HCPCS Special Bulletin

2015 Healthcare Common Procedure Coding System (HCPCS) Special Bulletin

JANUARY 2015 NO. 7

2015 HCPCS Implementation

On January 1, 2015, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2015 annual Healthcare Common Procedure Coding System (HCPCS) updates that are effective for dates of service on or after January 1, 2015.

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 2015 updates for HCPCS and Current Procedural Terminology (CPT®).

All providers are encouraged to review the General Information Section of this bulletin. Policy updates for a specific program or provider type are discussed in the 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.

All new, revised, and discontinued 2015 HCPCS procedure codes are effective for dates of service on or after January 1, 2015. 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 19 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 banner message or web article 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

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INSIDE

Texas Medicaid Benefit Changes

The following Texas Medicaid benefit changes have been made to support the 2015 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2015. For more information, call the Texas Medicaid & Healthcare Partnership (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 articles in this bulletin 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, 2014.
- ***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, 2014, and the replacement procedure codes are effective for dates of service on or after January 1, 2015. Not all discontinued procedure codes have direct replacements.

Anesthesia Reimbursement

Discontinued Procedure Codes	
00452	00622

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.6, "Anesthesia," for additional information.

Blood Factor Products

Added Procedure Codes			
C9136	J7181	J7200	J7201
Discontinued Procedure Code			
C9133			

Limitations for added procedure codes: Procedure codes C9136, J7181, J7200, and J7201 may be reimbursed as follows:

- To physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), and physician providers for services rendered in the office setting
- To hospital providers for services rendered in the outpatient hospital setting

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.39.8, "Blood Factor Products," for additional information.

Brachytherapy

Added Procedure Codes		
77316	77317	77318

Limitations for added procedure codes: Procedure codes 77316, 77317, and 77318 may be reimbursed as follows:

- The total component may be reimbursed to physician providers and radiation treatment center providers for services rendered in the office setting. Services rendered in the outpatient hospital setting may be reimbursed to radiation treatment center and hospital providers.
- The professional component may be reimbursed to physician and radiation treatment center providers for services rendered in the office and outpatient hospital settings. Services rendered in the inpatient hospital setting may be reimbursed to physician providers.
- The technical component may be reimbursed to physician and radiation treatment center providers for services rendered in the office setting. Services rendered in the outpatient hospital setting may be reimbursed to radiation treatment center providers.

Diagnostic Endoscopies

Added Procedure Codes				
44406	44407	G6021	G6027	G6028
Discontinued Procedure Codes				
45355	C9735			

Limitations for added procedure codes: Procedure code G6021, G6027, and G6028 may be reimbursed to physician providers in the office, inpatient, and outpatient hospital settings.

Procedure codes 44406 and 44407 may be reimbursed as follows:

- To physician providers in the office, inpatient, and outpatient hospital settings
- To ambulatory surgical center (ASC) providers in the outpatient hospital setting

Doctor of Dentistry Services as a Limited Physician

Discontinued Procedure Code
42508

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, Section 9.3, "Doctor of Dentistry Practicing as a Limited Physician," and the *Children's Services Handbook*, subsection 4.1.4, "Doctor of Dentistry Practicing as a Limited Physician," for additional information.

Evoked Response Tests and Neuromuscular Procedures

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with a modifier, that indicates a distinct procedural service.

Use the following most descriptive HCPCS modifier when appropriate: XE, XP, XS, or XU. Modifier 59 should be used only when modifier XE, XP, XS, or XU is not appropriate.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians and Physician Assistants Handbook*, subsection 9.2.28, "Evoked Response Tests and Neuromuscular Procedures," for additional information.

Extracorporeal Membrane Oxygenation (ECMO)

Added Procedure Codes									
33946	33947	33948	33949	33951	33952	33953	33954	33955	33956
33957	33958	33959	33962	33963	33964	33965	33966	33969	33984
33985	33986	33987	33988	33989					
Discontinued Procedure Codes									
33960	33961	36822							

Limitations for added procedure codes: The above procedure codes may be reimbursed to physician providers in the inpatient hospital setting.

Procedure codes 33946, 33947, 33948, and 33949 are limited to one per day, any provider.

Procedure code 33946 will be denied as part of procedure code 33948 if billed by any provider on the same date of service. Procedure code 33947 will be denied as part of procedure code 33949 if billed by any provider on the same date of service.

Procedure codes 33951, 33952, 33953, 33954, 33955, and 33956 will not be reimbursed when submitted with the same date of service as procedure code 33946, 33947, 33948, or 33949.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.29, "Extracorporeal Membrane Oxygenation (ECMO)," for additional information.

Genetic Testing for Colorectal Cancer

Added Procedure Code
81288

Limitations for added procedure code: Procedure code 81288 may be reimbursed to independent laboratory providers in the laboratory setting.

Procedure code 81288 is limited to one service per lifetime, any provider.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.15.3, "Genetic Testing for Colorectal Cancer," for additional information.

Hyperbaric Oxygen Therapy

Added Procedure Code
G0277
Discontinued Procedure Code
C1300

Limitations for added procedure code: Procedure code G0277 may be reimbursed to hospital providers for services rendered in the outpatient hospital setting.

Procedure code G0277 will require prior authorization before the date the service is initiated, and must be billed with revenue code B-413 on the same claim. If procedure code G0277 is not on the same claim as revenue code B-413, the claim will be denied.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Inpatient and Outpatient Hospital Services Handbook*, subsection 4.2.13, "Hyperbaric Oxygen Therapy (HBOT)," and the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.33, "Hyperbaric Oxygen Therapy (HBOT)," for additional information.

