



HCPCS SPECIAL BULLETIN

2012 Healthcare Common Procedure Coding System (HCPCS) Special Bulletin

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2012 HCPCS Implementation

On January 1, 2012, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2012 annual Healthcare Common Procedure Coding System (HCPCS) updates that are effective for dates of service on or after January 1, 2012.

This combined special bulletin includes the HCPCS updates for Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program. This bulletin is intended to notify providers of program and coding changes related to the 2012 updates for HCPCS and Current Procedural Terminology (CPT[®]).

All providers are encouraged to review the general information on this page. Policy updates for a specific program or provider type are discussed in designated sections of the bulletin. ■

Rate Hearings and Expenditure Review

New and increased benefits that are adopted by Texas Medicaid must complete the rate hearing process in order to receive comments on new and increased Texas Medicaid reimbursement rates. The CSHCN Services Program reviews the adopted Texas Medicaid rates to determine whether the rates are fiscally feasible for the CSHCN Services Program.

The proposed expenditures for Texas Medicaid and the CSHCN Services Program are reviewed by the Texas Legislative Budget Board (LBB), and upon approval of expenditures, Texas Medicaid and the CSHCN Services Program implement the approved rates.

All new, revised, and discontinued 2012 HCPCS procedure codes are effective for dates of service on or after January 1, 2012. The new procedure codes that are designated with asterisks (*) in the “Texas Medicaid Allowable” and the “CSHCN Services Program Allowable” columns of the table located on page 29 of this bulletin must complete the rate hearing process, and expenditures must be approved before the rates are adopted by Texas Medicaid and the CSHCN Services Program. Providers will be notified in a future notification if a new procedure code will not be reimbursed because the expenditures were not approved.

Providers may refer to the following resources for more information about the public rate hearings and approval of expenditures:

- Title 2 Human Resources Code, §32.0282, and Title 1 Texas Administrative Code (TAC), §355.201, which require public hearings.
- House Bill 1, 80th Legislature, Regular Session, 2007, Article II, Department of State Health Services, Rider 79a.

Important: *To avoid fraudulent billing, providers must submit the procedure codes that are most appropriate for the services provided.* ■

Code Updates Web Page

Providers are encouraged to refer to the TMHP Code Updates – HCPCS web page at www.tmhp.com/Pages/CodeUpdates/HCPCS_2012.aspx for reimbursement rates, quarterly HCPCS updates, and all other notifications about HCPCS procedure codes.

The 2012 HCPCS reimbursement rates and quarterly updates will also be included in the *Texas Medicaid Bulletin* as updates are made and rates and updates become available. ■

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MEDICAID FEE-FOR-SERVICE AND MANAGED CARE PROVIDERS

Texas Medicaid HCPCS Updates

The 2012 HCPCS updates including prior authorization updates for Texas Medicaid are included in the HCPCS tables in the “All Code Changes: Added, Revised, Replacement, and Discontinued” section of this bulletin beginning on page 31. The 2012 HCPCS deletions and replacements are effective January 1, 2012, for dates of service on or after January 1, 2012, for Texas Medicaid. Providers may refer to the general information on page 1 for more information.



Authorization and Prior Authorization Update Reminder

Effective January 1, 2012, the 2012 HCPCS discontinued procedure codes are no longer reimbursed by Texas Medicaid. Unless otherwise indicated on page 54 of this bulletin, providers who have received prior authorizations for dates of service that occur on, after, or encompass January 1, 2012, must submit a written request on the appropriate, completed Texas Medicaid prior authorization request form in order to update the HCPCS procedure codes authorized for those services.

Providers may refer to the section of this bulletin titled, “Authorization Changes,” for information about obtaining authorization or prior authorization. ■

Texas Medicaid Benefit Changes

The following Texas Medicaid benefit changes have been made to support the 2012 HCPCS and CPT updates and are effective for dates of service on or after January 1, 2012. For questions, call the TMHP Contact Center at 1-800-925-9126.

Note: *These changes apply to Texas Medicaid fee-for-service and Medicaid managed care claims and authorization requests that are submitted to TMHP for processing.*

The policy tables below contain the following information:

- **Revised:** The description has been revised for these procedure codes. Providers may refer to the appropriate copyright holder for the revised descriptions.
- **Discontinued:** Discontinued procedure codes are no longer reimbursed after December 31, 2011.
- **Added:** Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS). Procedure codes noted with an asterisk (*) require a rate hearing for pricing.
- **Limitations:** Additional benefit and limitation information for the added procedure codes.
- **Replacement:** Replacement procedure codes directly replace the indicated discontinued procedure code. The discontinued procedure codes are no longer reimbursed after December 31, 2011, and the replacement procedure codes are effective for dates of service on or after January 1, 2012. Not all discontinued procedure codes have direct replacements.

Abatacept (Orencia)

Revised Procedure Codes	
J0129	

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.37.1.1, “Prior Authorization for Abatacept (Orencia),” for more information.

Alglucosidase Alfa

Revised Procedure Codes	
J0220	
Added	
J0221	

Limitations for added procedure codes: Medical service procedure code J0221 may be reimbursed to nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA), and physician providers for services rendered in the office setting, and to hospital providers for services rendered in the outpatient hospital setting.

Prior authorization is required.

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection, 8.2.37.3.1, “Prior Authorization for Alglucosidase Alfa (*Myozyme*),” for more information.

Anesthesia Reimbursement

Revised Procedure Codes	
00528	00529

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.6.8, “Reimbursement Methodology,” for more information.

Antihemophilic Factor

Added	
J7180	J7183

Limitations for added procedure codes: Medical services procedure code J7180 may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.

Procedure code J7180 may be reimbursed when submitted with diagnosis code 2863.

Medical services procedure code J7183 may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.

Procedure code J7183 may be reimbursed when submitted with diagnosis code 2864.

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistant Handbook*, Subsection 8.2.37.7, “Antihemophilic Factor,” for more information.

Botulinum Toxin Type A and Type B

Discontinued			
Q2040			
Added			
95885	95886	95887	J0588

Limitations for added procedure codes: The following benefit limitations apply for medical services procedure code J0588 which replaces discontinued procedure code Q2040:

- Procedure code J0588 may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting, and to hospital providers for services rendered in the outpatient hospital setting.
- Procedure code J0588 is limited to a total of 120 units and may be reimbursed when billed with diagnosis code 33381, 33383, 34210, 34211, or 34212. If a quantity greater than 120 units is billed with the same date of service, documentation supporting medical necessity for the larger quantity must be submitted with the claim.
- Procedure code J0588 will be denied when it is billed with the same date of service by any provider as procedure codes J0585 and J0586. Procedure code J0587 will be denied when it is billed with the same date of service by any provider as procedure code J0588.

The following benefit limitations apply for laboratory services procedure codes 95885, 95886, and 95887:

- The total laboratory component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center and hospital providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting; and to physician providers for services rendered in the inpatient hospital and outpatient hospital setting.
- The technical component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center providers for services rendered in the outpatient hospital setting.
- Procedure codes 95885, 95886, and 95887 must be submitted with an appropriate diagnosis code.
Refer to: The *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.24.7, “Electrodiagnostic (EDX) Testing,” for the list of appropriate diagnosis codes.
- Procedure codes 95885, 95886, and 95887 must be billed subsequent to primary procedure codes 95900, 95903, and 95904.
- Procedure codes 95885 and 95886 are limited to 4 units per day, any combination, any providers.

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistant Handbook*, Subsection 8.2.37.8, “Botulinum Toxin Type A,” for more information.

BRCA Testing

Added						
81211	81212	81213	81214	81215	81216	81217

Limitations for added procedure codes: The total laboratory component may be reimbursed to physician providers for services rendered in the office setting; to hospital providers for services rendered in the outpatient hospital setting, and to independent laboratory providers for services rendered in the independent laboratory setting.

One service per lifetime may be reimbursed with prior authorization.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistant Handbook](#), Subsection 8.2.13, “BRCA Testing,” for more information.

Chemotherapy

Revised Procedure Codes
95991

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistant Handbook](#), Subsection 8.2.18.1, “Chemotherapy Procedure Codes,” for more information.

Computed Tomography and Magnetic Resonance Imaging

Added
74174

Limitations for added procedure codes: Radiology services procedure code 74174 may be reimbursed as follows:

- The total radiology component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center and hospital providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting; and to physician providers for services rendered in the inpatient hospital or outpatient hospital setting.
- The technical component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center providers for services rendered in the outpatient hospital setting.

Prior authorization is required and must be submitted to the MedSolutions Radiology Prior Authorization Department.

One radiology procedure code may be reimbursed per day. If an additional radiology procedure is medically necessary, a second procedure code may be reimbursed the same day when it is billed with modifier 76.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook](#), Subsection 3.2.2, “Computed Tomography and Magnetic Resonance Imaging,” for more information.

Critical Care and Newborn Services

Revised Procedure Codes								
93561	93562	99218	99219	99220	99354	99355	99356	99357

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.57.6.4, “Critical Care,” and Subsection 8.2.43.4, “Hospital Visits and Routine Care,” for more information.

Developmental and Neurological Assessment and Testing

Revised Procedure Codes	
96110	96111

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.23, “Developmental and Neurological Assessment and Testing,” for more information.

Diagnostic Doppler Sonography

Discontinued Procedure Code
93875

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, and Physical Assistants Handbook*, Subsection 8.2.25, “Diagnostic Doppler Sonography,” for more information.

Diagnostic Endoscopies

Revised Procedure Codes		
32601		
Discontinued		
32602	32603	32605
Added		
32607	32608	32609

Limitations for added procedure codes: Surgical services procedure codes 32607, 32608, and 32609 may be reimbursed to physician providers for services rendered in the inpatient hospital or outpatient hospital setting.



Primary Care Case Management (PCCM) precertification is required for services rendered in the inpatient hospital setting between January 1, 2012, and February 29, 2012.

Note: *The PCCM delivery model will no longer be available after March 1, 2012. Beginning March 1, 2012, providers that render services to former PCCM clients who are enrolled in a Medicaid managed care organization (MCO), must contact the client’s managed care plan for benefit limitations and authorization requirements.*

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialist, Physicians, and Physician Assistant Handbook*, Subsection 8.2.26, “Endoscopies,” for more information.

Doctor of Dentistry Services as a Limited Physician

Revised Procedure Codes									
15155	15156	15157	70355	J1561					
Discontinued									
15175	15176	15320	15321	15335	15336	15365	15366	15400	15420
15421									
Added									
15275	15276	15277	15278	J1557					

Limitations for added procedure codes: Surgical services procedure codes 15275 and 15277 may be reimbursed as follows:

- To NP, CNS, PA, physician, dentist, and podiatrist providers for services rendered in the office setting.
- To physician, dentist, and podiatrist providers for services rendered in the inpatient hospital or outpatient hospital setting.

