</tr>
<tr>
<td>El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.</td>
</tr>
<tr>
<td>Nombre del Proveedor del Equipo Medico Duradero</td>
</tr>
<tr>
<td>Firma del Proveedor del Equipo Medico Duradero</td>
</tr>
</tbody>
</table>

Effective Date_07/01/2011/Revised Date_10/06/2011
**DME Certification and Receipt Form**
Certificación y Recibo de Equipo Medico Duradero (DME)
(Page 2 of 4)

<table>
<thead>
<tr>
<th>Section E: Qualified Rehabilitation Professional (QRP) Verification for Wheeled Mobility Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) ___________________________ the client received a wheeled mobility system or major modification to a wheeled mobility system as prescribed by the physician.</td>
</tr>
<tr>
<td>By signing this form, I verify all the following:</td>
</tr>
<tr>
<td>• I participated in the seating assessment for the wheeled mobility system or have obtained authorization to perform the fitting as the QRP, and</td>
</tr>
<tr>
<td>• The wheeled mobility system and/or major modification has been properly fitted to the client, and</td>
</tr>
<tr>
<td>• The wheeled mobility system and/or major modification meets the client’s functional needs for seating, positioning, and mobility, and</td>
</tr>
<tr>
<td>• The client, parent, guardian of the client, and/or caregiver of the client has been trained and instructed regarding the wheeled mobility system’s proper use and maintenance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Printed name of QRP</th>
<th>QRP TPI /NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of QRP</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form must be submitted to TMHP for a single DME product with an allowed amount of $2500 or more, for multiple DME products submitted on the same date of service that meet or exceed a total billed amount of $2500, or for a wheeled mobility system or major modification of a wheeled mobility system. Section E must be completed for all wheeled mobility systems and major modifications to wheeled mobility systems. Submit this form with claim form or fax this form to 512-506-6615. Information submitted in this form must match the claim form.

This form must be filled out completely; place none or N/A where applicable. Incomplete forms will be returned and will cause a delay in the verification and payment process. Failure to submit this form will affect claim payment.

**Notice to Clients:** You may be contacted to verify receipt of the equipment provided.

**Notificación al cliente:** Puede que usted sea contactado para verificar el recibo del equipo proporcionado.

Effective Date_07/01/2011/Revised Date_10/06/2011
### DME Certification and Receipt Form

**Certificación y Recibo de Equipo Medico Duradero (DME)**

(Page 3 of 4—Required only for requests containing six or more items)

<table>
<thead>
<tr>
<th><strong>Client Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Provider Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Prior Authorization Number (PAN):</td>
</tr>
<tr>
<td>NPI/API:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Product Information (Continuation)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service:</td>
</tr>
<tr>
<td>Procedure Code:</td>
</tr>
<tr>
<td>Description:</td>
</tr>
<tr>
<td>Serial No.:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Certification</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This is to certify that on (month/day/year) ____________ the client received the ____________ (equipment) as prescribed by the physician. The equipment has been properly fitted to the client and/or meets the client's needs.</td>
</tr>
<tr>
<td>The client, parent, or the guardian of the client, and/or caregiver of the client has received training and instruction regarding the equipment's proper use and maintenance.</td>
</tr>
<tr>
<td>Printed name of DME Supplier</td>
</tr>
<tr>
<td>Printed name of Client, Parent, Guardian, or Primary Caregiver</td>
</tr>
<tr>
<td>Signature of DME Supplier</td>
</tr>
<tr>
<td>Signature of Client, Parent, Guardian, or Primary Caregiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Certification (Spanish)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Esto certifica que el: (mes/día/año) ____________ el cliente recibió [el] [la] [los] [las] ____________ (equipo) que el doctor recetó. El equipo ha sido adaptado correctamente para el cliente o satisface las necesidades del cliente.</td>
</tr>
<tr>
<td>El cliente, padre, o tutor, o el cuidador principal del cliente ha recibido entrenamiento e instrucción con respecto al uso y mantenimiento apropiado del equipo.</td>
</tr>
<tr>
<td>Nombre del Proveedor del Equipo Medico Duradero</td>
</tr>
<tr>
<td>Nombre del Cliente, Padre, Tutor, o Cuidador Principal</td>
</tr>
<tr>
<td>Firma del Proveedor del Equipo Medico Duradero</td>
</tr>
<tr>
<td>Firma del Cliente, Padre, Tutor, o Cuidador Principal</td>
</tr>
</tbody>
</table>

Effective Date: 07/01/2011/Revised Date: 10/06/2011

---

**MD-254**

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MD.3 Hospital Report (Newborn Child or Children) (Form 7484)

MAIL FORM TO:

☐ Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin TX 78714-9030

Date Rec’d in Integrity Control

PURPOSE: This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Has the mother relinquished her rights to the newborn child? ☐ Yes ☐ No
If “Yes,” give date of relinquishment ________________________

<table>
<thead>
<tr>
<th>Mother’s Name (Last, First, MI)</th>
<th>Admission Date (mm/dd/yy)</th>
<th>Mother’s Medicaid Recipient No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s Mailing Address – Street</th>
<th>Mother’s D.O.B. (mm/dd/yy)</th>
<th>Mother’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State, ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child’s DOB (mm/dd/yy)</th>
<th>Child’s Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s Attending Physician</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physician’s Medical License No.</th>
<th>TPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Address – Street</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Completed By (please type or print)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City, State, ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital Telephone No.</th>
<th>Date Form Mailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MD.4 Hysterectomy Acknowledgment Form

**MEDICAID CLIENT IDENTIFICATION NUMBER _/_/_/_/_/_/_/_/_/_**

---

**Hysterectomy Acknowledgment**

I hereby acknowledge that I was, prior to surgery ________________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

________________________________________ ____________________
Signature of Client or Designated Representative Date

---

**Reconocimiento**

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía ________________ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

________________________________________ ____________________
Firma del Cliente o Representante Designado Fecha

---

**Interpreter’s Statement**

To be used if an interpreter is provided to assist the individual having the hysterectomy.