Intravenous (IV) Therapy and Supplies

Added Procedure Code
A4602

Limitations for added procedure code: Procedure code A4602 may be reimbursed to home health DME and medical supplier (DME) providers in the home setting.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*, subsection 2.2.11.5, "External Insulin Pump and Supplies," subsection 2.2.14, "Intravenous (IV) Therapy Equipment and Supplies," and subsection 2.2.14.1, "Prior Authorization," for additional information.

Iron Injections

Added Procedure Code
J1439

Limitations for added procedure code: Procedure code J1439 may be reimbursed as follows:

- To PA, NP, CNS, and physician providers for services rendered in the office setting
- To hospital providers for services rendered in the outpatient hospital setting

Ferric carboxymaltose (J1439) may be indicated for, but is not limited to, treatment of iron deficiency anemia for adult clients with:

- Intolerance or unsatisfactory response to oral iron
- Non-dialysis-dependent chronic kidney disease

Providers may refer to the T*exas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physicians Assistants Handbook*, subsection 9.2.39, "Medications - Injectable," for additional information.

Joint Injections and Trigger Point Injections

Added Procedure Codes		
20604	20606	20611

Limitations for added procedure codes: Procedure codes 20604, 20606, and 20611 may be reimbursed as follows:

- To PA, NP, CNS, physician, dentists practicing as a limited physician, and podiatrist providers for services rendered in the office, inpatient, and outpatient hospital settings
- To ASC providers for services rendered in the outpatient hospital setting

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.39.19, "Joint Injections and Trigger Point Injections," for additional information.

Neurostimulators and Neuromuscular Stimulators

Added Procedure Code
L8696
Discontinued Procedure Code
61875

Limitations for added procedure code: Procedure code L8696 may be reimbursed as follows:

- To physician providers for services rendered in the office setting
- To home health DME and medical supplier (DME) providers for services rendered in the home setting
- To hospital providers for services rendered in the outpatient hospital setting

Procedure code L8696 may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the last 5 years.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.44, "Neurostimulators," for additional information.

Outpatient Behavioral Health Services

Discontinued Procedure Code
M0064

Note: *Pharmacological management and oversight must be billed using the most appropriate evaluation and management (E/M) procedure code as part of the E/M visit.*

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Behavioral Health, Rehabilitation, and Case Management Services Handbook*, Section 6.4, "Outpatient Behavioral Health Services," and Section 6.8, "Pharmacological Regimen Oversight," for additional information.

Prognostic Breast and Gynecological Cancer Studies

Added Procedure Codes								
81519	88341	88344	88364	88366	88369	88373	88374	88377

Limitations for added procedure codes: Procedure codes 88341, 88344, 88364, 88366, 88369, 88373, 88374, and 88377 may be reimbursed as follows:

- To physician providers for services rendered in the office setting
- To hospital providers for services rendered in the outpatient hospital setting
- To laboratory providers for services rendered in the independent laboratory setting

Procedure code 88341 is an add-on code and must be billed along with primary procedure code 88342.

Procedure code 88364 is an add-on code and must be billed along with primary procedure code 88365.

Procedure code 88369 is an add-on code and must be billed along with primary procedure code 88368.

Procedure code 88373 is an add-on code and must be billed along with primary procedure code 88367.

Procedure code 81519 may be reimbursed for female clients as follows:

- To physician providers for services rendered in the office setting
- To hospital providers for services rendered in the outpatient hospital setting
- To physician and laboratory providers for services rendered in the independent laboratory setting

Procedure code 81519 is limited to the following diagnosis codes:

Diagnosis Codes									
1740	1741	1742	1743	1744	1745	1746	1748	1749	2330
V860									

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.15.5, "Prognostic Breast and Gynecological Cancer Studies," for additional information.

Screening and Diagnostic Studies of the Breast

Added Procedure Codes	
76641	76642
Discontinued Procedure Code	
76645	

Limitations for added procedure codes: Procedure codes 76641 and 76642 may be reimbursed as follows:

- The total component rendered in the office setting may be reimbursed to PA, NP, CNS, and physician providers; services rendered in the outpatient hospital setting may be reimbursed to hospital providers.
- The professional component may be reimbursed to PA, NP, CNS, and physician providers in the office setting; services rendered in the inpatient hospital and outpatient hospital settings may be reimbursed to physician providers.

- The technical component may be reimbursed to PA, NP, CNS, physician, portable x-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.15.4, "Mammography (Screening and Diagnostic Studies of the Breast)," for additional information.

Stereotactic Radiosurgery

Added Procedure Code	
G6002	
Discontinued Procedure Code	
77421	G0251

Limitations for added procedure code: Procedure code G6002 may be reimbursed as follows:

- To physician and radiation treatment center providers for services rendered in the office setting.
- To radiation treatment centers and hospital providers for services rendered in the outpatient hospital setting.
- To physician providers for professional component services rendered in the office, inpatient, and outpatient hospital settings.
- To physician and radiation treatment center providers for technical component services rendered in the office setting.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.63.2.1, "Prior Authorization for Stereotactic Radiosurgery," and the *Inpatient and Outpatient Hospital Services Handbook*, subsection 4.2.9, "Computated Tomography and Magnetic Resonance Imaging," for additional information.

Telemedicine and Telehealth Services

Added Procedure Code
M0064

Note: *Pharmacological management and oversight must be billed using the most appropriate evaluation and management (E/M) procedure code as part of the E/M visit.*

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Telecommunication Services Handbook*, subsection 3.1.1, "Distant Site," for additional information.