Surgical services procedure codes 15276 and 15278 may be reimbursed as follows:

- To NP, CNS, PA, physician, dentist, and podiatrist providers for services rendered in the office setting.
- To physician, dentist, and podiatrist providers for services rendered in the inpatient hospital or outpatient hospital setting.

Procedure codes 15276 and 15278 must be billed subsequent to primary procedure codes 15275 and 15277.

Medical services procedure code J1557 may be reimbursed as follows:

- To NP, CNS, PA, physician, and dentist providers for services rendered in the office setting.
- To durable medical equipment (DME) medical supplier providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpa-hospital setting.
- When billed with an appropriate diagnosis code.

Refer to: The [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.37.14, “Gamma Globulin/Immune Globulin” for the list of appropriate diagnosis codes.

The following procedure codes will be denied when they are billed with the same date of service by the same provider as procedure code J1557:

Procedure Codes									
90284	J1459	J1460	J1559	J1560	J1561	J1562	J1566	J1568	J1569
J1572									
J1599									



Procedure code J1557 will be denied when it is billed with the same date of service by the same provider as the following procedure codes:

Procedure Codes									
90284	J1459	J1460	J1559	J1560	J1561	J1562	J1566	J1568	J1569
J1572	J1599	J7504	J7511						

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.37.14, “Gamma Globulin/Immune Globulin,” and Subsection 8.3.3.3, “Additional Payable Procedure Codes,” for more information.

Electromyography (EMG) and Nerve Conduction Studies (NCS)

Added		
95885*	95886*	95887*

Limitations for added procedure codes: The following benefit limitations apply for laboratory services procedure codes 95885, 95886, and 95887:

- The total laboratory component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center and hospital providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting; and to physician providers for services rendered in the inpatient hospital and outpatient hospital setting.
- The technical component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center providers for services rendered in the outpatient hospital setting.
- Procedure codes 95885, 95886, and 95887 must be submitted with an appropriate diagnosis code.
Refer to: The *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.24.7, “Electrodiagnostic (EDX) Testing,” for the list of appropriate diagnosis codes.
- Procedure codes 95885, 95886, and 95887 must be billed subsequent to primary procedure codes 95900, 95903, and 95904.
- Procedure codes 95885 and 95886 are limited to 4 units per day, any combination, any providers.

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.24.7.2, “Nerve Conduction Studies,” for more information.

Evoked Potential Testing – Brainstem, Somatosensory, and Visual

Added	
95938	95939

Limitations for added procedure codes: Laboratory services procedure codes 95938 and 95939 may be reimbursed as follows:

- The total laboratory component may be reimbursed to CNS, NP, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center and hospital providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting; and to physician providers for services rendered in the inpatient hospital or outpatient hospital setting.
- The technical component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center providers for services rendered in the outpatient hospital setting.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook](#), Subsection 2.2.4, “Nonclinical Laboratory Procedures,” for more information.

Extracorporeal Membrane Oxygenation

Revised Procedure Codes	
33960	33961

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.27, “Extracorporeal Membrane Oxygenation (ECMO),” for more information.

Genetic Testing for Colorectal Cancer

Added									
81210	81275	81292	81293	81294	81295	81296	81297	81298	81299
81300	81301	81317	81318	81319					

Limitations for added procedure codes: The laboratory procedure codes above may be reimbursed to independent laboratory providers for services rendered in the independent laboratory setting.

Prior authorization is required.

Procedure codes 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, and 81319 are limited to once per lifetime. Additional services will not be authorized.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.13.7, “Genetic Testing for Colorectal Cancer,” for more information.

Genetic Testing – Other

Added	
81200	

Limitations for added procedure codes: Procedure codes 82100 and S3851 will be denied if they are billed by the same provider with the same date of service.

Gynecological and Reproductive Health Services

Discontinued	
11975	11977

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Gynecological and Reproductive Health, Obstetrics, and Family Planning Handbook](#), Subsection 2.3.5.3, “Contraceptive Capsules;” Subsection 3.3.5, “Contraceptive Devices and Related Procedures;” and Subsection 4.3.5.3, “Contraceptive Capsules,” for more information.

Hearing Devices

Revised Procedure Codes	
L7368	

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook](#), Subsection 3.2.1, “Cochlear Implants,” for more information.

Immunizations (Vaccines/Toxoids)

Revised Procedure Codes		
90460	90461	90581

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.33, “Immunization Guidelines and Administration,” for more information.

Immunosuppressive Drugs

Added	
J0257	J0490

Limitations for added procedure codes: Medical services procedure codes J0257 and J0490 may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.

Procedure code J0257 may be indicated for, but is not limited to, 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.

Procedure code J0490 may be indicated for, but is not limited to, treatment of clients with moderate to severe systemic lupus erythematosus when other forms of treatment have failed to control moderate to severe symptoms.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Section 8.2.32, “Medications - Injectable,” for more information.

Implantable Infusion Pumps

Revised Procedure Codes		
62367	95990	95991
Added		
62369	62370	

Limitations for added procedure codes: Medical services procedure code 62369 may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.

Medical services procedure code 62370 may be reimbursed to physician providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.

Procedure codes 62369 and 62370 will be denied if they are billed with the same date of service by the same provider as procedure code 62362.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.37.22.2, “Implantation of Catheters, Reservoirs, and Pumps,” for more information.

Injections - Immune Globulins

Revised Procedure Codes	
J1561	
Added	
J1557	

Limitations for added procedure codes: Medical services procedure code J1557 may be reimbursed as follows:

- To NP, CNS, PA, physician, and dentist providers for services rendered in the office setting.
- To DME medical supplier providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.
- When billed with an appropriate diagnosis code.

Refer to: The [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.37.14, “Gamma Globulin/Immune Globulin” for the list of appropriate diagnosis codes.

The following procedure codes will be denied when they are billed with the same date of service by the same provider as procedure code J1557:

Procedure Codes									
90284	J1459	J1460	J1559	J1560	J1561	J1562	J1566	J1568	J1569
J1572	J1599								

Procedure code J1557 will be denied when it is billed by the same provider with the same date of service as the following procedure codes:

Procedure Codes									
90284	J1459	J1460	J1559	J1560	J1561	J1562	J1566	J1568	J1569
J1572	J1599	J7504	J7511						

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.37.14, “Gamma Globulin/Immune Globulin,” and Subsection 8.3.3.3, “Additional Payable Procedure Codes,” for more information.

Laboratory Services

Added Procedure Codes									
81200	81205	81206	81207	81208	81209	81210	81211	81212	81213
81214	81215	81216	81217	81220	81221	81222	81223	81224	81225
81226	81227	81228	81229	81240	81241	81242	81243	81244	81245
81250	81251	81255	81256	81257	81260	81261	81262	81263	81264
81265	81266	81267	81268	81270	81275	81280	81281	81282	81290
81291	81292	81293	81294	81295	81296	81297	81298	81299	81300
81301	81302	81303	81304	81310	81315	81316	81317	81318	81319
81330	81331	81332	81340	81341	81342	81350	81355	81370	81371
81372	81373	81374	81375	81376	81377	81378	81379	81380	81381
81382	81383	81400	81401	81402	81403	81404	81405	81406	81407
81408									

Limitations for added procedure codes: The following procedure codes may be reimbursed once per lifetime:

Procedure Codes									
81200	81205	81209	81211	81212	81213	81214	81215	81216	81217
81220	81221	81222	81223	81224	81225	81226	81227	81228	81229
81240	81241	81242	81243	81244	81250	81251	81255	81256	81257
81260	81265	81266	81267	81268	81270	81280	81281	81282	81290
81291	81292	81293	81294	81295	81296	81297	81298	81299	81300
81301	81302	81303	81304	81310	81317	81318	81319	81330	81331
81332	81350	81355	81370	81371	81372	81375	81378	81379	

The following procedure codes may be reimbursed three per lifetime:

Procedure Codes									
81206	81207	81208	81245	81261	81262	81263	81264	81315	81316
81340	81341	81342	81373	81374	81376	81377	81380	81381	81382
81383	81400	81401	81402	81403	81404	81405	81406	81407	81408

Lung Volume Reduction Surgery

Revised Procedure Codes									
32491									
Discontinued									
32095	32402	32602							

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.40, “Lung Volume Reduction Surgery (LVRS),” for more information.

Neurostimulators

Revised Procedure Codes									
64553	64555	64561	64580	64581	64585	95970	95971	95972	95973
95974	95975								

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Outpatient Services Handbook](#), Subsection 2.2.14, “Neurostimulators,” for more information.

Obstetric Services

Discontinued
Q2042
Added
J1725

Limitations for added procedure codes: Medical services procedure code J1725 may be reimbursed to NP, CNS, PA, physician, and certified nurse midwife (CNM) providers for services rendered in the office setting; to DME medical supplier providers for services rendered in the home setting; and to hospital providers for services rendered in the outpatient hospital setting. Procedure code J1725 replaces procedure code J3490 with modifier TH and procedure code Q2042.

Procedure code J1725 may be reimbursed when billed with diagnosis code V2341.

Important: *Procedure code J3490 with modifier TH will no longer be reimbursed for the compounded form of the hydroxyprogesterone caproate injection.*

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Section 8.2.37.4, “17-Alpha Hydroxyprogesterone Caproate,” for more information.

Otology and Audiometry Services

Revised Procedure Codes	
92587	92588
Added	
92558	

Limitations for added procedure codes: Medical services procedure code 92558 may be reimbursed to NP, CNS, PA, physician, and audiologist providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting. Procedure code 92558 is limited to one service per day.

Note: *For services rendered by audiologist providers to Medicaid managed care clients, procedure code 92558 is a carve-out service and must be submitted to TMHP and not the MCO that administers the client’s health plan.*

Providers may refer to the 2011 [Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook](#), Section 2, “Nonimplantable Hearing Aid Devices and Related Services,” for more information.

Physician Evaluation and Management Services

Revised Procedure Codes						
99218	99219	99220	99354	99355	99356	99357

Note: *These physician evaluation and management services changes apply for physician inpatient and outpatient services and behavioral health inpatient and outpatient services.*

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.57.1.5, “Observation Services;” Subsection 8.2.57.3, “Physician Services Provided in the Emergency Department;” Subsection 8.2.57.6.1, “Hospital Admissions, Initial Visits, and Subsequent Visits;” and Subsection 8.2.43.4, “Hospital Visits and Routine Care,” for more information.