I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to ______________________ in ______________________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

________________________________________ ____________________
Signature of Interpreter Date

Revised 8/22/95
**MD.5 Medicaid Certificate of Medical Necessity for Reduction Mammaplasty**

**Section A: To be completed by the physician or physician staff**

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Medicaid number:</td>
</tr>
<tr>
<td>Height:</td>
</tr>
<tr>
<td>Weight:</td>
</tr>
<tr>
<td>Date of birth:</td>
</tr>
<tr>
<td>Breast size (must include photograph):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Medical license number:</td>
</tr>
<tr>
<td>TPI:</td>
</tr>
<tr>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
</tr>
<tr>
<td>Benefit Code:</td>
</tr>
</tbody>
</table>

**Section B: To be completed by the physician**

- [ ] Client has evidence of a restrictive pulmonary defect (provide results of pulmonary function studies in narrative section). Yes □ No □
- [ ] Client has evidence of severe neck and back pain (provide results of therapies tried in narrative section). Yes □ No □
- [ ] Client has evidence of ulnar paresthesia from thoracic nerve root compression (provide results of therapies tried in narrative section). Yes □ No □
- [ ] Client has evidence of ischemic heart disease (provide results of abnormal EKG and/or coronary angiography). Yes □ No □
- [ ] This client, if age 40 or over, has had a mammogram within the past year that was negative for cancer. Yes □ No □
- [ ] Estimated the grams of breast tissue to be removed from each breast. Right: Left: Yes □ No □
- [ ] The client is in a weight reduction program and has lost _____ lbs. Yes □ No □

**Section C: Physician prescribing Reduction Mammaplasty must complete narrative information regarding the medical necessity as requested above.**

Narrative note for medical necessity (write legibly):

Physician signature: Date: / / 

Refer to the Reduction Mammaplasty policy in the Physician section of the *Texas Medicaid Provider Procedures Manual*. 

Effective Date_07/30/2007/Revised Date_06/01/2007
Non-emergency Ambulance Prior Authorization Request Form

<table>
<thead>
<tr>
<th>Non-emergency Ambulance Prior Authorization Request</th>
<th>Texas Medicaid and CSHCN Services Program</th>
</tr>
</thead>
</table>

1.) Is an ambulance the only appropriate means of transport?  
☐ Yes  ☐ No

2.) If no, this client does not qualify for non-emergency ambulance transport.

3.) If yes, please complete the remainder of the form.

In order for this service to be covered, the service must be medically necessary and reasonable. Medical necessity is established when the client's medical condition is such that the use of an ambulance is the only appropriate means of transport, and other alternate means of transport are medically contraindicated. Alternate means of transport include services provided through Medicaid’s Medical Transportation Program or services included in the rate for Long Term Care - Nursing Facilities, if applicable.

This form is to be completed by the provider requesting non-emergency ambulance transportation. [Medicaid Reference: Chapter 32.024(t) Texas Human Resources Code]

<table>
<thead>
<tr>
<th>Requesting Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: __________________________</td>
</tr>
<tr>
<td>Provider TPI: ____________ NPI: ____________ Taxonomy: __________________</td>
</tr>
<tr>
<td>Contact Name: ______________ Phone: ______________ Fax: ______________</td>
</tr>
<tr>
<td>Ambulance Provider Name: __________________</td>
</tr>
<tr>
<td>Ambulance Provider Identifier: __________________</td>
</tr>
</tbody>
</table>

Submit by Fax: 1-512-514-4205

<table>
<thead>
<tr>
<th>Client Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name: __________________</td>
</tr>
<tr>
<td>First Name: __________________</td>
</tr>
<tr>
<td>MI: __________________</td>
</tr>
<tr>
<td>DOB: __ <strong>/</strong> <strong>/</strong> __ __ __</td>
</tr>
<tr>
<td>Client Medicaid/CSHCN Number: __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client’s Current Condition Affecting Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses affecting transport: __________________</td>
</tr>
</tbody>
</table>

☐ Physical restraint or chemical sedation *
☐ Decreased level of consciousness *
☐ Isolation precautions (VRE, MRSA, etc.) *
☐ Wound precautions *
☐ Advanced decubitus ulcers *
☐ Contractures limiting mobility *
☐ Must remain immobile (i.e., fracture, etc.) *
☐ Decreased sitting tolerance time or balance *
☐ Active Seizures *

* Provide additional detail (i.e. type of seizure or IV therapy, body part affected, supports needed, or time period for the condition), or provide detail of the client’s other conditions requiring transport by ambulance.

| Extra Attendant Reason: __________________ |

<table>
<thead>
<tr>
<th>Reason for Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital discharge?  ☐ Yes  ☐ No</td>
</tr>
<tr>
<td>☐ Other purpose: __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method of Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Ground  ☐ Fixed Wing  ☐ Helicopter  ☐ Specialized Vehicle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ One Time, Non-repeating Medicaid, CSHCN or Medicare</td>
</tr>
<tr>
<td>☐ Short Term (2 - 60 days) Medicaid, CSHCN or Medicare * Begin Date: __ <strong>/</strong> <strong>/</strong> __ __ __</td>
</tr>
<tr>
<td>☐ Long Term (61 - 180 days) Medicaid and CSHCN Only * End Date: __ <strong>/</strong> <strong>/</strong> __ __ __</td>
</tr>
</tbody>
</table>

* Physician signature required for Short Term and Long Term

<table>
<thead>
<tr>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and / or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.</td>
</tr>
</tbody>
</table>

| Name: __________________ |
| Title: __________________ |
| Provider Identifier: __________________ |

| Signature: __________________ |
| Date Signed: __ __/__ __/__ __ __ __ |

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Provider Instructions for Non-emergency Ambulance Prior Authorization Request Form

All non-emergency ambulance transportation must be medically necessary. Texas Medicaid, CSHCN Services Program, and Medicare have similar requirements for this service to qualify for reimbursement. This form is intended to accommodate all of the programs’ requirements. The criteria for determining medical necessity include: the client is bed-confined and other methods of transportation are contraindicated, or the client’s condition is such that transportation by ambulance is medically required. For additional information and changes to this policy and process refer to the respective program information: Texas Medicaid’s Provider Procedures Manual, CSHCN Services Program Provider Manual, and Banner Messages; and to Medicare’s manuals, newsletters and other publications.