Vaccines and Toxoids

Added Procedure Code
90630

Limitations for added procedure code: Procedure code 90630 may be reimbursed for clients who are 21 years of age and older as follows:

- To PA, NP, CNS, certified nurse midwife (CNM), physician, comprehensive care program (CCP), pharmacist, federally qualified health center (FQHC), and Texas Health Steps (THSteps) medical providers for services rendered in the office setting
- To PA, NP, CNS, physician, CCP, FQHC, and THSteps medical providers for services rendered in the home setting

CCP Services Benefit Changes

The following Texas Medicaid CCP benefit changes have been made to support the 2015 HCPCS and CPT updates and are effective for dates of service on or after January 1, 2015. For more information, call the TMHP Contact Center at 1-800-925-9126.

Orthoses CCP

Added Procedure Code
L3981

Limitations for added procedure code: Procedure code L3981 requires prior authorization and may be reimbursed for clients who are birth through 20 years of age as follows:

- To orthotist and medical supplier (DME) providers in the home setting
- To hospital providers in the outpatient hospital setting

Prosthesis CCP

Added Procedure Codes		
L6026	L7259	
Discontinued Procedure Codes		
L6025	L7260	L7261

Limitations for added procedure code: Procedure codes L6026 and L7259 require prior authorization and may be reimbursed for clients who are birth through 20 years of age to prosthetist and medical supplier (DME) providers in the home setting.

Screening Brief Intervention and Referral to Treatment (SBIRT) CCP

Discontinued Procedure Code
M0064

Note: *Pharmacological management and oversight must be billed using the most appropriate evaluation and management (E/M) procedure code as part of the E/M visit.*

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Behavioral Health, Rehabilitation, and Case Management Services Handbook*, Section 7.5, "Reimbursement and Limitations," for additional information. ■

Anesthesia Services

Discontinued Procedure Codes	
00452	00622

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 31.2.4, "Anesthesia Services," for additional information.

Behavioral Health

Discontinued Procedure Code
M0064

Note: *Pharmacological management and oversight must be billed using the most appropriate evaluation and management (E/M) procedure code as part of the E/M visit.*

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 29.2.4, "Pharmacological Regimen Oversight Documentation," and subsection 29.2.9, "Pharmacological Regimen Oversight and Pharmacological Management," for additional information.

Cleft-Craniofacial Services

Discontinued Procedure Codes
62116

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 14.2.7.3, "Cleft/Craniofacial Surgery by a Dentist Physician," and subsection 31.2.36.11, "Cleft/Craniofacial Procedures," for additional information.

Dental – Therapeutic Services

Added Procedure Code				
D6549				
Discontinued Procedure Codes				
D6053	D6054	D6078	D6079	D6975

Limitations for added procedure code: Procedure code D6549 may be reimbursed for clients who are 16 through 20 years of age to dental and FQHC providers for services rendered in the office, inpatient, and outpatient hospital settings.

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 14.2.2.5, "Radiographs or Diagnostic Imaging," for additional information.

Diabetic Equipment and Supplies

Added Procedure Code
A4602

Limitations for added procedure code: Procedure code A4602 may be reimbursed to home health DME, medical supplier (DME), and custom DME providers in the home setting.

Procedure code A4602 is limited to 1 per 6 months.

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 15.2.2, "Insulin Pump," for additional information.

Doctor of Dentistry Services as a Limited Physician

Discontinued Procedure Code
42508

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 14.2.7, "Doctor of Dentistry Services as a Limited Physician," for additional information.

Evoked Response Tests and Neuromuscular Procedures

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with a modifier that indicates a distinct procedural service.

Use the following most descriptive HCPCS modifier when appropriate: XE, XS, XP, or XU. Modifier 59 should be used only when modifier XE, XP, XS, or XU is not appropriate.

Providers may refer to the *CSHCN Services Program Provider Manual*, Section 31, "Evoked Response Tests and Neuromuscular Procedures," for additional information.

Genetic Testing for Colorectal Cancer

Added Procedure Code
81288

Limitations for added procedure code: Procedure code 81288 may be reimbursed to independent laboratory providers in the laboratory setting.

Procedure code 81288 is limited to one service per lifetime, any provider.

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 25.2.5.2, "Genetic Testing for Colorectal Cancer," for additional information.

Hyperbaric Oxygen Therapy

Added Procedure Code
G0277
Discontinued Procedure Code
C1300

Limitations for added procedure code: Procedure code G0277 may be reimbursed to hospital providers for services rendered in the outpatient hospital setting.

Prior authorization is required for procedure code G0277.

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 24.4.1.6, "Hyperbaric Oxygen Therapy," subsection 31.2.22, "Hyperbaric Oxygen Therapy (HBOT)," and subsection 31.2.22.1, "Prior Authorization Requirements," for additional information.

Medications Blood Factor Products

Added Procedure Codes			
C9136	J7181	J7200	J7201
Discontinued Procedure Code			
C9133	C9134		

Limitations for added procedure codes: Procedure codes C9136 and J7201 may be reimbursed as follows:

- To PA, APRN, and physician providers for services rendered in the office setting
- To medical supplier (DME) and hemophilia factor providers in the home setting
- To hospital providers in the outpatient hospital setting

Procedure codes C9136 and J7201 are restricted to diagnosis codes 2860 and 2863.

Procedure codes J7181 and J7200 may be reimbursed as follows:

- To PA, APRN, and physician providers for services rendered in the office setting
- To medical supplier (DME) and hemophilia factor providers in the home setting
- To hospital providers in the outpatient hospital setting

Procedure codes J7181 and J7200 are restricted to diagnosis code 2863.

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 24.4.1.1 "Blood Factor Products," and subsection 31.2.8 "Blood Factor Products," for additional information.

Neurostimulators and Neuromuscular Stimulators

Added Procedure Code
L8696
Discontinued Procedure Codes
61875

Limitations for added procedure code: Procedure code L8696 may be reimbursed as follows:

- To home health DME, medical supplier (DME), and custom DME providers for services rendered in the home setting
- To hospital providers for services rendered in the outpatient hospital setting

Procedure code L8696 may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the last 5 years.