Pulmonary Function Studies

Discontinued				
94240	94260	94350	94360	94370
Added				
94726	94727	94728	94729	

Limitations for added procedure codes: Laboratory procedure codes 94726, 94727, 94728, and 94729 may be reimbursed as follows:

- The total laboratory component may be reimbursed to NP, CNS, PA, physician, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to NP, CNS, PA, and physician providers, may be reimbursed for services rendered in the office setting; and to physician providers for services rendered in the outpatient hospital or inpatient hospital setting.
- The technical component may be reimbursed to NP, CNS, PA, physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to radiation treatment center providers for services rendered in the outpatient hospital setting.

Procedure code 94729 must be billed subsequent to primary procedure codes 94010, 94060, 94070, 94375, 94726, 94727, and 94728.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Hospital Services Handbook](#), Subsection 2.3.3.19.3 “Pulmonary Function Studies,” for more information.

Skin Therapy

Revised Procedure Codes
17004

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook](#), Subsection 8.2.67, “Skin Therapy,” for more information.

Telemedicine Services

Revised Procedure Codes		
G0425	G0426	G0427

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Subsection 8.2.71.1, “Distant Site,” for more information.

Transplants-Nonsolid Organ

Revised Procedure Codes		
38230		
Added		
38232		

Limitations for added procedure codes: Surgical services procedure code 38232 may be reimbursed to physician providers for services rendered in the inpatient hospital or outpatient hospital setting; and to ambulatory surgical center providers for services rendered in the outpatient hospital setting.

Prior authorization is required.

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialist, Physicians, and Physician Assistant Handbook*, Subsection 8.2.47.7.1, “Allogeneic and Autologous Bone Marrow and Stem Cell Transplantation,” for prior authorization and diagnosis information.

Tuberculosis Services

Revised Procedure Codes	
86703	96367

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Outpatient Services Handbook*, Subsection 9.2.2, “Ancillary Services,” for more information.

Vision Services – Nonsurgical

Discontinued		
92070	92120	92130
Added		
92071	92072	

Limitations for added procedure codes: Medical services procedure codes 92071 and 92072 may be reimbursed to NP, CNS, PA, physician, and optometrist providers for services rendered in the office or outpatient hospital setting. Procedure codes 92071 and 92072 may be reimbursed each once per day per modifier.

Modifier LT or RT is required.

Procedure codes 92071 and 92072 will be denied if it is billed with the same date of service as procedure codes 92018 and 92019.

Providers may refer to the *2011 Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook*, Subsection 4.3.6.2 “Contact Lenses”, for more information.

Women’s Health Program (WHP)

Discontinued	
11975	11977

Limitations for added procedure codes: Procedure code 11981 is a benefit for WHP that replaces discontinued procedure codes 11975 and 11977. Procedure code 11981 may be reimbursed when it is submitted with a WHP family planning diagnosis code.

Providers may refer to the 2011 *Texas Medicaid Provider Procedures Manual, Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook*, Subsection 3, “Women’s Health Program (Title XIX Family Planning),” for more information including a list of family planning diagnosis codes. ■

ASC/HASC Code Additions

Additions for ambulatory surgical center/hospital ambulatory surgical center (ASC/HASC) facilities are listed with appropriate group payments in the 2012 HCPCS procedure code additions table located on page 29 and replacement procedure codes table located on page 52 of this bulletin.

For more information, call the TMHP Contact Center at 1-800-925-9126. ■

HOME HEALTH AND COMPREHENSIVE CARE PROGRAM (CCP) PROVIDERS

Home Health Services Benefit Changes

The following Texas Medicaid home health services benefit changes have been made to support the 2012 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT[®]) updates and are effective for dates of service on or after January 1, 2012. For questions, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Incontinence Supplies – Home Health

Added	
A5056	A5057

Limitations for added procedure codes: Procedure codes A5056 and A5057 may be reimbursed to home health durable medical equipment (DME) and DME medical supplier providers for services rendered in the home setting.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook](#), Subsection 2.2.12, “Incontinence Supplies,” for more information.

Mobility Aids – Home Health

Revised Procedure Codes	
E0638	E0641
Added	
E2359	

Procedure code E2359 may be reimbursed to home health DME, DME medical supplier, and specialized/custom wheeled mobility providers for services rendered in the home setting.

Prior authorization is required.

Note: *Services billed by the specialized/custom wheeled mobility group provider must have a QRP as the performing provider.*

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook](#) Section 2.2.14.21, “Accessories,” for more information.

Respiratory Equipment and Supplies – Home Health

Discontinued	
E0571	

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook](#), Subsection 2.2.19, “Respiratory Equipment and Supplies,” for more information.

Wound Care Supplies and/or Systems – Home Health

Added	
A9272	

Limitations for added procedure codes: Procedure code A9272 may be reimbursed to home health DME and DME medical supplier providers for services rendered in the home setting.

Prior authorization is required.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook](#), Subsection 2.2.23.6, “Wound Care Procedures and Limitations,” for more information.

CCP Services Benefit Changes

The following Texas Medicaid CCP benefit changes have been made to support the 2012 HCPCS and CPT updates and are effective for dates of service on or after January 1, 2012. For questions, call the TMHP Contact Center at 1-800-925-9126.

Clinician Directed Care Coordination – CCP

Revised Procedure Codes	
99358	99359

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Children’s Services Handbook](#), Subsection 2.3.1.1.6, “Non-Face-to-Face Prolonged Services,” for more information.

Mobility Aids – CCP

Revised Procedure Codes							
E0638	E0642						
Discontinued							
L1500	L1510	L1520					
Added							
E2626	E2627	E2628	E2629	E2630	E2631	E2632	E2633

Limitations for added procedure codes: Procedure codes E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 may be reimbursed as follows:

- A purchase may be reimbursed to DME medical supplier and specialized/custom wheeled mobility CCP providers for services rendered in the home setting.
Note: *Services billed by the specialized/custom wheeled mobility group provider must have a QRP as the performing provider.*
- Prior authorization is required.
- A purchase is limited to one per 5 years.

Procedure codes E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 may be reimbursed for services rendered to clients who are 20 years of age and younger.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Children’s Services Handbook](#), Subsection 2.5.9.1.6, “Mobility Aids - CCP HCPCS Procedure Codes and Limitations,” for more information.

Orthoses – CCP

Revised Procedure Codes								
L2005								
Discontinued								
L3964	L3965	L3966	L3968	L3969	L3970	L3972	L3974	L4380

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Children's Services Handbook](#), Subsection 2.7.2, "Orthotics Services," for more information.

Prostheses – CCP

Revised Procedure Codes		
L6000	L6010	L6020
Discontinued		
L5311	L7500	
Added		
L5312	L6715	L6880

Limitations for added procedure codes: Procedure codes L5312, L6715, and L6880 may be reimbursed to DME medical supplier providers for services rendered in the home setting.

Procedure codes L5312, L6715, and L6880 may be reimbursed for services rendered to clients who are 20 years of age and younger.

Prior authorization is required.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Children's Services Handbook](#), Subsection 2.7.5, "Prosthetic Services," for more information. ■

THSTEPS PROVIDERS**THSteps Medical Benefit Changes**

The following Texas Health Steps (THSteps) medical services benefit changes have been made to support the 2012 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT[®]) updates and are effective for dates of service on or after January 1, 2012. For questions, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

THSteps Preventive Care Medical Checkups

Revised Procedure Codes
96110

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Children's Services Handbook](#), Subsection 5.3.2, "Screening Components With Additional Requirements," for more information. ■

TITLES V, X, AND XX FAMILY PLANNING PROVIDERS

Titles V, X, and XX Family Planning Services Benefit Changes

The following Titles V, X, and XX family planning benefit changes have been made to support the 2012 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT[®]) updates and are effective for dates of service on or after January 1, 2012. For questions, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Implantable Contraceptive Capsules

Discontinued	
11975	11977

Limitations for added procedure codes: Procedure code 11981 has been made a benefit for Titles V, X, and XX family planning to replace discontinued procedure codes 11975 and 11977. Procedure code 11981 may be reimbursed when it is submitted with a family planning diagnosis code.

Providers may refer to the [2011 Texas Medicaid Provider Procedures Manual, Gynecological and Reproductive Health, Obstetrics, and Family Planning Services Handbook](#), Subsection 4, “Department of State Health Services (DSHS) Titles V, X, and XX Family Planning Services,” for more information including a list of family planning diagnosis codes.

Note: *The changes identified in this section apply for Title V, X, and XX family planning from January 1, 2012, through January 14, 2012. Effective for dates of service on or after January 15, 2012, these changes will also apply to the DSHS Family Planning Program. For more information, providers can refer to the article titled “Family Planning Titles V, X, and XX Program Changes Effective January 15, 2012,” which was posted on November 22, 2011, on the TMHP website at www.tmhp.com. ■*

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM PROVIDERS

CSHCN Services Program Updates

The 2012 Healthcare Common Procedure Coding System (HCPCS) updates including authorization and prior authorization updates for the CSHCN Services Program are included in the HCPCS tables in the “All Code Changes: Added, Revised, Replacement, and Discontinued” section of this bulletin beginning on page 29. The 2012 HCPCS deletions and replacements are effective January 1, 2012, for dates of service on or after January 1, 2012, for the CSHCN Services Program.

Authorization and Prior Authorization Update Reminder

Effective January 1, 2012, the 2012 HCPCS discontinued procedure codes will no longer be reimbursed by the CSHCN Services Program. Unless otherwise indicated on page 52 of this bulletin, providers who have received authorizations or prior authorizations for dates of service that occur on, after, or encompass January 1, 2012, must submit a written request on the appropriate, completed CSHCN Services Program authorization or prior authorization request form in order to update the HCPCS procedure codes authorized for those services.

Providers may refer to the section of this bulletin titled, “Authorization Changes,” for information about obtaining authorization or prior authorization.

For additional information, call the TMHP-CSHCN Services Program Contact Center 1-800-568-2413. ■

CSHCN Services Program Benefit Changes

The following CSHCN Services Program benefit changes have been made to support the 2012 HCPCS and Current Procedural Terminology (CPT[®]) updates and are effective for dates of service on or after January 1, 2012. For questions, call the TMHP-CSHCN Services Program Contact Center at 1-800-925-9126.

The policy articles below contain the following information:

- **Revised:** The description has been revised for these procedure codes. Providers may refer to the appropriate copyright holder for the revised descriptions.
- **Discontinued:** Discontinued procedure codes are no longer reimbursed after December 31, 2011.
- **Added:** Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS). Procedure codes noted with an asterisk (*) require a rate hearing for pricing.
- **Limitations:** Additional benefit and limitation information for the added procedure codes.
- **Replacement:** Replacement procedure codes directly replace the indicated discontinued procedure code. The discontinued procedure codes are no longer reimbursed after December 31, 2011, and the replacement procedure codes are effective for dates of service on or after January 1, 2012. Not all discontinued procedure codes have direct replacements.