1. Request Date—Enter the date the form is submitted.
2. Requesting Provider Information—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
3. Requesting Provider Identifiers—Enter the following information for the requesting provider (facility or physician):
   - Enter the Texas Provider Identifier (TPI) number.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
   - Enter the primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
4. Ambulance Provider Identifier—Enter the TPI or NPI number of the requested ambulance provider. If the ambulance provider changes from the provider you originally requested, notify TMHP of the new provider by phone (1-800-540-0694, Option 3) or fax (1-512-514-4205).
5. Client’s Current Condition—This section must be filled out to indicate the client’s current condition and not to list all historical diagnoses. Do not submit a list of the client’s diagnoses unless the diagnoses are relevant to transport (i.e., if client has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to TMHP when reviewing the request form, exactly why the client requires transport by ambulance and cannot be safely transported by any other means.
6. Isolation Precautions—Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.
7. Details for Checked Boxes—For each checked answer, a detailed explanation is required (i.e., if contractures is checked, please give the location and degree of contracture[s]). If a client has a decreased tolerance for sitting time, please indicate why the client has a decreased tolerance as well as the maximum length of time the client is able to sit upright. Additional documentation can be submitted with this request form if needed.
8. Request Type—Check the box for the request type. A One Time, non-repeating request is for a one day period. A Short Term request is for a period of 2-60 days when repeated transports are expected to occur; Medicaid, CSHCN Services Program, and Medicare permit short term requests. A Long Term request is for a period of 61-180 days when repeated transports are expected to occur; Medicare does not permit a Long Term request. Medicaid and CSHCN Services Programs require a physician signature for Short Term and Long Term requests. Enter the begin and end dates of the authorization period for short and long term requests.
9. Transport Time—This field must be filled out for all hospital discharge requests. The anticipated time of transport must be entered in order to ensure the request was initiated prior to the actual time of transport.
10. Name of Person Signing the Request—All request forms require a signature, date, and title of the person signing the form. A One Time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client’s condition. A request of a Short Term or Long Term authorization period must be signed and dated by the physician. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
11. Signing Provider Identifier—This field is for the TPI or NPI number of the requesting facility or provider signing the form. The signature must be dated no earlier than 60 days prior to the transport.
### Obstetric Ultrasound Prior Authorization Request Instructions

Medicaid clients are limited to three obstetric ultrasounds per pregnancy. Obstetrical ultrasounds procedures performed in the emergency room, outpatient observation, or inpatient hospital setting are excluded from this limitation.

If it is medically necessary to perform more than three obstetrical ultrasounds on a client during a pregnancy, the provider must complete this form to request prior authorization. A request for retroactive authorization must be submitted no later than 14 calendar days beginning the day after the study is completed.

---

**Use the guidelines below in filling out the Obstetric Ultrasound Prior Authorization Request form.**

#### Client Information
- **Client’s name**: Last name (required), first name (required), middle initial (optional)
- **Date of birth**: Date of birth given by month, day and year (required)
- **Medicaid number**: Nine-digit number from client’s current Medicaid identification card. (required)

#### Requesting Provider Information
- **Name**: Name of Provider (required)
- **Address**: Agency address given by street, city, state and ZIP code (required)
- **TPI**: Texas Provider Identifier number (10-digit) (optional)
- **NPI**: National Provider Identifier number (10-digit) (required)
- **Taxonomy**: Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provider (optional)
- **Telephone**: Area code and telephone number (required)
- **Fax Number**: Area code and fax number (required)

#### Performing / Facility Provider Information (complete only if different from requesting provider)
- **Name**: Name of Provider (required)
- **Address**: Agency address given by street, city, state and ZIP code (required)
- **TPI**: Texas Provider Identifier number (10-digit) (optional)
- **NPI**: National Provider Identifier number (10-digit) (required)
- **Taxonomy**: Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provider (optional)
- **Telephone**: Area code and telephone number (required)
- **Fax Number**: Area code and fax number (required)

#### Procedures Requested Section
- **CPT Codes**: The five digit code from the most recent edition of the Current Procedural Terminology manual (required)
- **Quantity**: The number of ultrasounds requested for that CPT code (required)
- **Performed Trimester**: The trimester(s) during which the requested ultrasounds will be performed (required)
- **Dates of Service (from and to)**: Indicate the date range during which the procedure(s) will be performed (required)

**Note:** If requesting more than one CPT code complete the additional lines

#### Client’s Estimated Date of Confinement
- **Provide current estimated month, day, and year of delivery at the time the request is submitted (required)

#### Gravidity
- **Total number of a woman’s pregnancies (optional)

#### Parity
- **Total number of viable pregnancies (optional)

#### Diagnosis Codes
- **Include all applicable ICD-9-CM diagnosis codes (required)

#### Clinical Documentation Section
- **Treatment History**: Summary of previous treatment, if any for the clients condition (required, if applicable)
- **Treatment Plan**: Proposed treatment plan related to obstetric ultrasounds and pregnancy (required, if applicable)
- **Medications**: List of current medications, if any (required, if applicable)
- **Previous Imaging Results**: List type of imaging, date(s) and results (required, if applicable)
- **Serial Ultrasounds**: If requesting serial ultrasounds provide the intended frequency for the procedures and the clinical rationale to support the need for serial ultrasounds

#### Provider Signature Section
- **Requesting Provider signature, Date signed, Printed provider name, Provider license number**: Requesting provider for OB ultrasounds must be a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). The provider’s signature, the date the form was signed by the provider, and the provider’s printed name are all required, and the provider’s license number is optional.
Obstetric Ultrasound Prior Authorization Request Form

Texas Medicaid Program

This form is to be used to obtain prior authorization for greater than three obstetric ultrasounds per pregnancy. Forms that are submitted without all of the required information will be returned for correction. Fax the completed form to 1-512-302-5039 or call 1-888-302-6167 for authorization.

Client Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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DOB: Client Medicaid Number:

Requesting Provider Information

<table>
<thead>
<tr>
<th>Taxonomy:</th>
<th>NPI:</th>
<th>City:</th>
<th>State:</th>
<th>Address:</th>
<th>Zip:</th>
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</table>

TPI: Telephone number: Fax number:

Performing/Facility Provider Information (if different from requesting provider)

<table>
<thead>
<tr>
<th>Taxonomy:</th>
<th>NPI:</th>
<th>City:</th>
<th>State:</th>
<th>Address:</th>
<th>Zip:</th>
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TPI: Telephone number: Fax number:

Procedure(s) Requested: CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Qty Trimester Performed</th>
<th>From Date</th>
<th>To Date</th>
<th>CPT Code</th>
<th>Qty Trimester Performed</th>
<th>From Date</th>
<th>To Date</th>
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Client’s Estimated Date of Confinement (EDC): Gravida: Parity: Diagnosis:

Clinical documentation supporting medical necessity for obstetric ultrasounds includes treatment history, treatment plan, medications, and previous imaging results:

If requesting serial ultrasounds, please provide intended frequency and clinical rationale.

Provider (Physician, CNM, NP, CNS, or PA) must complete and sign this form prior to requesting authorization.

Requesting Provider Signature: Date: 

Print Name: License Number:

Effective Date_12012009/Revised Date_05032010
### Special Medical Prior Authorization (SMPA) Request Form

Use only for requests submitted to the TMHP-SMPA department. Mail completed form to the TMHP Special Medical Prior Authorization at 12357-B Riata Trace Parkway Ste. 150, Austin, TX 78727 or fax to 1-512-514-4213.