Providers may refer to the *CSHCN Services Program Provider Manual*, Section 27, "Neurostimulators and Neuromuscular Stimulators," for additional information.

Orthoses and Prostheses

Added Procedure Codes		
L3981	L6026	L7259

Discontinued Procedure Codes		
L6025	L7260	L7261

Limitations for added procedure codes: Procedure codes L3981, L6026, and L7259 require prior authorization and may be reimbursed to home health DME, orthotist, prosthetist, and medical supplier (DME) providers in the home setting.

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 28.4.2, "Prostheses Procedure Codes," for additional information.

Radiation Therapy Services

Added Procedure Codes									
77306	77307	77316	77317	77318	77385	77386	77387	G6002	G6003
G6004	G6005	G6006	G6007	G6008	G6009	G6010	G6011	G6012	G6013
G6014	G6015	G6016	G6017						
Discontinued Procedure Codes									
77305	77310	77315	77326	77327	77328	77403	77404	77406	77408
77409	77411	77413	77414	77416	77418	77421	G0251		

Limitations for added procedure codes: The added procedure codes listed in the table above for the total radiation therapy component may be reimbursed to physician and radiation treatment center providers for services rendered in the office setting and to radiation treatment center and hospital providers in the outpatient hospital setting.

Procedure codes 77306, 77307, 77316, 77317, 77318, and 77387 may be reimbursed for the professional component to physician providers in the office, inpatient hospital, and outpatient hospital settings.

Procedure codes 77306, 77307, 77316, 77317, 77318, and 77387 may be reimbursed for the technical component to physician and radiation treatment center providers for services rendered in the office setting and to radiation treatment center providers in the outpatient hospital setting.

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 33.2.3, "Intensity Modulated Radiation Therapy (IMRT)," subsection 33.2.8, "Stereotactic Radiosurgery," subsection 33.2.4, "Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services," and subsection 33.2.7, "Radiation Treatment Management and Delivery," for additional information.

Telemedicine and Telehealth Services

Discontinued Procedure Code
M0064

Note: *Pharmacological management and oversight must be billed using the most appropriate evaluation and management (E/M) procedure code as part of the E/M visit.*

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 37.2.1.1, "Distant Site," for additional information.

Vaccines and Toxoids

Added Procedure Code
90630

Limitations for added procedure code: Procedure code 90630 may be reimbursed for clients who are six months of age and older as follows:

- To PA, APRN, physician, and pharmacist providers for services rendered in the office setting
- To PA, APRN, and physician providers for services rendered in the home and other location settings
- To hospital providers for services rendered in the outpatient hospital setting

Providers may refer to the *CSHCN Services Program Provider Manual*, subsection 31.2.23.9, "Vaccine and Toxoid Procedure Codes," for additional information. ■

ALL CODE CHANGES: ADDED, REVISED, REPLACEMENT, AND DISCONTINUED

2015 HCPCS Procedure Code Additions

The following is a list of new Healthcare Common Procedure Coding System (HCPCS) procedure codes that do not replace existing codes:

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
2	20604	*	*		None	MD
F	20604	*	*		None	MD
2	20606	*	*		None	MD
F	20606	*	*		None	MD
2	20611	*	*		None	MD
F	20611	*	*		None	MD
2	20983	NC	NC		None	
F	20983	NC	NC		None	
2	21811	NC	NC		None	
8	21811	NC	NC		None	
2	21812	NC	NC		None	
8	21812	NC	NC		None	
2	21813	NC	NC		None	
8	21813	NC	NC		None	

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

MC in the Authorization Requirements column indicates that a Medicaid managed care prior authorization is required. None in the Authorization Requirements column indicates that authorization or prior authorization is not required.

MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
2	22510	*	*		None	
F	22510	*	*		None	
2	22511	*	*		None	
F	22511	*	*		None	
2	22512	*	*		None	
F	22513	*	*		None	
2	22514	*	*		None	
F	22514	*	*		None	
2	22515	*	*		None	
2	22858	NC	NC		None	
8	22858	NC	NC		None	
2	27279	NC	NC		None	
8	27279	NC	NC		None	
F	27279	NC	NC		None	
2	33270	NC	NC		None	
F	33270	NC	NC		None	
2	33271	NC	NC		None	
F	33271	NC	NC		None	
2	33272	NC	NC		None	
2	33273	NC	NC		None	
F	33273	NC	NC		None	
2	33418	NC	NC		None	
2	33419	NC	NC		None	
2	33946	*	NC		None	MD
2	33947	*	NC		None	MD
2	33948	*	NC		None	MD
2	33949	*	NC		None	MD
2	33951	*	NC		None	MD
2	33952	*	NC		None	MD
2	33953	*	NC		None	MD
2	33954	*	NC		None	MD
2	33955	*	NC		None	MD
2	33956	*	NC		None	MD
2	33957	*	NC		None	MD

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

MC in the Authorization Requirements column indicates that a Medicaid managed care prior authorization is required. None in the Authorization Requirements column indicates that authorization or prior authorization is not required.

MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
2	33958	*	NC		None	MD
2	33959	*	NC		None	MD
2	33962	*	NC		None	MD
2	33963	*	NC		None	MD
2	33964	*	NC		None	MD
2	33965	*	NC		None	MD
2	33966	*	NC		None	MD
2	33969	*	NC		None	MD
2	33984	*	NC		None	MD
2	33985	*	NC		None	MD
2	33986	*	NC		None	MD
2	33987	*	NC		None	MD
2	33988	*	NC		None	MD
2	33989	*	NC		None	MD
2	34839	*	*		None	
2	37218	*	*		None	
2	43180	*	*		None	
F	43180	*	*		None	
2	44381	*	*		None	
F	44381	*	*		None	
2	44384	NC	NC		None	
F	44384	NC	NC		None	
2	44401	NC	NC		None	
F	44401	NC	NC		None	
2	44402	NC	NC		None	
F	44402	NC	NC		None	
2	44403	*	*		None	
F	44403	*	*		None	
2	44404	*	*		None	
F	44404	*	*		None	
2	44405	*	*		None	
F	44405	*	*		None	
2	44406	*	*		None	MD
F	44406	*	*		None	MD

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
2	44407	*	*		None	MD, CSHCN
F	44407	*	*		None	MD, CSHCN
2	44408	*	*		None	
F	44408	*	*		None	
2	45346	*	*		None	
F	45346	*	*		None	
2	45347	*	*		None	
F	45347	*	*		None	
2	45349	*	*		None	
F	45349	*	*		None	
2	45350	*	*		None	
F	45350	*	*		None	
2	45388	*	*		None	
F	45388	*	*		None	
2	45389	*	*		None	
F	45389	*	*		None	
2	45390	*	*		None	
F	45390	*	*		None	
2	45393	*	*		None	
F	45393	*	*		None	
2	45398	*	*		None	
F	45398	*	*		None	
2	45399	NC	NC		None	
2	46601	NC	NC		None	
2	46607	NC	NC		None	
F	46607	NC	NC		None	
2	47383	*	*		None	
F	47383	*	*		None	
2	52441	NC	NC		None	
2	52442	NC	NC		None	
2	62302	*	*		None	
2	62303	*	*		None	
2	62304	*	*		None	
2	62305	*	*		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
2	64486	NC	NC		None	
2	64487	NC	NC		None	
2	64488	NC	NC		None	
2	64489	NC	NC		None	
2	66179	*	*		None	
8	66179	*	*		None	
F	66179	*	*		None	
2	66184	*	*		None	
8	66184	*	*		None	
F	66184	*	*		None	
4	76641	*	*	EPHC	None	MD
I	76641	*	*	EPHC	None	MD
T	76641	*	*	EPHC	None	MD
4	76642	*	*	EPHC	None	MD
I	76642	*	*	EPHC	None	MD
T	76642	*	*	EPHC	None	MD
4	77061	NC	NC		None	
I	77061	NC	NC		None	
T	77061	NC	NC		None	
4	77062	NC	NC		None	
I	77062	NC	NC		None	
T	77062	NC	NC		None	
4	77063	NC	NC		None	
I	77063	NC	NC		None	
T	77063	NC	NC		None	
4	77085	*	*	EPHC	None	
I	77085	*	*	EPHC	None	
T	77085	*	*	EPHC	None	
4	77086	*	*	EPHC	None	
I	77086	*	*	EPHC	None	
T	77086	*	*	EPHC	None	
6	77306	*	*		None	CSHCN
I	77306	*	*		None	CSHCN
T	77306	*	*		None	CSHCN

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
6	77307	*	*		None	CSHCN
I	77307	*	*		None	CSHCN
T	77307	*	*		None	CSHCN
6	77316	*	*		None	MD, CSHCN
I	77316	*	*		None	MD, CSHCN
T	77316	*	*		None	MD, CSHCN
6	77317	*	*		None	MD, CSHCN
I	77317	*	*		None	MD, CSHCN
T	77317	*	*		None	MD, CSHCN
6	77318	*	*		None	MD, CSHCN
I	77318	*	*		None	MD, CSHCN
T	77318	*	*		None	MD, CSHCN
6	77385	*	*		None	CSHCN
6	77386	*	*		None	CSHCN
6	77387	*	*		None	CSHCN
I	77387	*	*		None	CSHCN
T	77387	*	*		None	CSHCN
5	80163	*	*	EPHC	None	
5	80165	*	*	EPHC	None	
5	80300	*	*	EPHC	None	
5	80301	*	*	EPHC	None	
5	80302	*	*	EPHC	None	
5	80303	*	*	EPHC	None	
5	80304	*	*	EPHC	None	
5	80320	*	*	EPHC	None	
5	80321	*	*	EPHC	None	
5	80322	*	*	EPHC	None	
5	80323	*	*	EPHC	None	
5	80324	*	*	EPHC	None	
5	80325	*	*	EPHC	None	
5	80326	*	*	EPHC	None	
5	80327	*	*	EPHC	None	
5	80328	*	*	EPHC	None	
5	80329	*	*	EPHC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
5	80330	*	*	EPHC	None	
5	80331	*	*	EPHC	None	
5	80332	*	*	EPHC	None	
5	80333	*	*	EPHC	None	
5	80334	*	*	EPHC	None	
5	80335	*	*	EPHC	None	
5	80336	*	*	EPHC	None	
5	80337	*	*	EPHC	None	
5	80338	*	*	EPHC	None	
5	80339	*	*	EPHC	None	
5	80340	*	*	EPHC	None	
5	80341	*	*	EPHC	None	
I	80341	*	*	EPHC	None	
T	80341	*	*	EPHC	None	
5	80342	*	*	EPHC	None	
I	80342	*	*	EPHC	None	
T	80342	*	*	EPHC	None	
5	80343	*	*	EPHC	None	
5	80344	*	*	EPHC	None	
5	80345	*	*	EPHC	None	
5	80346	*	*	EPHC	None	
5	80347	*	*	EPHC	None	
5	80348	*	*	EPHC	None	
5	80349	*	*	EPHC	None	
5	80350	*	*	EPHC	None	
5	80351	*	*	EPHC	None	
5	80352	*	*	EPHC	None	
5	80353	*	*	EPHC	None	
5	80354	*	*	EPHC	None	
5	80355	*	*	EPHC	None	
5	80356	*	*	EPHC	None	
5	80357	*	*	EPHC	None	
5	80358	*	*	EPHC	None	
5	80359	*	*	EPHC	None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
5	80360	*	*	EPHC	None	
5	80361	*	*	EPHC	None	
5	80362	*	*	EPHC	None	
5	80363	*	*	EPHC	None	
5	80364	*	*	EPHC	None	
5	80365	*	*	EPHC	None	
5	80366	*	*	EPHC	None	
5	80367	*	*	EPHC	None	
5	80368	*	*	EPHC	None	
5	80369	*	*	EPHC	None	
5	80370	*	*	EPHC	None	
5	80371	*	*	EPHC	None	
5	80372	*	*	EPHC	None	
5	80373	*	*	EPHC	None	
5	80374	*	*	EPHC	None	
5	80375	*	*	EPHC	None	
5	80376	*	*	EPHC	None	
5	80377	*	*	EPHC	None	
5	81246	*	*		None	
5	81288	*	*		None	MD, CSHCN
5	81313	*	*		None	
5	81410	*	*		None	
5	81411	*	*		None	
5	81415	NC	NC		None	
5	81416	NC	NC		None	
5	81417	NC	NC		None	
5	81420	NC	NC	EPHC	None	
5	81425	NC	NC		None	
5	81426	NC	NC		None	
5	81427	NC	NC		None	
5	81430	NC	NC		None	
5	81431	NC	NC		None	
5	81435	NC	NC		None	
5	81436	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
5	81440	NC	NC		None	
5	81445	NC	NC		None	
5	81450	NC	NC		None	
5	81455	NC	NC		None	
5	81460	NC	NC		None	
5	81465	NC	NC		None	
5	81470	NC	NC		None	
5	81471	NC	NC		None	
5	81519	*	*		None	MD
5	83006	*	*	EPHC	None	
5	87505	*	*	EPHC	None	
5	87506	*	*	EPHC	None	
5	87507	*	*	EPHC	None	
5	87623	*	*	EPHC	None	
5	87624	*	*	EPHC	None	
5	87625	*	*	EPHC	None	
5	87806	*	*	EPHC	None	
5	88341	*	*	EPHC	None	MD
I	88341	*	*	EPHC	None	MD
T	88341	*	*	EPHC	None	MD
5	88344	*	*	EPHC	None	MD
I	88344	*	*	EPHC	None	MD
T	88344	*	*	EPHC	None	MD
5	88364	*	*		None	MD
I	88364	*	*		None	MD
T	88364	*	*		None	MD
5	88366	*	*		None	MD
I	88366	*	*		None	MD
T	88366	*	*		None	MD
5	88369	*	*		None	MD
I	88369	*	*		None	MD
T	88369	*	*		None	MD
5	88373	*	*		None	MD
I	88373	*	*		None	MD