Note: For the purposes of this section for CSHCN Services Program benefit changes, “advanced practice registered nurse (APRN)” includes nurse practitioner (NP) and clinical nurse specialist (CNS) providers only.

Anesthesia Services

Prostheses – Comprehensive Care Program (CCP)

Revised Procedure Codes	
00528	00529

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.4, “Anesthesia Services,” for more information.

Bone Anchored Hearing Devices

Revised Procedure Codes	
62318	62319

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 19.3.1.2, “Limitations,” for more information.

Botulinum Toxin Type A and Type B

Discontinued	
64626	Q2040
Added	
J0588	

Limitations for added procedure codes: The following benefit limitations apply for medical services procedure code J0588 which replaces discontinued procedure code Q2040:

- Procedure code J0588 may be reimbursed to APRN, physician assistant (PA), and physician providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.
- Procedure code J0588 is limited to a total of 120 units and may be reimbursed when billed with diagnosis code 33381, 33383, 34210, 34211, 34212. If a quantity greater than 120 units is billed with the same date of service, documentation supporting medical necessity for the larger quantity must be submitted with the claim.
- Procedure code J0588 will be denied when it is billed with the same date of service by any provider as procedure code J0585 or J0586. Procedure code J0587 will be denied when it is billed with the same date of service by any provider as procedure code J0588.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 3.2.25.5, “Botulinum Toxin (Type A and Type B),” for more information.

Chemotherapy

Revised Procedure Codes	
95991	

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, on the TMHP website at www.tmhp.com for more information.

Clinician Directed Care Coordination

Revised Procedure Codes	
99358	99359

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.13, “Clinician-Directed Care Coordination Services,” for more information.

Computed Tomography

Added
74174

Limitations for added procedure codes: Radiology services procedure code 74174 may be reimbursed as follows:

- The total radiology component may be reimbursed to physician, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to physician providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.
- The technical component may be reimbursed to physician, radiological laboratory, and physiological laboratory providers for services rendered in the office setting.

Procedure code 74174 may be reimbursed for up to 4 services per rolling year when billed by any provider.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 16.2.4, “Computed Tomography (CT) Scan,” for more information.

Critical Care Services

Revised Procedure Codes				
93561	93562	99218	99219	99220

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.16, “Critical Care Services,” for more information.

Doctor of Dentistry Services as a Limited Physician

Revised Procedure Codes			
15155	15156	15157	70355
Discontinued			
15175	15176	15320	15321
15335	15336	15365	15366
15400	15420	15421	
Added			
15275	15276	15277	15278

Limitations for added procedure codes: Surgical services procedure codes 15275, 15276, 15277, and 15278 may be reimbursed to physician, dentist, and podiatrist providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.

Procedure code 15276 must be billed subsequent to primary procedure code 15275; and procedure code 15278 must be billed subsequent to primary procedure code 15277.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 14.2.7, “Doctor of Dentistry Services as a Limited Physician,” for more information.

Durable Medical Equipment (DME)

Revised Procedure Codes								
E0638	E0641	E0642						
Discontinued								
L1500	L1510	L1520						
Added								
E2359	E2626	E2627	E2628	E2629	E2630	E2631	E2632	E2633

Limitations for added procedure codes: Procedure codes E2359, E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 may be reimbursed to DME medical supplier and CSHCN Services Program custom DME providers for services rendered in the home setting.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 17, “Durable Medical Equipment,” and Section 27, “Orthotic and Prosthetic Devices,” for more information.

Electrodiagnostic Testing (Electromyography and Nerve Conduction Studies)

Added		
95885	95886	95887

Limitations for added procedure codes: Laboratory procedure codes 95885, 95886, and 95887 may be reimbursed as follows:

- The total radiology component may be reimbursed to physician, radiological laboratory, and physiological laboratory providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to physician providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.
- The technical component may be reimbursed to APRN, PA, physician, radiological laboratory, and physiological laboratory providers for services rendered in the office setting.
- Procedure codes 95885, 95886, and 95887 may be reimbursed when billed with an appropriate diagnosis code.

Refer to: The January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.18, “Electrodiagnostic Testing,” for the list of appropriate diagnosis codes.

- Procedure codes 95885, 95886, and 95887 must be billed subsequent to primary procedure codes 95900, 95903, and 95904.
- Procedure codes 95885 and 95886 are limited to 4 units per day, any combination, any providers.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.18, “Electrodiagnostic Testing,” for more information including the list of appropriate diagnosis codes.

Expendable Medical Supplies

Added	
A5056	A5057

Limitations for added procedure codes: Procedure codes A5056 and A5057 may be reimbursed to DME medical supplier and CSHCN Services Program custom DME providers for services rendered in the home setting.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 18.2, “Benefits, Limitations, and Authorization Requirements,” for more information.

Hearing Services

Revised Procedure Codes	
92587	92588
Added	
92558	

Limitations for added procedure codes: Medical service procedure code 92558 may be reimbursed as follows:

- One service per day may be reimbursed to physician and audiologist providers for services rendered in the office setting; and to hospital providers for services rendered in the outpatient hospital setting.
- Procedure code 92558 will be denied if it is billed with the same date of service by the same provider as procedure code G0153.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 19.2.2, “Audiology and Audiometry Evaluation and Diagnostic Services,” for more information.

Immune Globulins

Revised Procedure Codes	
J1561	
Added	
J1557	

Limitations for added procedure codes: Medical services procedure code J1557 may be reimbursed as follows:

- To APRN, PA, physician, and dentist providers for services rendered in the office setting.
- To DME supplier providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.
- When billed with an appropriate diagnosis code.

Refer to: The January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.25.8, “Immune Globulins,” for the list of appropriate diagnosis codes.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.25.8, “Immune Globulins,” for more information.

Laboratory Services

Added Procedure Codes									
81200	81205	81206	81207	81208	81209	81210	81211	81212	81213
81214	81215	81216	81217	81220	81221	81222	81223	81224	81225
81226	81227	81228	81229	81240	81241	81242	81243	81244	81245
81250	81251	81255	81256	81257	81260	81261	81262	81263	81264
81265	81266	81267	81268	81270	81275	81280	81281	81282	81290
81291	81292	81293	81294	81295	81296	81297	81298	81299	81300
81301	81302	81303	81304	81310	81315	81316	81317	81318	81319
81330	81331	81332	81340	81341	81342	81350	81355	81370	81371
81372	81373	81374	81375	81376	81377	81378	81379	81380	81381
81382	81383	81400	81401	81402	81403	81404	81405	81406	81407
81408									

Limitations for added procedure codes: The following procedure codes may be reimbursed once per lifetime:

Procedure Codes									
81200	81205	81209	81211	81212	81213	81214	81215	81216	81217
81220	81221	81222	81223	81224	81225	81226	81227	81228	81229
81240	81241	81242	81243	81244	81250	81251	81255	81256	81257
81260	81265	81266	81267	81268	81270	81280	81281	81282	81290
81291	81292	81293	81294	81295	81296	81297	81298	81299	81300
81301	81302	81303	81304	81310	81317	81318	81319	81330	81331
81332	81350	81355	81370	81371	81372	81375	81378	81379	

The following procedure codes may be reimbursed three per lifetime:

Procedure Codes									
81206	81207	81208	81245	81261	81262	81263	81264	81315	81316
81340	81341	81342	81373	81374	81376	81377	81380	81381	81382
81383	81400	81401	81402	81403	81404	81405	81406	81407	81408

Medications – Blood Factor Products

Added									
J7180									

Limitations for added procedure codes: Medical services procedure code J7180 is manually priced and may be reimbursed to APRN, PA, and physician providers for services rendered in the office setting; to DME medical supplier providers for services rendered in the home setting; and to hospital providers for services rendered in the outpatient hospital setting.

Procedure code J7180 may be reimbursed when it is billed with diagnosis code 2863.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.9, “Blood Factor Products,” for more information.

Neurostimulators

Revised Procedure Codes									
64553	64555	64561	64580	64581	64585	95970	95971	95972	95973
95974	95975								

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 26.2, “Benefits, Limitations, and Authorization Requirements,” for more information.

Orthoses and Prostheses

Revised Procedure Codes									
L2005	L6000	L6010	L6020						
Discontinued									
L1500	L1510	L1520	L3964	L3965	L3966	L3968	L3969	L3970	L3972
L3974	L4380	L5311	L7500						
Added									
L5312	L6715	L6880							

Limitations for added procedure codes: Procedure codes L5312, L6715 and L6880 may be reimbursed to home health DME, prosthetist, orthotist, and DME medical supplier providers for services rendered in the home setting.

Prior authorization is required.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 27, “Orthotic and Prosthetic Devices,” for more information.

Outpatient Hospital Observation Room Services

Revised Procedure Codes		
99218	99219	99220

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.19.7, “Observation Room Services,” for more information.

Physician Evaluation and Management Services

Revised Procedure Codes						
99218	99219	99220	99354	99355	99356	99357

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.19, “Evaluation and Management (E/M) Services,” for more information.

Preventive Care Medical Checkups and Developmental Testing

Revised Procedure Codes	
96110	96111

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.19.9, “Preventive Care Medical Checkups and Developmental Testing,” for more information.

Radiation Therapy Services

Revised Procedure Codes	
77470	

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 31.2.2, “Clinical Treatment Planning,” for more information.

Renal Dialysis Services

Discontinued	
J7130	

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 32.3.1, “In-Facility Services and Method I Home Dialysis Services,” for more information.

Telemedicine Services

Revised Procedure Codes		
G0425	G0426	G0427

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.38.1, “Distant Site,” for more information.

Transplants – Stem Cells

Revised Procedure Codes		
38230	38240	38241
Added		
38232		

Limitations for added procedure codes: Surgical services procedure code 38232 may be reimbursed to physician providers for services rendered in the inpatient hospital or outpatient hospital setting; and to ambulatory surgical center providers for services rendered in the outpatient hospital setting.

Prior authorization is required.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.40.2, “Stem Cell Transplant,” for more information.

Vaccines/Toxoids

Revised Procedure Codes	
90460	90461

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 30.2.24, “Immunizations (Vaccines and Toxoids),” for more information.

Vision Services – Nonsurgical

Discontinued	
92070	92120
Added	
92071	92072

Limitations for added procedure codes: Medical services procedure codes 92071 and 92072 may be reimbursed to APRN, PA, physician, and optometrist providers for services rendered in the office setting; and to physician and optometrist providers for services rendered in the outpatient hospital setting.