<table>
<thead>
<tr>
<th>Section A: Client information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Medicaid number:</td>
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<tr>
<td>Date of birth:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Section B: Requested procedure or service information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of request: Transplant Surgery ECG Other</td>
</tr>
<tr>
<td>Expected dates of service From To</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure requested - CPT code</th>
<th>Procedure code description</th>
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<thead>
<tr>
<th>Section C: To be completed by requesting physician or prescribing provider - Additional information may be attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses (ICD-9-CM):</td>
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<tr>
<td>Statement of medical necessity (Refer to the appropriate section of the Texas Medicaid Provider Procedures Manual for specific prior authorization requirements):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician’s name:</th>
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<tbody>
<tr>
<td>Address/City/ZIP:</td>
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<tr>
<td>Telephone number:</td>
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<tr>
<td>Fax number:</td>
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<td>TPI:</td>
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<tr>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
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<tr>
<td>Physician’s signature: Date signed:</td>
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<thead>
<tr>
<th>Section D: Service provider or facility information - If different from provider in Section C</th>
</tr>
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<tbody>
<tr>
<td>Provider printed name:</td>
</tr>
<tr>
<td>Contact person:</td>
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<tr>
<td>Date:</td>
</tr>
<tr>
<td>Address/City/ZIP:</td>
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<tr>
<td>Telephone number:</td>
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<tr>
<td>Fax number:</td>
</tr>
<tr>
<td>TPI:</td>
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<tr>
<td>NPI:</td>
</tr>
<tr>
<td>Taxonomy:</td>
</tr>
</tbody>
</table>
Sterilization Consent Form Instructions

Per Title 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be at least 21 years of age when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 72 hours between the date of consent and the date of surgery. The informed consent must have been given at least 30 days before the expected date of delivery. (2) Emergency Abdominal Surgery - There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of all sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter's Statement is not required as long as the consent form is written in the client's language, or the person obtaining the consent speaks the client's language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields

All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization

- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client’s Date of Birth (month, day, year).
- Client’s Name (first and last names are required).
- Name of Doctor or Clinic.
- Name of the Sterilization Operation.
- Client’s Signature.
- Date of Client Signature - Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.

Effective Date_07/30/2007/Revised Date_03/10/2010
Interpreter’s Statement (If applicable)
• Name of Language Used by Interpreter.
• Interpreter’s Signature.
• Date of Interpreter’s Signature (month, day, year).

Statement of Person Obtaining Consent
• Client's Name (first and last names are required).
• Name of the Sterilization Operation.
• Signature of Person Obtaining Consent - The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
• Date of the Person Obtaining Consent’s Signature (month, day, year) - Must be the same date as the client's signature date.
• Facility Name - Clinic/office where the client received the sterilization information.
• Facility Address - Clinic/office where the client received the sterilization information.

Physician’s Statement
• Client’s Name (first and last names are required).
• Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the client’s consent except in cases of premature delivery or emergency abdominal surgery.
• Name of the Sterilization Operation.
• Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Client’s signature date must be at least 30 days prior to EDD.
• Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
• Physician’s Signature - Stamped or computer-generated signatures are not acceptable.
• Date of Physician’s Signature (month, day, year) - This date must be on or after the date of surgery.

Paperwork Reduction Act Statement
This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields
• Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below.
• Date Client Signed the Consent (month, day, year).
• The following provider identification numbers will be required to expedite the processing of the consent form:
  o TPI
  o NPI
  o Taxonomy
  o Benefit Code
• Provider/Clinic Phone Number.
• Provider/Clinic Fax Number (If available).
• Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.
# MD.11 Sterilization Consent Form (English)

## Sterilization Consent Form

(Fax Consent Form to 1-512-514-4229)

| Client Medicaid or Family Planning Number: | Date Client Signed: |  |  |  | (month/day/year) |
| Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds. |

### Consent to Sterilization

I have asked for and received information about sterilization from ______________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment, I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible. I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children. I was told that these temporary methods of birth control that are available and could be provided to me which will allow me to be sterilized by __________________________________ (doctor or clinic) by a method called _____________________________ (specify type of operation). I understand that I will be sterilized by an operation known as a _____________________________ (specify type of operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs. I am at least 21 years of age and was born on _____(month)___(day)___(year). I, ___________________________________________________________________________________________________________________________________, hereby consent of my own free will to be sterilized by _____________________________ (doctor or clinic) by a method called _____________________________ (specify type of operation). My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

| Client’s Signature: | Date of Signature: | / | / | (month/day/year) |
| Notice: You are requested to supply the following information, but it is not required. |

### Race and Ethnicity Designation

- [ ] Not Hispanic or Latino
- [ ] Hispanic or Latino
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] White
- [ ] Asian
- [ ] Black or African American
- [ ] Hispanic or Latino
- [ ] Native Hawaiian or Other Pacific Islander
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- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] White

### Interpreter’s Statement

If an interpreter is provided to assist the individual to be sterilized:

- [ ] I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________ (language) and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

| Interpreter’s Signature: | Date of Signature: | / | / | (month/day/year) |

### Statement of Person Obtaining Consent

Before ___________________________________________________________________________________________________________________________________, I explained to him/her the nature of the sterilization operation _____________________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

| Signature of Person Obtaining Consent: | Date of Signature: | / | / | (month/day/year) |

### Facility Name: Facility Address:

#### Physician’s Statement

Shortly before I performed a sterilization operation upon ____________________________________________________________________________________________________________________________________________________________, I explained to him/her the nature of the sterilization operation _____________________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I explained to the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

| Physician’s Signature: | Date of Signature: | / | / | (month/day/year) |

### Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used:

1. At least 30 days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances: ____________________________________________________________________________________________________________________________________________________________

| Physician’s Signature: | Date of Signature: | / | / | (month/day/year) |

### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer HHS-687

### All Fields in This Box Required for Processing

| TPI: | NPI: | Taxonomy: |
| Benefit Code: | Provider/Clinic Telephone: | Provider/Clinic Fax Number: |
| Client Medicaid or Family Planning Number: | Date Client Signed: | / | / | (month/day/year) |

Effective Date_09012010_Revised Date_07012010
### Consentimiento para Esterilización

Cuando inicialmente solicite esta información, me dieron que la decisión de ser esterilizada/o es completamente mía. Me dieron que yo podía decidir no ser esterilizada/o. Si decidí no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como Asistencia Temporal para Familias Necesitadas o Medicaid, que recibo actualmente o para los cuales podría calificar.

Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedarme embarazada, no quiero tener hijos o no quiero procrear hijos. Me informaron sobre otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que seré esterilizada/o por medio de una operación conocida como __________________ (especificar el tipo de operación). Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se llevará a cabo hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el ______ (mes), ______ (día), ______ (año). Yo, __________________________, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por ___________________________ (especificar el tipo de operación). Mi consentimiento vence 180 días a partir de la fecha en que aparece abajo con mi firma.