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
T	88373	*	*		None	MD
5	88374	*	*		None	MD
I	88374	*	*		None	MD
T	88374	*	*		None	MD
5	88377	*	*		None	MD
I	88377	*	*		None	MD
T	88377	*	*		None	MD
5	89337	NC	NC		None	MD, CSHCN
1	90630	*	*		None	MD, CSHCN
S	90630	*	NC		None	
1	90651	NC	NC		None	
S	90651	NC	NC		None	
5	91200	NC	NC		None	
I	91200	NC	NC		None	
T	91200	NC	NC		None	
5	92145	NC	NC		None	
I	92145	NC	NC		None	
T	92145	NC	NC		None	
2	93260	*	*		None	
I	93260	*	*		None	
T	93260	*	*		None	
2	93261	*	*		None	
I	93261	*	*		None	
T	93261	*	*		None	
4	93355	*	*		None	
2	93644	*	*		None	
I	93644	*	*		None	
T	93644	*	*		None	
1	93702	NC	NC		None	
4	93895	NC	NC		None	
1	96127	NC	NC		None	
1	97607	NC	NC		None	
1	97608	NC	NC		None	
1	99184	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
1	99188	NC	NC		None	
1	99490	NC	NC		None	
1	99497	NC	NC		None	
1	99498	NC	NC		None	
9	A4459	NC	NC		None	
9	A4602	*	*		None	MD, CSHCN
9	A7048	*	*		None	
9	A9606	*	*		None	
9	C2624	NC	NC		None	
9	C2644	NC	NC		None	
1	C9025	*	*		None	
1	C9026	*	*		None	
1	C9027	NC	NC		None	
1	C9136	*	*		None	MD, CSHCN
1	C9349	NC	NC		None	
1	C9442	*	*		None	
1	C9443	NC	NC		None	
1	C9444	NC	NC		None	
1	C9446	*	*		None	
1	C9447	NC	NC		None	
2	C9742	NC	NC		None	
W	D0171	NC	NC		None	
W	D0351	*	*		None	
W	D1353	NC	NC		None	
W	D6110	NC	NC		None	
W	D6111	NC	NC		None	
W	D6112	NC	NC		None	
W	D6113	NC	NC		None	
W	D6114	NC	NC		None	
W	D6115	NC	NC		None	
W	D6116	NC	NC		None	
W	D6117	NC	NC		None	
W	D6549	*	*		MD, CSHCN	MD, CSHCN
W	D9219	NC	NC		None	
W	D9931	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
W	D9986	Informational Only	Informational Only		None	
W	D9987	*	*		None	
1	G0276	NC	NC		None	
1	G0277	*	*		MD, CSHCN	MD, CSHCN
I	G0279	NC	NC		None	
T	G0279	NC	NC		None	
5	G0464	NC	NC		None	
1	G0466	*	*		None	
1	G0467	*	*		None	
1	G0468	*	*		None	
1	G0469	*	*		None	
1	G0470	*	*		None	
5	G0471	NC	NC		None	
5	G0472	NC	NC		None	
1	G0473	NC	NC		None	
6	G6001	*	*		None	
I	G6001	*	*		None	
T	G6001	*	*		None	
6	G6002	*	*		None	MD, CSHCN
I	G6002	*	*		None	MD, CSHCN
T	G6002	*	*		None	MD, CSHCN
6	G6003	*	*		None	
6	G6004	*	*		None	CSHCN
6	G6005	*	*		None	CSHCN
6	G6006	*	*		None	CSHCN
6	G6007	*	*		None	CSHCN
6	G6008	*	*		None	CSHCN
6	G6009	*	*		None	CSHCN
6	G6010	*	*		None	CSHCN
6	G6011	*	*		None	CSHCN
6	G6012	*	*		None	CSHCN
6	G6013	*	*		None	CSHCN
6	G6014	*	*		None	CSHCN