Procedure codes 92071 and 92072 will be denied if billed by the same provider with the same date of service as procedure codes 92018 and 92019.

Providers may refer to the January 2012 *CSHCN Services Program Provider Manual*, Section 36.2.1.4 “Contact Lenses,” for more information. ■

ALL CODE CHANGES: ADDED, REVISED, REPLACEMENT, AND DISCONTINUED**2012 HCPCS Procedure Code Additions**

The following is a list of new procedure codes that do not replace existing codes:

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
2	15271	*	*	MC	
8	15271	NC	NC	None	
2	15272	*	*	MC	
8	15272	NC	NC	None	
2	15273	*	*	MC	
8	15273	NC	NC	None	
2	15274	*	*	MC	
8	15274	NC	NC	None	
2	15275	*	*	MC	MD, CSHCN
8	15275	NC	NC	None	MD, CSHCN
2	15276	*	*	MC	MD, CSHCN
8	15276	NC	NC	None	MD, CSHCN
2	15277	*	*	MC	MD, CSHCN
8	15277	NC	NC	None	MD, CSHCN
2	15278	*	*	MC	MD, CSHCN
8	15278	NC	NC	None	MD, CSHCN
2	15777	*	*	MC	
8	15777	NC	NC	None	
F	15777	*	*	MC, CSHCN	
2	20527	*	*	None	
8	20527	NC	NC	MC	
2	22633	*	*	MC	
8	22633	*	*	MC	
2	22634	*	*	MC	
8	22634	*	*	MC	
2	26341	*	*	CSHCN	
8	26341	NC	NC	None	
2	29582	*	*	None	
8	29582	NC	NC	None	
2	29583	*	*	None	
8	29583	NC	NC	None	

*Texas Medicaid rate hearing required, TOS = Type of Service, NC = Procedure code not a benefit

In the Authorization Requirements Column: "MD" in this column indicates that a Medicaid prior authorization is required.

"CSHCN" in this column indicates that a CSHCN Services Program authorization or prior authorization is required.

"MC" in this column indicates that a Medicaid Managed Care prior authorization is required.

"None" in this column indicates that authorization or prior authorization is not required.

In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
2	29584	*	*	None	
8	29584	NC	NC	None	
2	32096	*	*	MC (inpatient/outpatient services)	
8	32096	*	*	MC (inpatient/outpatient services)	
2	32097	*	*	MC (inpatient/outpatient services)	
8	32097	*	*	MC (inpatient/outpatient services)	
2	32098	*	*	MC (inpatient/outpatient services)	
8	32098	*	*	MC (inpatient/outpatient services)	
2	32505	*	*	MC (inpatient/outpatient services)	
8	32505	*	*	MC (inpatient/outpatient services)	
2	32506	*	*	MC (inpatient/outpatient services)	
8	32506	*	*	MC (inpatient/outpatient services)	
2	32507	*	*	MC (inpatient/outpatient services)	MD
8	32507	*	*	MC (inpatient/outpatient services)	MD
2	32607	*	*	MC (inpatient services)	MD
8	32607	NC	NC	None	MD
2	32608	*	*	MC (inpatient services)	MD
8	32608	NC	NC	None	MD
2	32609	*	*	MC (inpatient services)	MD
8	32609	NC	NC	None	MD
2	32666	*	*	MC (inpatient/outpatient services)	
8	32666	*	*	MC (inpatient/outpatient services)	
2	32667	*	*	MC (inpatient/outpatient services)	
8	32667	*	*	MC (inpatient/outpatient services)	
2	32668	*	*	MC (inpatient/outpatient services)	
8	32668	*	*	MC (inpatient/outpatient services)	
2	32669	*	*	None	
8	32669	*	*	None	
2	32670	*	*	None	
8	32670	*	*	None	
2	32671	*	*	MC (inpatient/outpatient services)	
8	32671	*	*	MC (inpatient/outpatient services)	
2	32672	*	*	None	
8	32672	*	*	None	
2	32673	*	*	None	
8	32673	*	*	None	

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 "None" in this column indicates that authorization or prior authorization is not required.

In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
2	32674	*	*	None	
8	32674	*	*	None	
2	33221	*	*	None	
8	33221	NC	NC	None	
F	33221	*	*	CSHCN	
2	33227	*	*	None	
8	33227	NC	NC	None	
F	33227	*	*	CSHCN	
2	33228	*	*	None	
8	33228	NC	NC	None	
F	33228	*	*	CSHCN	
2	33229	*	*	None	
8	33229	NC	NC	None	
F	33229	*	*	CSHCN	
2	33230	*	*	None	
8	33230	NC	NC	None	
F	33230	*	*	CSHCN	
2	33231	*	*	None	
8	33231	NC	NC	None	
F	33231	*	*	CSHCN	
2	33262	*	*	None	
8	33262	NC	NC	None	
F	33262	*	*	CSHCN	
2	33263	*	*	None	
8	33263	NC	NC	None	
F	33263	*	*	CSHCN	
2	33264	*	*	None	
8	33264	NC	NC	None	
F	33264	*	*	CSHCN	
2	36251	*	*	None	
8	36251	NC	NC	None	
2	36252	*	*	None	
8	36252	NC	NC	None	
2	36253	*	*	None	
8	36253	NC	NC	None	
2	36254	*	*	None	

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"MC" in this column indicates that a Medicaid Managed Care prior authorization is required.

"None" in this column indicates that authorization or prior authorization is not required.

In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
8	36254	*	*	None	
2	37191	*	*	MC (inpatient/outpatient services)	
8	37191	NC	NC	None	
2	37192	*	*	None	
8	37192	NC	NC	None	
2	37193	*	*	None	
8	37193	NC	NC	None	
2	37619	*	*	MC (inpatient/outpatient services)	
8	37619	*	*	MC (inpatient/outpatient services)	
2	38232	*	*	MD, MC, CSHCN	MD, CSHCN
8	38232	NC	NC	None	MD, CSHCN
F	38232	*	*	MC, CSHCN	MD, CSHCN
2	49082	*	*	None	
8	49082	NC	NC	None	
2	49083	*	*	None	
8	49083	NC	NC	None	
2	49084	*	*	None	
8	49084	NC	NC	None	
1	62369	*	*	None	MD
1	62370	*	*	None	MD
2	64633	*	*	MC (inpatient/outpatient services), CSHCN	
8	64633	NC	NC	None	
F	64633	*	*	MC, CSHCN	
2	64634	*	*	MC (inpatient/outpatient services)	
8	64634	NC	NC	None	
2	64635	*	*	MC (inpatient/outpatient services)	
8	64635	NC	NC	None	
F	64635	*	*	MC, CSHCN	
2	64636	*	*	MC (inpatient/outpatient services)	
8	64636	NC	NC	None	
F	64636	*	*	MC, CSHCN	
4	74174	*	*	MD, MC (MedSolutions)	MD, CSHCN
I	74174	*	*	MD, MC (MedSolutions)	MD, CSHCN
T	74174	*	*	MD, MC (MedSolutions)	MD, CSHCN
6	77424	*	NC	None	

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 "MC" in this column indicates that a Medicaid Managed Care prior authorization is required.
 "None" in this column indicates that authorization or prior authorization is not required.

In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	77424	NC	NC	None	
T	77424	NC	NC	None	
6	77425	*	NC	None	
I	77425	NC	NC	None	
T	77425	NC	NC	None	
6	77469	*	NC	None	
I	77469	NC	NC	None	
T	77469	NC	NC	None	
4	78226	*	*	None	
I	78226	*	*	None	
T	78226	*	*	None	
4	78227	*	*	None	
I	78227	*	*	None	
T	78227	*	*	None	
4	78579	*	*	None	
I	78579	*	*	None	
T	78579	*	*	None	
4	78582	*	*	None	
I	78582	*	*	None	
T	78582	*	*	None	
4	78597	*	*	None	
I	78597	*	*	None	
T	78597	*	*	None	
4	78598	*	*	None	
I	78598	*	*	None	
T	78598	*	*	None	
5	81200	*	*	None	
I	81200	NC	NC	None	
T	81200	NC	NC	None	
5	81205	*	*	None	
I	81205	NC	NC	None	
T	81205	NC	NC	None	
5	81206	*	*	None	
I	81206	NC	NC	None	
T	81206	NC	NC	None	
5	81207	*	*	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81207	NC	NC	None	
T	81207	NC	NC	None	
5	81208	*	*	None	
I	81208	NC	NC	None	
T	81208	NC	NC	None	
5	81209	*	*	None	
I	81209	NC	NC	None	
T	81209	NC	NC	None	
5	81210	*	*	MD, MC, CSHCN	MD
I	81210	NC	NC	None	MD
T	81210	NC	NC	None	MD
5	81211	*	*	MD, MC, CSHCN	MD
I	81211	NC	NC	None	MD
T	81211	NC	NC	None	MD
5	81212	*	*	MD, MC, CSHCN	MD
I	81212	NC	NC	None	MD
T	81212	NC	NC	None	MD
5	81213	*	*	MD, MC, CSHCN	MD
I	81213	NC	NC	None	MD
T	81213	NC	NC	None	MD
5	81214	*	*	MD, MC, CSHCN	MD
I	81214	NC	NC	None	MD
T	81214	NC	NC	None	MD
5	81215	*	*	MD, MC, CSHCN	MD
I	81215	NC	NC	None	MD
T	81215	NC	NC	None	MD
5	81216	*	*	MD, MC, CSHCN	MD
I	81216	NC	NC	None	MD
T	81216	NC	NC	None	MD
5	81217	*	*	MD, MC, CSHCN	MD
I	81217	NC	NC	None	MD
T	81217	NC	NC	None	MD
5	81220	*	*	None	
I	81220	NC	NC	None	
T	81220	NC	NC	None	
5	81221	*	*	None	

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 "MC" in this column indicates that a Medicaid Managed Care prior authorization is required.
 "None" in this column indicates that authorization or prior authorization is not required.