Declaración Del Intérprete

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada por el individuo que ha obtenido este consentimiento. También le he leído a ella/él la Forma de Consentimiento en idioma y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

**Firma:**

Fecha: / / (mes, día, año)

---

### Declaración De La Persona Que Obtiene Consentimiento

Antes de que __________________________ (nombre completo del cliente) firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de esta operación para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento. Le he explicado que la esterilización es diferente porque es permanente. Le he explicado la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

**Firma de la persona que obtiene el consentimiento:**

Fecha: / / (mes, día, año)

---

### Declaración Del Médico

Un poco antes de realizar la operación para la esterilización a __________________________ (nombre de persona por ser esterilizada/o), en / / (fecha de esterilización), le expliqué a ella/él los detalles de esta operación para la esterilización, el hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación. Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales.

Le expliqué que la esterilización es diferente porque es permanente. Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento. Le expliqué a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales.

(1) Han transcurrido por lo menos 30 días entre la fecha en que la persona firmó esta Forma de Consentimiento y la fecha en que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

<table>
<thead>
<tr>
<th>Circunstancia</th>
<th>Fecha de la operación</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parto prematuro</td>
<td>/ / (mes, día, año)</td>
</tr>
<tr>
<td>Cirugía abdominal de urgencia</td>
<td>/ / (mes, día, año)</td>
</tr>
</tbody>
</table>

**Firma del médico:**

Fecha: / / (mes, día, año)

---

### Declaración Sobre Ley De Reducción De Trámites

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una solicitud de información a menos que muestre un número de control válido de OMB. El número de control válido de OMB para esta solicitud es 0937-0166. Se ha estimado que el tiempo promedio necesario para completar esta recolección de información es 1 hora y 15 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de información existente, reunir los datos necesarios y completar y revisar la recolección de información. Si tiene algún comentario sobre la exactitud del cálculo del tiempo o sugerencias para mejorar esta forma, por favor escriba al U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.

All Fields in This Box Required for Processing
# Texas Medicaid Palivizumab (Synagis) Prior Authorization Request Form

**Patient’s Name:**

**Date of birth:** / / 

**County of residence:**

**Telephone Number:**

**Address:**

**City:**

**State:**

**ZIP:**

**Parent/Legal Guardian (if applicable):**

**Age in months as of October 1:**

**Estimated gestational age at birth:** and /7 weeks

**Requested dates of service—From:**

**To:**

**Quantity Requested (doses):**

---

**Choose one of the following:**

- □ Active diagnosis of hemodynamically significant heart disease (ICD-9-CM code:__________)
- □ Active diagnosis of chronic lung disease of infancy (CLDI)* (ICD-9-CM code:__________) and required any of the following therapies within the past 6 months:
  - Supplemental oxygen
  - Digitalis
  - Steroids (systemic or inhaled)
  - Diuretics
  - Mechanical ventilation
  - Routine/frequent use of bronchodilators
  - Solid organ or stem cell transplant recipient (ICD-9-CM code:__________)

---

**Choose one of the following:**

- □ Date of birth on or after 09/30/2010
  - Clients who are younger than 24 months chronological age at the start of the RSV season can qualify based on the criteria to the right. Diagnoses and conditions must be clearly documented in the client’s medical record.
  - (Refer to the Texas Medicaid Provider Procedures Manual for more details about congenital heart and chronic lung disease diagnoses.)

---

**Choose one of the following:**

- □ Date of birth on or after 09/30/2011
  - Clients who are younger than 12 months chronological age at the start of the RSV season can qualify based on criteria to the right.

---

**Choose one of the following:**

- □ Date of birth on or after 03/31/2012
  - Clients who are younger than 6 months of age at the start of RSV season can qualify based on criteria to the right. Diagnoses, conditions, and risk factors must be clearly documented in client’s medical record.

**Current clinical information and diagnoses that pertain to medical necessity (if necessary, add additional pages):**

---

**Physician Name (printed):**

**Date:** / / 

**Address:**

**City:**

**State:**

**ZIP:**

**Telephone Number:**

**Fax Number:**

**TPI:**

**NPI:**

**Taxonomy:**

**Benefit Code:**

**Physician Signature:**

**License number:**

---

* CLDI was formerly called “bronchopulmonary dysplasia.” It can develop in pre-term neonates who are treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RDS). CLDI is not asthma, croup, a recurrent upper respiratory infection, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.
### Texas Medicaid Vendor Drug Program for Outpatient Pharmacies Synagis (Palivizumab) Prior Authorization Request & Prescription Form for 2012

**Pharmacy Name:**

**Prescribing practitioner should fax completed form to the dispensing pharmacy**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Texas Medicaid Recipient Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>County of residence:</td>
<td></td>
</tr>
<tr>
<td>Parent/Legal Guardian (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Age (in months) as of October 1*:</td>
<td>Estimated gestational age at birth:</td>
</tr>
<tr>
<td>Current weight</td>
<td>_completed weeks: _days</td>
</tr>
</tbody>
</table>

- **Active diagnosis of hemodynamically significant heart disease:**
  - (Specify ICD-9 Code(s)): __________
  - OR
- **Active diagnosis of Chronic Lung Disease of Infancy:**
  - (Specify ICD-9 Code(s)): __________
  - AND (applying to either both of above)
  - Required any of the following therapies within the past 6 months
    - Supplemental oxygen
    - Steroids (systemic or inhaled)
    - Digitalis
    - Mechanical ventilation
    - Diuretics
    - Routine/frequent use of bronchodilators

- **If < 24 months chronological age at the start of the RSV season, can qualify based on criteria to the right.**
- **Date of birth on or after 09/30/2010**
  - (See Medicaid Bulletin No. 199 November/December 2006 for details related to congenital heart and chronic lung disease diagnoses.)
- **If < 12 months chronological age at the start of the RSV season, can qualify based on criteria to the right.**
  - **Date of birth on or after 09/30/2011**
  - ≤ 28 6/7 weeks gestational age at birth (Specify ICD-9 Code): __________
  - OR
  - <35 weeks gestational age and severe neuromuscular disease (including chronic respiratory failure) (Specify ICD-9 Code): __________
  - OR
  - <35 weeks gestational age and significant congenital anomalies of the airway, expected to compromise ventilation (Specify ICD-9 Code): __________

- **If < 6 months chronological age at the start of the RSV season, can qualify based on criteria to the right.**
- **Date of birth on or after 03/31/2012**
  - 29 through 31 6/7 weeks gestational age: (Specify ICD-9 code) __________
  - OR
  - 32 through 34 6/7 weeks gestational age: (Specify ICD-9 code) __________
  - AND two of the following:
    - Direct exposure to tobacco smoke or other documented environmental air pollutants.
    - Attends child care.
    - Siblings who attend school or child care.