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
6	G6015	*	*		None	CSHCN
6	G6016	*	*		None	CSHCN
6	G6017	*	*		None	CSHCN
2	G6018	*	*		None	
2	G6019	*	*		None	
2	G6020	*	*		None	
2	G6021	*	*		CSHCN	MD
2	G6022	NC	NC		None	
2	G6023	NC	NC		None	
2	G6024	NC	NC		None	
2	G6025	NC	NC		None	
2	G6027	*	*		None	MD
2	G6028	*	*		None	MD
5	G6030	NC	NC		None	
5	G6031	NC	NC		None	
5	G6032	NC	NC		None	
5	G6034	NC	NC		None	
5	G6035	NC	NC		None	
5	G6036	NC	NC		None	
5	G6037	NC	NC		None	
5	G6038	NC	NC		None	
5	G6039	NC	NC		None	
5	G6040	NC	NC		None	
5	G6041	NC	NC		None	
5	G6042	NC	NC		None	
5	G6043	NC	NC		None	
5	G6044	NC	NC		None	
5	G6045	NC	NC		None	
5	G6046	NC	NC		None	
5	G6047	NC	NC		None	
5	G6048	NC	NC		None	
5	G6049	NC	NC		None	
5	G6050	NC	NC		None	
5	G6051	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
5	G6052	NC	NC		None	
5	G6053	NC	NC		None	
5	G6054	NC	NC		None	
5	G6055	NC	NC		None	
5	G6056	NC	NC		None	
5	G6057	NC	NC		None	
5	G6058	NC	NC		None	
1	G9362	NC	NC		None	
1	G9363	NC	NC		None	
1	G9364	NC	NC		None	
1	G9365	NC	NC		None	
1	G9366	NC	NC		None	
1	G9367	NC	NC		None	
1	G9368	NC	NC		None	
1	G9369	NC	NC		None	
1	G9370	NC	NC		None	
1	G9376	NC	NC		None	
1	G9377	NC	NC		None	
1	G9378	NC	NC		None	
1	G9379	NC	NC		None	
1	G9380	NC	NC		None	
1	G9381	NC	NC		None	
1	G9382	NC	NC		None	
1	G9383	NC	NC		None	
1	G9384	NC	NC		None	
1	G9385	NC	NC		None	
1	G9386	NC	NC		None	
1	G9389	NC	NC		None	
1	G9390	NC	NC		None	
1	G9391	NC	NC		None	
1	G9392	NC	NC		None	
1	G9393	NC	NC		None	
1	G9394	NC	NC		None	
1	G9395	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
1	G9396	NC	NC		None	
1	G9399	NC	NC		None	
1	G9400	NC	NC		None	
1	G9401	NC	NC		None	
1	G9402	NC	NC		None	
1	G9403	NC	NC		None	
1	G9404	NC	NC		None	
1	G9405	NC	NC		None	
1	G9406	NC	NC		None	
1	G9407	NC	NC		None	
1	G9408	NC	NC		None	
1	G9409	NC	NC		None	
1	G9410	NC	NC		None	
1	G9411	NC	NC		None	
1	G9412	NC	NC		None	
1	G9413	NC	NC		None	
1	G9414	NC	NC		None	
1	G9415	NC	NC		None	
1	G9416	NC	NC		None	
1	G9417	NC	NC		None	
1	G9418	NC	NC		None	
1	G9419	NC	NC		None	
1	G9420	NC	NC		None	
1	G9421	NC	NC		None	
1	G9422	NC	NC		None	
1	G9423	NC	NC		None	
1	G9424	NC	NC		None	
1	G9425	NC	NC		None	
1	G9426	NC	NC		None	
1	G9427	NC	NC		None	
1	G9428	NC	NC		None	
1	G9429	NC	NC		None	
1	G9430	NC	NC		None	
1	G9431	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
1	G9432	NC	NC		None	
1	G9433	NC	NC		None	
1	G9434	NC	NC		None	
1	G9435	NC	NC		None	
1	G9436	NC	NC		None	
1	G9437	NC	NC		None	
1	G9438	NC	NC		None	
1	G9439	NC	NC		None	
1	G9440	NC	NC		None	
1	G9441	NC	NC		None	
1	G9442	NC	NC		None	
1	G9443	NC	NC		None	
1	G9448	NC	NC		None	
1	G9449	NC	NC		None	
1	G9450	NC	NC		None	
1	G9451	NC	NC		None	
1	G9452	NC	NC		None	
1	G9453	NC	NC		None	
1	G9454	NC	NC		None	
1	G9455	NC	NC		None	
1	G9456	NC	NC		None	
1	G9457	NC	NC		None	
1	G9458	NC	NC		None	
1	G9459	NC	NC		None	
1	G9460	NC	NC		None	
1	G9463	NC	NC		None	
1	G9464	NC	NC		None	
1	G9465	NC	NC		None	
1	G9466	NC	NC		None	
1	G9467	NC	NC		None	
1	G9468	NC	NC		None	
1	G9469	NC	NC		None	
1	G9470	NC	NC		None	
1	G9471	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
1	G9472	NC	NC		None	
1	J0153	NC	NC		None	
1	J0571	NC	NC		None	
1	J0572	NC	NC		None	
1	J0573	NC	NC		None	
1	J0574	NC	NC		None	
1	J0575	NC	NC		None	
1	J0887	NC	NC		None	
1	J0888	NC	NC		None	
1	J1071	*	*		None	
1	J1322	*	*		None	
1	J1439	*	*		None	MD
1	J2274	NC	NC		None	
1	J2704	NC	NC		None	
1	J3121	*	*		None	
1	J3145	*	*		None	
1	J7181	*	*		None	MD, CSHCN
1	J7182	NC	NC		None	
1	J7200	*	*		None	MD, CSHCN
1	J7201	*	*		None	MD, CSHCN
1	J7327	NC	NC		None	
1	J7336	NC	NC		None	
1	J9267	*	*		None	
1	J9301	*	*		None	
9	L3981	*	*		MD, CSHCN	MD, CSHCN
9	L6026	*	*		MD, CSHCN	MD, CSHCN
9	L7259	*	*		MD, CSHCN	MD, CSHCN
9	L8696	*	*		MD, CSHCN	MD, CSHCN
1	Q4150	NC	NC		None	
1	Q4151	NC	NC		None	
1	Q4152	NC	NC		None	
1	Q4153	NC	NC		None	
1	Q4154	NC	NC		None	
1	Q4155	NC	NC		None	
1	Q4156	NC	NC		None	