In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81221	NC	NC	None	
T	81221	NC	NC	None	
5	81222	*	*	None	
I	81222	NC	NC	None	
T	81222	NC	NC	None	
5	81223	*	*	None	
I	81223	NC	NC	None	
T	81223	NC	NC	None	
5	81224	*	*	None	
I	81224	NC	NC	None	
T	81224	NC	NC	None	
5	81225	*	*	None	
I	81225	NC	NC	None	
T	81225	NC	NC	None	
5	81226	*	*	None	
I	81226	NC	NC	None	
T	81226	NC	NC	None	
5	81227	*	*	None	
I	81227	NC	NC	None	
T	81227	NC	NC	None	
5	81228	NC	NC	None	
I	81228	NC	NC	None	
T	81228	NC	NC	None	
5	81229	NC	NC	None	
I	81229	NC	NC	None	
T	81229	NC	NC	None	
5	81240	*	*	None	
I	81240	NC	NC	None	
T	81240	NC	NC	None	
5	81241	*	*	None	
I	81241	NC	NC	None	
T	81241	NC	NC	None	
5	81242	*	*	None	
I	81242	NC	NC	None	
T	81242	NC	NC	None	
5	81243	*	*	None	

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"MC" in this column indicates that a Medicaid Managed Care prior authorization is required.

"None" in this column indicates that authorization or prior authorization is not required.

In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81243	NC	NC	None	
T	81243	NC	NC	None	
5	81244	*	*	None	
I	81244	NC	NC	None	
T	81244	NC	NC	None	
5	81245	*	*	None	
I	81245	NC	NC	None	
T	81245	NC	NC	None	
5	81250	*	*	None	
I	81250	NC	NC	None	
T	81250	NC	NC	None	
5	81251	*	*	None	
I	81251	NC	NC	None	
T	81251	NC	NC	None	
5	81255	*	*	None	
I	81255	NC	NC	None	
T	81255	NC	NC	None	
5	81256	*	*	None	
I	81256	NC	NC	None	
T	81256	NC	NC	None	
5	81257	*	*	None	
I	81257	NC	NC	None	
T	81257	NC	NC	None	
5	81260	*	*	None	
I	81260	NC	NC	None	
T	81260	NC	NC	None	
5	81261	*	*	None	
I	81261	NC	NC	None	
T	81261	NC	NC	None	
5	81262	*	*	None	
I	81262	NC	NC	None	
T	81262	NC	NC	None	
5	81263	*	*	None	
I	81263	NC	NC	None	
T	81263	NC	NC	None	
5	81264	*	*	None	

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 "MC" in this column indicates that a Medicaid Managed Care prior authorization is required.
 "None" in this column indicates that authorization or prior authorization is not required.
 In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81264	NC	NC	None	
T	81264	NC	NC	None	
5	81265	*	*	None	
I	81265	NC	NC	None	
T	81265	NC	NC	None	
5	81266	*	*	None	
I	81266	NC	NC	None	
T	81266	NC	NC	None	
5	81267	*	*	None	
I	81267	NC	NC	None	
T	81267	NC	NC	None	
5	81268	*	*	None	
I	81268	NC	NC	None	
T	81268	NC	NC	None	
5	81270	*	*	None	
I	81270	NC	NC	None	
T	81270	NC	NC	None	
5	81275	*	*	MD, MC, CSHCN	MD
I	81275	NC	NC	None	MD
T	81275	NC	NC	None	MD
5	81280	*	*	None	
I	81280	NC	NC	None	
T	81280	NC	NC	None	
5	81281	*	*	None	
I	81281	NC	NC	None	
T	81281	NC	NC	None	
5	81282	*	*	None	
I	81282	NC	NC	None	
T	81282	NC	NC	None	
5	81290	*	*	None	
I	81290	NC	NC	None	
T	81290	NC	NC	None	
5	81291	*	*	None	
I	81291	NC	NC	None	
T	81291	NC	NC	None	
5	81292	*	*	MD, MC, CSHCN	MD

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In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81292	NC	NC	None	MD
T	81292	NC	NC	None	MD
5	81293	*	*	MD, MC, CSHCN	MD
I	81293	NC	NC	None	MD
T	81293	NC	NC	None	MD
5	81294	*	*	MD, MC, CSHCN	MD
I	81294	NC	NC	None	MD
T	81294	NC	NC	None	MD
5	81295	*	*	MD, MC, CSHCN	MD
I	81295	NC	NC	None	MD
T	81295	NC	NC	None	MD
5	81296	*	*	MD, MC, CSHCN	MD
I	81296	NC	NC	None	MD
T	81296	NC	NC	None	MD
5	81297	*	*	MD, MC, CSHCN	MD
I	81297	NC	NC	None	MD
T	81297	NC	NC	None	MD
5	81298	*	*	MD, MC, CSHCN	MD
I	81298	NC	NC	None	MD
T	81298	NC	NC	None	MD
5	81299	*	*	MD, MC, CSHCN	MD
I	81299	NC	NC	None	MD
T	81299	NC	NC	None	MD
5	81300	*	*	MD, MC, CSHCN	MD
I	81300	NC	NC	None	MD
T	81300	NC	NC	None	MD
5	81301	*	*	MD, MC, CSHCN	MD
I	81301	NC	NC	None	MD
T	81301	NC	NC	None	MD
5	81302	*	*	None	
I	81302	NC	NC	None	
T	81302	NC	NC	None	
5	81303	*	*	None	
I	81303	NC	NC	None	
T	81303	NC	NC	None	
5	81304	*	*	None	

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 In the Authorization Requirements Column: "MD" in this column indicates that a Medicaid prior authorization is required.
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 "MC" in this column indicates that a Medicaid Managed Care prior authorization is required.
 "None" in this column indicates that authorization or prior authorization is not required.
 In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81304	NC	NC	None	
T	81304	NC	NC	None	
5	81310	*	*	None	
I	81310	NC	NC	None	
T	81310	NC	NC	None	
5	81315	*	*	None	
I	81315	NC	NC	None	
T	81315	NC	NC	None	
5	81316	*	*	None	
I	81316	NC	NC	None	
T	81316	NC	NC	None	
5	81317	*	*	MD, MC, CSHCN	MD
I	81317	NC	NC	None	MD
T	81317	NC	NC	None	MD
5	81318	*	*	MD, MC, CSHCN	MD
I	81318	NC	NC	None	MD
T	81318	NC	NC	None	MD
5	81319	*	*	MD, MC, CSHCN	MD
I	81319	NC	NC	None	MD
T	81319	NC	NC	None	MD
5	81330	*	*	None	
I	81330	NC	NC	None	
T	81330	NC	NC	None	
5	81331	*	*	None	
I	81331	NC	NC	None	
T	81331	NC	NC	None	
5	81332	*	*	None	
I	81332	NC	NC	None	
T	81332	NC	NC	None	
5	81340	*	*	None	
I	81340	NC	NC	None	
T	81340	NC	NC	None	
5	81341	*	*	None	
I	81341	NC	NC	None	
T	81341	NC	NC	None	
5	81342	*	*	None	

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In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81342	NC	NC	None	
T	81342	NC	NC	None	
5	81350	*	*	None	
I	81350	NC	NC	None	
T	81350	NC	NC	None	
5	81355	*	*	None	
I	81355	NC	NC	None	
T	81355	NC	NC	None	
5	81370	*	*	None	
I	81370	NC	NC	None	
T	81370	NC	NC	None	
5	81371	*	*	None	
I	81371	NC	NC	None	
T	81371	NC	NC	None	
5	81372	*	*	None	
I	81372	NC	NC	None	
T	81372	NC	NC	None	
5	81373	*	*	None	
I	81373	NC	NC	None	
T	81373	NC	NC	None	
5	81374	*	*	None	
I	81374	NC	NC	None	
T	81374	NC	NC	None	
5	81375	*	*	None	
I	81375	NC	NC	None	
T	81375	NC	NC	None	
5	81376	*	*	None	
I	81376	NC	NC	None	
T	81376	NC	NC	None	
5	81377	*	*	None	
I	81377	NC	NC	None	
T	81377	NC	NC	None	
5	81378	*	*	None	
I	81378	NC	NC	None	
T	81378	NC	NC	None	
5	81379	*	*	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81379	NC	NC	None	
T	81379	NC	NC	None	
5	81380	*	*	None	
I	81380	NC	NC	None	
T	81380	NC	NC	None	
5	81381	*	*	None	
I	81381	NC	NC	None	
T	81381	NC	NC	None	
5	81382	*	*	None	
I	81382	NC	NC	None	
T	81382	NC	NC	None	
5	81383	*	*	None	
I	81383	NC	NC	None	
T	81383	NC	NC	None	
5	81400	*	*	None	
I	81400	NC	NC	None	
T	81400	NC	NC	None	
5	81401	*	*	None	
I	81401	NC	NC	None	
T	81401	NC	NC	None	
5	81402	*	*	None	
I	81402	NC	NC	None	
T	81402	NC	NC	None	
5	81403	*	*	None	
I	81403	NC	NC	None	
T	81403	NC	NC	None	
5	81404	*	*	None	
I	81404	NC	NC	None	
T	81404	NC	NC	None	
5	81405	*	*	None	
I	81405	NC	NC	None	
T	81405	NC	NC	None	
5	81406	*	*	None	
I	81406	NC	NC	None	
T	81406	NC	NC	None	
5	81407	*	*	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	81407	NC	NC	None	
T	81407	NC	NC	None	
5	81408	*	*	None	
I	81408	NC	NC	None	
T	81408	NC	NC	None	
5	86386	*	*	None	
5	87389	*	*	None	
1	90869	NC	NC	None	
1	92071	*	*	None	MD, CSHCN
1	92072	*	*	None	MD, CSHCN
1	92558	*	*	None	MD, CSHCN
1	92618	NC	NC	None	
4	93998	NC	NC	None	
I	93998	NC	NC	None	
T	93998	NC	NC	None	
5	94726	*	*	None	MD
I	94726	*	*	None	MD
T	94726	*	*	None	MD
5	94727	*	*	None	MD
I	94727	*	*	None	MD
T	94727	*	*	None	MD
5	94728	*	*	None	MD
I	94728	*	*	None	MD
T	94728	*	*	None	MD
5	94729	*	*	None	MD
I	94729	*	*	None	MD
T	94729	*	*	None	MD
1	94780	NC	NC	None	
1	94781	NC	NC	None	
5	95885	*	*	None	MD, CSHCN
I	95885	*	*	None	MD, CSHCN
T	95885	*	*	None	MD, CSHCN
5	95886	*	*	None	MD, CSHCN
I	95886	*	*	None	MD, CSHCN
T	95886	*	*	None	MD, CSHCN
5	95887	*	*	None	MD, CSHCN