- **Cystic Fibrosis (Specify ICD-9 Code): __________**

**Current clinical information and diagnoses pertaining to medical necessity: (add additional page if necessary)**

**Rx:**
- **Synagis ® (palivizumab) Liquid Solution 50mg and/or 100mg vials**
  - Sig: Inject 15mg/kg one time per month.
  - Quantity: QS for weight based dosing
  - Refills: __________
  - Syringes 1ml 25G 5/8”
  - Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed

- **Other:**

- **Known Allergies:**

- **Physician Name (printed):**

**Address:**

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>

**Physician Signature:**

**Texas License No.:**

**Dispensing Pharmacy should fax completed form to Texas Prior Authorization Center for approval: 1-866-617-8864**

This form should be used for clients in fee-for-service Medicaid only. Please contact the appropriate Managed Care Organization (MCO) for Medicaid clients that are enrolled health plan members.
MD.15 THSteps Dental Mandatory Prior Authorization Request Form

THSteps Dental Mandatory Prior Authorization Request Form

If any portion of this form is incomplete and/or missing any required documentation, it will be returned.

Mail completed form and all supporting documentation to:
THSteps Dental Prior Authorization Unit
PO Box 204206
Austin TX 78720-4206

Client Name (Last, First, MI):

Medicaid Number (PCN):

Date of Birth: / /

☐ Restorative
☐ Intermediate Care Facility for the Mentally Retarded (ICF-MR)
NOTE: Check all documentation submitted for review with the prior authorization request.

☐ Panorex ☐ FM X-ray ☐ Periapicals ☐ Photos ☐ Other Documentation

☐ Orthodontic Services
NOTE: Check all documentation submitted for review with the prior authorization request.

☐ Plaster cast models ☐ HLD ☐ Panorex ☐ Cephalometric X-ray with tracing ☐ FM X-ray

☐ Photos ☐ Other Documentation (please specify)

Date of Service Diagnostic Tools Were Produced: / /

Proposed Treatment Plan

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number or Letter</th>
<th>Surface</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dentist’s Certifications—To be completed by the performing dentist.

By checking the boxes below and signing this form:

☐ I certify all radiographs, photographs, and other documentation of medical necessity for the requested services are unaltered.

☐ I certify I have discussed all treatment options with the client and parent or legal guardian, including the recommended surgical treatment plan. I have addressed the client’s risks if the treatment plan is not followed to completion and explained the treatment plan should not be started if the family does not agree to this course of treatment.

☐ I certify all primary dentition have been exfoliated (D8080).

I certify I have one of the following designations from the Texas Board of Dental Examiners, or I meet the continuing education requirements to provide orthodontic services:

☐ Board certified or board eligible pediatric dentist.

☐ Board certified or board eligible orthodontist.

☐ General dentist attesting to completion of a minimum of 200 continuing dental education hours in orthodontics, only 8 hours can be online or self-instruction.

NOTE: Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services, but documentation must be produced by the dentist during retrospective review.

Signature of performing dentist: Date:

Printed or typed name of dentist: Dentist telephone:

Address: Fax:

TPI: NPI: Taxonomy: Benefit Code:

Effective Date_03/01/2012/Revised Date_08/07/2012
Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia = 22.

<table>
<thead>
<tr>
<th>Age of client at time of examination</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than four years of age</td>
<td>8</td>
</tr>
<tr>
<td>Four and five years of age</td>
<td>6</td>
</tr>
<tr>
<td>Six and seven years of age</td>
<td>4</td>
</tr>
<tr>
<td>Eight years of age and older</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Requirements (Carious and/or Abscessed Teeth)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 teeth or one sextant</td>
<td>3</td>
</tr>
<tr>
<td>3-4 teeth or 2-3 sextants</td>
<td>6</td>
</tr>
<tr>
<td>5-8 teeth or 4 sextants</td>
<td>9</td>
</tr>
<tr>
<td>9 or more teeth or 5-6 sextants</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior of Client**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely negative—unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat negative—defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator’s hand, refusal to take radiographs</td>
<td>4</td>
</tr>
<tr>
<td>Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general anesthesia</td>
<td>0</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

<table>
<thead>
<tr>
<th>Additional Factors**</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**</td>
<td>15</td>
</tr>
<tr>
<td>Failed conscious sedation**</td>
<td>15</td>
</tr>
<tr>
<td>Medically compromising of handicapping condition**</td>
<td>15</td>
</tr>
</tbody>
</table>

** Requires that narrative fully describing circumstances be present in the client’s chart

I understand and agree with the dentist’s assessment of my child’s behavior.

PARENT/GUARDIAN SIGNATURE: ____________________________________________________ DATE: ________________

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client’s chart. The client’s chart must be available for review by representatives of TMHP and/or HHSC.

PERFORMING DENTIST’S SIGNATURE: ____________________________________________________

DATE: ________________ License No. ____________________________________
Medicaid Dental Policy Regarding Criteria for Dental Therapy
Under General Anesthesia–Attachment 1

Purpose: To justify I.V. Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child’s Dental Record.

Elements: Note those required* and those as appropriate**:
1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client’s demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan of Care.
8) Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
10) The parent\guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist’s assessment of their child’s behavior.
11) Dentist’s attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand alone form.

“I attest that the client’s condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client’s record and is available in my office.”

REQUESTING DENTIST’S SIGNATURE: ____________________________DATE: ________________

Effective Date_01012009/Revised Date_12172008
13. CLAIM FORM EXAMPLES
**1500 HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDICARE</td>
<td>Medicare # [X] (Member Def)</td>
</tr>
<tr>
<td>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Doe, Jane K.</td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS (No., Street)</td>
<td>1200 N. Main Street</td>
</tr>
<tr>
<td>6. PATIENT RELATIONSHIP TO INSURED</td>
<td>Self</td>
</tr>
<tr>
<td>8. PATIENT STATUS</td>
<td>Single</td>
</tr>
<tr>
<td>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
<td>Doe, Jane K.</td>
</tr>
<tr>
<td>10. IS PATIENT'S CONDITION RELATED TO:</td>
<td>YES</td>
</tr>
<tr>
<td>11. INSURED'S POLICY GROUP OR FENC NUMBER</td>
<td>123456789</td>
</tr>
<tr>
<td>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the undersigned physician or supplier for services described below.</td>
</tr>
<tr>
<td>13. INSURED'S SIGNATURE</td>
<td>Susan Johnson, M.D.</td>
</tr>
<tr>
<td>14. DATE OF CURRENT ILLNESS</td>
<td>04/03/2010</td>
</tr>
<tr>
<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
<td>YES</td>
</tr>
<tr>
<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>YES</td>
</tr>
<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>Susan Johnson, M.D.</td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>YES</td>
</tr>
<tr>
<td>19. RESERVED FOR LOCAL USE</td>
<td>YES</td>
</tr>
<tr>
<td>20. OUTSIDE LAB RESULTS</td>
<td>YES</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
<td>641 01</td>
</tr>
<tr>
<td>22. MEDICAID RESUBMISSION</td>
<td>YES</td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
<td>646 21</td>
</tr>
<tr>
<td>24. DATE OF SERVICE</td>
<td>01/01/2011</td>
</tr>
<tr>
<td>25. FEDERAL TAX ID. NUMBER</td>
<td>123456789</td>
</tr>
<tr>
<td>26. PATIENT'S ACCOUNT NO.</td>
<td>32654321</td>
</tr>
<tr>
<td>27. ACCEPT ASSIGNMENT</td>
<td>YES</td>
</tr>
<tr>
<td>28. TOTAL CHARGE</td>
<td>$500.00</td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td>$500.00</td>
</tr>
<tr>
<td>30. BALANCE DUE</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**NUCC Instruction Manual available at: www.nucc.org**