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 In the Authorization Requirements Column: "MD" in this column indicates that a Medicaid prior authorization is required.
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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
I	95887	*	*	None	MD, CSHCN
T	95887	*	*	None	MD, CSHCN
5	95938	*	*	None	MD
I	95938	*	*	None	MD
T	95938	*	*	None	MD
5	95939	*	*	None	MD
I	95939	*	*	None	MD
T	95939	*	*	None	MD
9	A5056	*	*	None	MD, CSHCN
9	A5057	*	*	None	MD, CSHCN
9	A9272	*	*	MD, MC	MD
9	A9584	NC	NC	None	
9	A9585	NC	NC	None	
9	C1886	NC	NC	None	
1	C9287	*	*	None	
1	C9366	*	*	None	
2	C9732	*	*	None	
8	C9732	NC	NC	None	
9	E0988	NC	NC	None	
9	E2358	NC	NC	None	
J	E2359	*	*	MD (HH), MC, CSHCN	MD, CSHCN
J	E2626	\$455.78	\$455.78	MD (CCP), MC, CSHCN	MD, CSHCN
J	E2627	\$789.09	\$789.09	MD (CCP), MC, CSHCN	MD, CSHCN
J	E2628	\$538.63	\$538.63	MD (CCP), MC, CSHCN	MD, CSHCN
J	E2629	\$719.75	\$719.75	MD (CCP), MC, CSHCN	MD, CSHCN
J	E2630	\$524.41	\$524.41	MD (CCP), MC, CSHCN	MD, CSHCN
J	E2631	\$208.60	\$208.60	MD (CCP), MC, CSHCN	MD, CSHCN
J	E2632	\$176.47	\$176.47	MD (CCP), MC, CSHCN	MD, CSHCN
J	E2633	\$141.39	\$141.39	MD (CCP), MC, CSHCN	MD, CSHCN
1	G0442	NC	NC	None	
1	G0443	NC	NC	None	
1	G0444	NC	NC	None	
1	G0445	NC	NC	None	
1	G0446	NC	NC	None	
1	G0447	NC	NC	None	
1	G0448	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	G0449	NC	NC	None	
1	G0450	NC	NC	None	
1	G0451	NC	NC	None	
1	G0908	NC	NC	None	
1	G0909	NC	NC	None	
1	G0910	NC	NC	None	
1	G0911	NC	NC	None	
1	G0912	NC	NC	None	
1	G0913	NC	NC	None	
1	G0914	NC	NC	None	
1	G0915	NC	NC	None	
1	G0916	NC	NC	None	
1	G0917	NC	NC	None	
1	G0918	NC	NC	None	
1	G0919	NC	NC	None	
1	G0920	NC	NC	None	
1	G0921	NC	NC	None	
1	G0922	NC	NC	None	
1	G8694	NC	NC	None	
1	G8695	NC	NC	None	
1	G8696	NC	NC	None	
1	G8697	NC	NC	None	
1	G8698	NC	NC	None	
1	G8699	NC	NC	None	
1	G8700	NC	NC	None	
1	G8701	NC	NC	None	
1	G8702	NC	NC	None	
1	G8703	NC	NC	None	
1	G8704	NC	NC	None	
1	G8705	NC	NC	None	
1	G8706	NC	NC	None	
1	G8707	NC	NC	None	
1	G8708	NC	NC	None	
1	G8709	NC	NC	None	
1	G8710	NC	NC	None	
1	G8711	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	G8712	NC	NC	None	
1	G8713	NC	NC	None	
1	G8714	NC	NC	None	
1	G8715	NC	NC	None	
1	G8716	NC	NC	None	
1	G8717	NC	NC	None	
1	G8718	NC	NC	None	
1	G8720	NC	NC	None	
1	G8721	NC	NC	None	
1	G8722	NC	NC	None	
1	G8723	NC	NC	None	
1	G8724	NC	NC	None	
1	G8725	NC	NC	None	
1	G8726	NC	NC	None	
1	G8727	NC	NC	None	
1	G8728	NC	NC	None	
1	G8730	NC	NC	None	
1	G8731	NC	NC	None	
1	G8732	NC	NC	None	
1	G8733	NC	NC	None	
1	G8734	NC	NC	None	
1	G8735	NC	NC	None	
1	G8736	NC	NC	None	
1	G8737	NC	NC	None	
1	G8738	NC	NC	None	
1	G8739	NC	NC	None	
1	G8740	NC	NC	None	
1	G8741	NC	NC	None	
1	G8742	NC	NC	None	
1	G8743	NC	NC	None	
1	G8744	NC	NC	None	
1	G8745	NC	NC	None	
1	G8746	NC	NC	None	
1	G8747	NC	NC	None	
1	G8748	NC	NC	None	
1	G8749	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	G8750	NC	NC	None	
1	G8751	NC	NC	None	
1	G8752	NC	NC	None	
1	G8753	NC	NC	None	
1	G8754	NC	NC	None	
1	G8755	NC	NC	None	
1	G8756	NC	NC	None	
1	G8757	NC	NC	None	
1	G8758	NC	NC	None	
1	G8759	NC	NC	None	
1	G8760	NC	NC	None	
1	G8761	NC	NC	None	
1	G8762	NC	NC	None	
1	G8763	NC	NC	None	
1	G8764	NC	NC	None	
1	G8765	NC	NC	None	
1	G8767	NC	NC	None	
1	G8768	NC	NC	None	
1	G8769	NC	NC	None	
1	G8770	NC	NC	None	
1	G8771	NC	NC	None	
1	G8772	NC	NC	None	
1	G8773	NC	NC	None	
1	G8774	NC	NC	None	
1	G8775	NC	NC	None	
1	G8776	NC	NC	None	
1	G8777	NC	NC	None	
1	G8778	NC	NC	None	
1	G8779	NC	NC	None	
1	G8780	NC	NC	None	
1	G8781	NC	NC	None	
1	G8782	NC	NC	None	
1	G8783	NC	NC	None	
1	G8784	NC	NC	None	
1	G8785	NC	NC	None	
1	G8786	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	G8787	NC	NC	None	
1	G8788	NC	NC	None	
1	G8789	NC	NC	None	
1	G8790	NC	NC	None	
1	G8791	NC	NC	None	
1	G8792	NC	NC	None	
1	G8793	NC	NC	None	
1	G8794	NC	NC	None	
1	G8795	NC	NC	None	
1	G8796	NC	NC	None	
1	G8797	NC	NC	None	
1	G8798	NC	NC	None	
1	G8799	NC	NC	None	
1	G8800	NC	NC	None	
1	G8801	NC	NC	None	
1	G8802	NC	NC	None	
1	G8803	NC	NC	None	
1	G8805	NC	NC	None	
1	G8806	NC	NC	None	
1	G8807	NC	NC	None	
1	G8808	NC	NC	None	
1	G8809	NC	NC	None	
1	G8810	NC	NC	None	
1	G8811	NC	NC	None	
1	G8812	NC	NC	None	
1	G8813	NC	NC	None	
1	G8814	NC	NC	None	
1	G8815	NC	NC	None	
1	G8816	NC	NC	None	
1	G8817	NC	NC	None	
1	G8818	NC	NC	None	
1	G8819	NC	NC	None	
1	G8820	NC	NC	None	
1	G8821	NC	NC	None	
1	G8822	NC	NC	None	
1	G8823	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	G8824	NC	NC	None	
1	G8825	NC	NC	None	
1	G8826	NC	NC	None	
1	G8827	NC	NC	None	
1	G8828	NC	NC	None	
1	G8829	NC	NC	None	
1	G8830	NC	NC	None	
1	G8831	NC	NC	None	
1	G8832	NC	NC	None	
1	G8833	NC	NC	None	
1	G8834	NC	NC	None	
1	G8835	NC	NC	None	
1	G8836	NC	NC	None	
1	G8837	NC	NC	None	
1	G8838	NC	NC	None	
1	G8839	NC	NC	None	
1	G8840	NC	NC	None	
1	G8841	NC	NC	None	
1	G8842	NC	NC	None	
1	G8843	NC	NC	None	
1	G8844	NC	NC	None	
1	G8845	NC	NC	None	
1	G8846	NC	NC	None	
1	G8847	NC	NC	None	
1	G8848	NC	NC	None	
1	G8849	NC	NC	None	
1	G8850	NC	NC	None	
1	G8851	NC	NC	None	
1	G8852	NC	NC	None	
1	G8853	NC	NC	None	
1	G8854	NC	NC	None	
1	G8855	NC	NC	None	
1	G8856	NC	NC	None	
1	G8857	NC	NC	None	
1	G8858	NC	NC	None	
1	G8859	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	G8860	NC	NC	None	
1	G8861	NC	NC	None	
1	G8862	NC	NC	None	
1	G8863	NC	NC	None	
1	G8864	NC	NC	None	
1	G8865	NC	NC	None	
1	G8866	NC	NC	None	
1	G8867	NC	NC	None	
1	G8868	NC	NC	None	
1	G8869	NC	NC	None	
1	G8870	NC	NC	None	
1	G8871	NC	NC	None	
1	G8872	NC	NC	None	
1	G8873	NC	NC	None	
1	G8874	NC	NC	None	
1	G8875	NC	NC	None	
1	G8876	NC	NC	None	
1	G8877	NC	NC	None	
1	G8878	NC	NC	None	
1	G8879	NC	NC	None	
1	G8880	NC	NC	None	
1	G8881	NC	NC	None	
1	G8882	NC	NC	None	
1	G8883	NC	NC	None	
1	G8884	NC	NC	None	
1	G8885	NC	NC	None	
1	G8886	NC	NC	None	
1	G8887	NC	NC	None	
1	G8888	NC	NC	None	
1	G8889	NC	NC	None	
1	G8890	NC	NC	None	
1	G8891	NC	NC	None	
1	G8892	NC	NC	None	
1	G8893	NC	NC	None	
1	G8894	NC	NC	None	
1	G8895	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	G8896	NC	NC	None	
1	G8897	NC	NC	None	
1	G8898	NC	NC	None	
1	G8899	NC	NC	None	
1	G8900	NC	NC	None	
1	G8901	NC	NC	None	
1	G8902	NC	NC	None	
1	G8903	NC	NC	None	
1	G8904	NC	NC	None	
1	G8905	NC	NC	None	
1	G8906	NC	NC	None	
1	G9156	NC	NC	None	
1	J0131	*	*	None	
1	J0221	*	*	MD, MC	MD
1	J0257	*	*	None	MD
1	J0490	\$39.66	NC	None	MD
1	J0588	\$5.64	\$5.64	None	MD, CSHCN
1	J0712	NC	NC	None	
1	J0840	\$1,689.12	NC	None	
1	J0897	\$14.52	\$14.52	None	
1	J1557	\$37.30	\$37.30	None	MD, CSHCN
1	J1725	\$2.96	NC	None	MD
1	J2265	NC	NC	None	
1	J2507	\$293.25	NC	None	
1	J7131	NC	NC	None	
1	J7180	*	*	None	MD, CSHCN
1	J7183	\$0.88	NC	None	MD
1	J7326	*	*	None	
1	J7665	*	*	None	
1	J8561	NC	NC	None	
1	J9043	\$141.33	NC	None	
1	J9179	\$901.00	NC	None	
1	J9228	*	NC	None	
9	L5312	*	*	CSHCN	MD, CSHCN
9	L6715	*	*	CSHCN	MD, CSHCN
9	L6880	*	*	CSHCN	MD, CSHCN
1	Q0162	NC	NC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Benefit Changes
1	Q4122	*	*	None	
1	Q4123	*	*	None	
1	Q4124	*	*	None	
1	Q4125	NC	NC	None	
1	Q4126	*	*	None	
1	Q4127	*	*	None	
1	Q4128	*	*	None	
1	Q4129	*	*	None	
1	Q4130	*	*	None	
1	S0119	NC	NC	None	
5	S3722	*	*	None	
9	S8130	NC	NC	None	
9	S8131	NC	NC	None	

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"None" in this column indicates that authorization or prior authorization is not required.

In the Benefit Changes Column: "MD" in this column indicates that additional information is available in the Medicaid program benefit changes sections at the beginning of this bulletin. "CSHCN" in this column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin.

Note: All new, revised, and discontinued 2012 HCPCS procedure codes are effective for dates of service on or after January 1, 2012. The new procedure codes that are indicated with an asterisk (*) in the above table are pending a rate hearing and approval of expenditures. Providers will be notified in a future notification if a new procedure code is not approved for reimbursement. Providers can refer to the "Rate Hearings and Expenditure Review" article located on the cover page of this bulletin for more information about benefits that are pending approval of expenditures.

The following new procedure codes are used for reporting purposes and are informational only:

Procedure Codes									
0262T	0263T	0264T	0265T	0266T	0267T	0268T	0269T	0270T	0271T
0272T	0273T	0274T	0275T	0276T	0277T	0278T	0279T	0280T	0281T
0282T	0283T	0284T	0285T	0286T	0287T	0288T	0289T	0290T	0291T
0292T	0293T	0294T	0295T	0296T	0297T	0298T	0299T	0300T	0301T
0550F	0551F	0555F	0556F	0557F	1010F	1011F	1012F	1031F	1032F
1033F	1052F	1175F	1181F	1182F	1183F	1450F	1451F	1460F	1461F
1490F	1491F	1493F	1494F	2015F	2016F	3019F	3055F	3056F	3115F
3117F	3118F	3119F	3125F	3267F	3394F	3395F	3517F	3520F	3725F
3750F	4008F	4010F	4013F	4069F	4086F	4140F	4142F	4144F	4145F
4322F	4350F	4450F	4470F	4480F	4481F	4500F	4510F	4525F	4526F
5250F	6100F	6101F	6102F	6110F	6150F				

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413. ■

Discontinued Procedure Codes

The 2012 HCPCS discontinued procedure codes are no longer reimbursed after December 31, 2011. The following is a list of procedure codes that have been discontinued:

Procedure Codes									
11975	11977	15170	15171	15175	15176	15300	15301	15320	15321
15330	15331	15335	15336	15340	15341	15360	15361	15365	15366
15400	15401	15420	15421	15430	15431	32095	32402	32500	32602
32603	32605	32657	32660	35548	35549	35551	35651	37620	49080
49081	64560	64577	64622	64623	64626	64627	69802	71090	73542
75722	75724	75940	77079	77083	78220	78223	78584	78585	78586
78587	78588	78591	78593	78594	78596	88107	88318	90470	90663
92070	92120	92130	93720	93721	93722	93875	94240	94260	94350
94360	94370	94720	94725	C9270*	C9272*	C9273	C9274*	C9276*	C9277
C9278	C9280*	C9281*	C9282	C9283	C9284	C9365	C9406	C9729	C9730
C9731	E0571	G0440	G0441	G8440	G8441	G8508	G8534	G8537	G8538
G8636	G8637	G8638	G8639	G8640	G8641	G8675	G8676	G8677	G8678
G8679	G8680	G8681	G8684	G8686	G8687	G8688	G8689	G8690	G8691
G8692	G8693	G9041	G9042	G9043	G9044	J7130	J7184	L1500	L1510
L1520	L3964*	L3965*	L3966*	L3968*	L3969*	L3970*	L3972*	L3974*	L4380
L5311	L7266	L7272	L7274	L7500	Q0179	Q1003	Q2040*	Q2041*	Q2042*
Q2044*	S0181	S0625	S2270	S2344	S3628	S3905	S9075		

The procedure codes indicated with an asterisk (*) have been replaced. Replacement procedure codes are available for the Texas Medicaid Program, the CSHCN Services Program, or both. Providers may refer to the “Replacement Procedure Codes” section below for details.

The following informational reporting procedure codes have been discontinued:

Procedure Codes									
0141T	0142T	0143T	0155T	0156T	0157T	0158T	0166T	0167T	0168T
4002F	4006F	4009F	4275F						

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413. ■

Replacement Procedure Codes

Effective for dates of service on or after January 1, 2012, the following discontinued procedure codes will be replaced by the corresponding replacement procedure codes:

Replacement codes	Discontinued codes	Medicaid Rate	CSHCN Rate	Authorization Requirement
E2626	L3964	\$455.78	\$455.78	CSHCN
E2627	L3965	\$789.09	\$789.09	MD, CSHCN
E2628	L3966	\$538.63	\$538.63	MD, CSHCN
E2629	L3968	\$719.75	\$719.75	MD, CSHCN

Replacement codes	Discontinued codes	Medicaid Rate	CSHCN Rate	Authorization Requirement
E2630	L3969	\$524.41	\$524.41	MD, CSHCN
E2631	L3970	\$208.60	\$208.60	MD, CSHCN
E2632	L3972	\$176.47	\$176.47	MD, CSHCN
E2633	L3974	\$141.39	\$141.39	MD, CSHCN
J0490	Q2044	\$39.66	NC	None
J0588	Q2040	\$5.64	\$5.64	None
J0840	C9274	\$1,689.12	NC	None
J0897	C9272	\$14.52	\$14.52	None
J1557	C9270	\$37.30	\$37.30	None
J1725	Q2042	\$2.96	NC	None
J2507	C9281	\$293.25	NC	None
J7183	Q2041	\$0.88	NC	None
J9043	C9276	\$141.33	NC	None
J9179	C9280	\$901.00	NC	None

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413. ■

Procedure Code Description Changes

Effective for dates of service on or after January 1, 2012, the following procedure code descriptions have changed:

Procedure Codes									
15150	15151	15152	15155	15156	15157	22520	22521	22522	22610
22612	27096	29581	29826	29880	29881	32100	32110	32120	32124
32140	32141	32150	32151	32160	32405	32440	32442	32445	32480
32482	32484	32486	32488	32491	32601	32655	32663	33050	33206
33207	33208	33212	33213	33218	33220	33224	33225	33226	33233
33240	33241	33249	33960	33961	36200	36245	36246	36247	36248
38208	38209	38230	38746	38792	39200	39220	39400	47000	62287
62310	62311	62318	62319	62367	63020	63030	63035	64553	64555
64561	64565	64575	64580	64581	64585	70355	72114	72120	75962
75964	77003	77470	78580	86703	88312	88313	88314	88319	90460
90461	90581	90644	90867	90868	91010	91013	92587	92588	92605
92621	93561	93562	95970	95971	95972	95973	95974	95975	95990
95991	96110	96111	96367	99218	99219	99220	99354	99355	99356
99357	99358	99359	E0637	E0638	E0641	E0642	E0691	G0406	G0407
G0408	G0425	G0426	G0427	G8431	G8432	G8433	G8482	G8509	G8510
G8511	G8539	G8542	G8553	G8573	G8574	G8575	G8576	G8577	G8578
G8580	G8583	G8586	G8605	G8608	G8611	G8614	G8617	G8620	G8623
G8626	J0129	J0220	J0256	J1561	L2005	L6000	L6010	L6020	L7368
S9900									

The descriptions of the following informational reporting procedure codes have changed:

Reporting Procedure Codes - Informational							
0080T	0240T	0241T	0260T	0261T	3111F	3112F	4004F

Providers must contact the appropriate copyright holder to obtain procedure code descriptions.

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413. ■

Modifiers

The following table lists new and revised modifiers:

New Modifier
PD
Revised Modifier
SC

New modifier PD is effective for dates of service on or after January 1, 2012. Providers may contact the appropriate copyright holder to obtain modifier description. ■

AUTHORIZATION CHANGES

Authorization or Prior Authorization

For procedure codes that require authorization or prior authorization but are awaiting a rate hearing and approval of expenditures, providers must follow the established authorization or prior authorization processes as defined in the following:

- 2011 *Texas Medicaid Provider Procedures Manual*
- 2012 *CSHCN Services Program Provider Manual*
- Bi-monthly *Texas Medicaid Bulletin* (which contains updates to the *Texas Medicaid Provider Procedures Manual*)

Providers must obtain a timely authorization or prior authorization for the service that they provide. Services that are submitted without the proper authorization will be denied. Providers are responsible for meeting all filing deadlines and for ensuring that the authorization or prior authorization number appears on the claim or that the appropriate documentation is submitted with the claim. Retroactive authorization requests for certain services will not be granted, unless otherwise indicated in the applicable authorization requirements sections of the 2011 *Texas Medicaid Provider Procedures Manual*, or the 2012 *CSHCN Services Program Provider Manual*.

The procedure codes that require authorization or prior authorization are indicated in the Authorization Requirements column of the 2012 HCPCS Procedure Code Additions table that begins on page 29 of this bulletin.

Important: *Authorization or prior authorization is a condition for reimbursement; it is not a guarantee of payment.* ■

Prior Authorization Update

Providers must update current authorizations for procedure codes that are discontinued on or after January 1, 2012, if the dates of service on the authorization occur on, after, or encompass January 1, 2012. Providers must contact the TMHP Prior Authorization Department to update the procedure codes that are prior authorized for those services.

For a list of Prior Authorization Department telephone numbers, providers may refer to the “TMHP Telephone and Address Guide” in the 2011 *Texas Medicaid Provider Procedures Manual, Vol. 1, General Information*, on page vii, and “TMHP-CSHCN Services Program Contact Information” in the January 2012 *CSHCN Services Program Provider Manual*, Section 1.1, on page 1-2.

Replacement procedure codes listed in the following table will be updated by TMHP and require no action on the part of the provider:

Procedure Code	Program
J7312 (Replacing C9256)	CSHCN, MD, MC
CSHCN = Prior authorization required for the CSHCN Services Program, MD = Prior authorization required for Texas Medicaid, MC = Managed care prior authorization required.	



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Texas Medicaid

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