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**

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**MD.17 Anesthesia**

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### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
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<th>Page Dimensions</th>
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<th>Signature</th>
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<tbody>
<tr>
<td>1500</td>
<td>612.0x792.0</td>
<td>01/17/2012</td>
<td>Alicia Thomas, CNM</td>
</tr>
</tbody>
</table>

#### CARRIER PATIENT AND INSURED INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSURED'S I.D. NUMBER</td>
<td>1234567890</td>
</tr>
<tr>
<td>MG</td>
<td>F</td>
</tr>
<tr>
<td>BILLING PROVIDER INFO &amp; PH #</td>
<td>9876543201</td>
</tr>
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#### PHYSICIAN OR SUPPLIER INFORMATION

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<th>Value</th>
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<td>1234567890</td>
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<td>NPI</td>
<td>1234567890</td>
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#### DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODE</td>
<td>V22</td>
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</tbody>
</table>

#### DATE(S) OF SERVICE

<table>
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<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>01 01 2012</td>
</tr>
<tr>
<td>MM DD YY</td>
<td>01 01 2012</td>
</tr>
</tbody>
</table>

#### PROCEDURES, SERVICES, OR SUPPLIES

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
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<tr>
<td>CPT/HCPCS</td>
<td>99211</td>
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#### TOTAL CHARGE

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>$</td>
<td>7204</td>
</tr>
</tbody>
</table>

#### SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

Alicia Thomas, CNM

**NUCC Instruction Manual available at:** www.nucc.org

---

MD.18 Certified Nurse-Midwife (CNM)

---

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# MD.19 Certified Registered Nurse Anesthetist (CRNA)

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/95**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>1a.</td>
<td>INSURED’S I.D. NUMBER (For Program in Item 1)</td>
</tr>
<tr>
<td>1b.</td>
<td>MEDICARE MEDICARE</td>
</tr>
<tr>
<td>1c.</td>
<td>TRICARE CHAMPUS (Sponsor’s SSN)</td>
</tr>
<tr>
<td>1d.</td>
<td>CHAIN HEALTH PLAN (SIGN or ID) }</td>
</tr>
<tr>
<td>1e.</td>
<td>FEDRA (SIGN or ID) }</td>
</tr>
<tr>
<td>1f.</td>
<td>OTHER</td>
</tr>
<tr>
<td>4.</td>
<td>INSURED’S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>PATIENT’S ADDRESS (No., Street)</td>
</tr>
<tr>
<td>7.</td>
<td>CITY</td>
</tr>
<tr>
<td>8.</td>
<td>STATE</td>
</tr>
<tr>
<td>9.</td>
<td>OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>10.</td>
<td>EMPLOYER’S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>11.</td>
<td>OTHER INSURED’S POLICY GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>12.</td>
<td>INSURED’S POLICY GROUP OR FECA NUMBER</td>
</tr>
<tr>
<td>13.</td>
<td>INSURED’S I.D. NUMBER</td>
</tr>
<tr>
<td>14.</td>
<td>MEDICAID MEDICAID</td>
</tr>
<tr>
<td>15.</td>
<td>TRICARE TRICARE</td>
</tr>
<tr>
<td>16.</td>
<td>CHAMPUS CHAMPUS</td>
</tr>
<tr>
<td>17a.</td>
<td>PRIVATE HEALTH INSURANCE PLAN NAME OR PROGRAM NAME</td>
</tr>
<tr>
<td>17b.</td>
<td>PRIVATE HEALTH INSURANCE PLAN NAME OR PROGRAM NAME</td>
</tr>
<tr>
<td>18.</td>
<td>PATIENT’S BIRTH DATE</td>
</tr>
<tr>
<td>19.</td>
<td>PATIENT’S SEX</td>
</tr>
<tr>
<td>20.</td>
<td>PATIENT’S SIGNATURE</td>
</tr>
<tr>
<td>21.</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER</td>
</tr>
<tr>
<td>22.</td>
<td>BILLING PROVIDER INFORMATION</td>
</tr>
<tr>
<td>23.</td>
<td>DEGREES OR CREDENTIALS</td>
</tr>
<tr>
<td>24.</td>
<td>PROCEDURES, SERVICES, OR SUPPLIES</td>
</tr>
<tr>
<td>25.</td>
<td>TOTAL CHARGE</td>
</tr>
<tr>
<td>26.</td>
<td>PATIENT’S ACCOUNT NO.</td>
</tr>
<tr>
<td>27.</td>
<td>ACCEPT ASSIGNMENT</td>
</tr>
<tr>
<td>28.</td>
<td>TOTAL CHARGE</td>
</tr>
<tr>
<td>29.</td>
<td>AMOUNT PAID</td>
</tr>
<tr>
<td>30.</td>
<td>BALANCE DUE</td>
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</table>

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MD.20  Chiropractic Services

HEALTH INSURANCE CLAIM FORM

1500

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

1. PROVIDER IDENTIFICATION

<table>
<thead>
<tr>
<th>ITEM</th>
<th>INFORMATION</th>
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<tbody>
<tr>
<td></td>
<td>1. Medicare # of provider</td>
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<tr>
<td></td>
<td>2. Medicaid # of provider</td>
</tr>
<tr>
<td></td>
<td>3. TRICARE # of provider</td>
</tr>
<tr>
<td></td>
<td>4. CHAMPUS # of provider</td>
</tr>
<tr>
<td></td>
<td>5. CHAMPVA # of provider</td>
</tr>
<tr>
<td></td>
<td>6. GROUP # of provider (if applicable)</td>
</tr>
<tr>
<td></td>
<td>7. FEECA # of provider (if applicable)</td>
</tr>
<tr>
<td></td>
<td>8. FECA S.E. L.U.N. # of provider (if applicable)</td>
</tr>
</tbody>
</table>

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM DD YY)

4. PATIENT'S SEX (Male [M] Female [F])

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. OTHER INSURED'S I.D. NUMBER

11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S I.D. NUMBER (For Program in Item 1)

14. INSURED'S DATE OF BIRTH (MM DD YY)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 20b by Line)

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE OF SERVICE FROM

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED DATE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

Signature on File

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
# 1500
## HEALTH INSURANCE CLAIM FORM

Approved by National Uniform Claim Committee 08/05

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<thead>
<tr>
<th>Item</th>
<th>Details</th>
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<tbody>
<tr>
<td>1.</td>
<td>MEDICARE</td>
</tr>
<tr>
<td>2.</td>
<td>PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3.</td>
<td>PATIENT'S BIRTH DATE</td>
</tr>
<tr>
<td>4.</td>
<td>INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5.</td>
<td>PATIENT'S ADDRESS (City, Street)</td>
</tr>
<tr>
<td>6.</td>
<td>PATIENT'S BIRTH DATE</td>
</tr>
<tr>
<td>7.</td>
<td>INSURED'S ADDRESS (City, State)</td>
</tr>
<tr>
<td>8.</td>
<td>PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
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<tr>
<td>9.</td>
<td>OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
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<tr>
<td>10.</td>
<td>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
</tr>
<tr>
<td>11.</td>
<td>INSURED'S POLICY GROUP OR FECA NUMBER</td>
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<td>12.</td>
<td>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
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<tr>
<td>13.</td>
<td>INSURED'S I.D. NUMBER</td>
</tr>
<tr>
<td>14.</td>
<td>DATE OF CURRENT ILLNESS</td>
</tr>
<tr>
<td>15.</td>
<td>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS</td>
</tr>
<tr>
<td>16.</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
</tr>
<tr>
<td>17.</td>
<td>NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
</tr>
<tr>
<td>18.</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
</tr>
<tr>
<td>19.</td>
<td>RESERVED FOR LOCAL USE</td>
</tr>
<tr>
<td>20.</td>
<td>OUTSIDE LAB?</td>
</tr>
<tr>
<td>21.</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Explain Unusual Circumstances)</td>
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<td>22.</td>
<td>MEDICAID RESUBMISSION CODE</td>
</tr>
<tr>
<td>23.</td>
<td>PRIOR AUTHORIZATION NUMBER</td>
</tr>
<tr>
<td>24.</td>
<td>DATE(S) OF SERVICE</td>
</tr>
<tr>
<td>25.</td>
<td>PROFESSIONAL SERVICES OR SUPPLIES</td>
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<td>26.</td>
<td>PATIENT'S ACCOUNT NO.</td>
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<tr>
<td>27.</td>
<td>PATIENT'S ACCOUNT NO.</td>
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<tr>
<td>28.</td>
<td>TOTAL CHARGE</td>
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<td>29.</td>
<td>AMOUNT PAID</td>
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<td>30.</td>
<td>BALANCE DUE</td>
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MD.23 Genetics

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CITY
Webster
STATE
TX
ZIP CODE
77591

PHYSICIAN OR SUPPLIER INFORMATION

SIGNATURE ON FILE

JANE SMITH, MD
01.10.2012

PICA PICA

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### MD.25 Surgery

**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE (CHAMPUS) (Sponsor's SSN)</th>
<th>CHAMPS-A (Member ID#)</th>
<th>GROUP HEALTH PLAN (GGN or ID)</th>
<th>FECA (SSN or ID)</th>
<th>OTHER</th>
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<tbody>
<tr>
<td>Medicare #</td>
<td>Medicaid #</td>
<td>CHAMPUS Sponsor's SSN</td>
<td>CHAMPS-A Member ID#</td>
<td>GROUP HEALTH PLAN GGN or ID</td>
<td>FECA SSN or ID</td>
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<table>
<thead>
<tr>
<th>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</th>
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<tbody>
<tr>
<td>Doe, Jane</td>
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<table>
<thead>
<tr>
<th>3. PATIENT'S BIRTHDATE MM DD YY</th>
<th>SEX</th>
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<tbody>
<tr>
<td>08 01 1981</td>
<td>F</td>
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<table>
<thead>
<tr>
<th>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
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<td>Jane Smith, MD</td>
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<th>5. PATIENT'S ADDRESS (No, Street)</th>
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<td>1523 Robinson Street</td>
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<table>
<thead>
<tr>
<th>6. PATIENT'S SIGNATURE</th>
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</thead>
<tbody>
<tr>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</td>
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<table>
<thead>
<tr>
<th>7. INSURED'S ADDRESS (No, Street)</th>
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<tbody>
<tr>
<td>Goliad, TX 77963</td>
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<tr>
<th>8. PATIENT STATUS</th>
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<tr>
<th>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</th>
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<tbody>
<tr>
<td>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID)</td>
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<table>
<thead>
<tr>
<th>10. IS PATIENT'S CONDITION RELATED TO:</th>
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<tbody>
<tr>
<td>a. EMPLOYMENT? (Current or Previous)</td>
</tr>
<tr>
<td>b. AUTO ACCIDENT?</td>
</tr>
<tr>
<td>c. OTHER ACCIDENT?</td>
</tr>
<tr>
<td>d. EMPLOYER'S NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>e. OTHER INSURED'S DATE OF BIRTH MM DD YY</td>
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<td>f. OTHER INSURED'S POLICY GROUP OR FECA NUMBER</td>
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<thead>
<tr>
<th>11. INSURED'S POLICY GROUP OR FECA NUMBER</th>
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<td>123456789 (For Program in Item 1)</td>
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<th>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</th>
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<tr>
<td>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</td>
</tr>
</tbody>
</table>

### Signature on File

**Date**

**SIGNED**

**DATE**

**SIGNER**

**Signature on File**

### **Hysterectomy acknowledgement attached**

**Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3 or 4 to Item 24E by Line)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>218</td>
<td>Hysterectomy</td>
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**Place of Service**

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<tbody>
<tr>
<td>626</td>
<td>Goliad, TX 77963</td>
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**Provider ID #**

**Rendering Physician Information**

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<td>5432109876</td>
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**Women's Health Center**

32. **Service Facility Location Information**

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<th>Description</th>
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<tbody>
<tr>
<td>Unity Hospital</td>
<td>923 Medical Drive Goliad, TX 77963</td>
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**Billing Provider Information**

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<th>Description</th>
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<tbody>
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