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Other Allowable	Authorization Requirements	Benefit Changes
1	Q4157	NC	NC		None	
1	Q4158	NC	NC		None	
1	Q4159	NC	NC		None	
1	Q4160	NC	NC		None	
9	S1034	NC	NC		None	
9	S1035	NC	NC		None	
9	S1036	NC	NC		None	
9	S1037	NC	NC		None	
1	S9901	NC	NC		None	

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MC in the Authorization Requirements column indicates that a Medicaid managed care prior authorization is required. None in the Authorization Requirements column indicates that authorization or prior authorization is not required.

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Note: *All new, revised, and discontinued 2015 HCPCS procedure codes are effective for dates of service on or after January 1, 2015. 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 section in this bulletin titled Rate Hearings and Expenditure Review 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									
Medical Procedures									
0358T	0359T	0360T	0361T	0362T	0363T	0364T	0365T	0366T	0367T
0368T	0369T	0370T	0371T	0372T	0373T	0374T	0378T	0379T	0380T
0381T	0382T	0383T	0384T	0385T	0386T	0389T	0390T	0391T	3126F
3775F	3776F								
Surgical Procedures									
0347T	0356T	0375T	0376T	0377T	0387T	0388T			
Radiological Procedures									
0348T	0349T	0350T	0351T	0353T	0355T				
Laboratory Procedures									
0001M	0002M	0003M	0004M	0006M	0007M	0008M			
Other DME Procedure									
0357T									
Professional Component Procedures									
0352T	0354T								

For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413. ■

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Replacement Procedure Codes

Effective for dates of service on or after January 1, 2015, the following discontinued procedure codes will be replaced by the corresponding replacement procedure codes:

Replacement Codes	Discontinued Codes	Medicaid Rate	CSHCN Rate	Authorization Requirement
G0277	C1300	*	*	MD, CSHCN
G0431	80101	$15.90	*	None
J0887	Q9972	NC	NC	None
J0888	Q9973	NC	NC	None
J1322	C9022	*	*	None
J2274	Q9974	NC	NC	None
J2704	S0144	NC	NC	None
J3145	C9023	*	*	None
J7181	C9134	*	*	None
J7200	C9133	$1.71	$1.05	None
J7201	C9135	*	*	None
* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit				

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, 2015, the following procedure code descriptions have changed:

Procedure Codes									
20600	20605	20610	20982	27280	27370	33215	33218	33220	33223
33224	33225	33230	33231	33240	33241	33243	33244	33249	33262
33263	33264	37215	37216	37217	43194	43197	43215	43216	43247
44360	44363	44380	44382	44385	44386	44388	44389	44390	44391
44392	44799	45330	45332	45333	45334	45337	45340	45378	45379
45380	45381	45382	45384	45385	45386	45391	45392	46600	61055
62284	66180	66185	67399	77401	77402	77407	77412	80162	80164
80171	80299	81245	82541	82542	82543	82544	84600	86900	86901
86902	86904	86905	86906	87501	87502	87503	87631	87632	87633
88342	88360	88361	88365	88367	88368	90654	90723	90734	93282
93283	93284	93287	93289	93295	93296	93642	95972	96110	97605
97606	99487	99489	A4601	C9741	D0350	D0481	D1208	D1550	D2910
D2915	D2920	D3351	D4260	D4261	D6092	D6093	D6101	D6102	D6103
D6194	D6930	D7285	D7286	D7292	D7293	D7294	D8660	D8670	D8693
D9241	D9242	D9248	E0856	E0986	G0204	G0206	G0416	G8461	G8474

Procedure Codes									
G8476	G8477	G8483	G8484	G8571	G8572	G8720	G8840	G8843	G8861
G8876	G8924	G8936	G8968	G9160	G9163	G9166	G9169	G9172	G9175
G9186	G9210	G9242	G9277	G9278	G9296	G9297	G9298	G9299	G9303
G9304	G9329	G9340	G9341	G9342	G9343	G9344	G9345	G9346	G9347
J7195	J7301	L7367	Q4119	Q4147	S0183	V2799			

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

Reporting Procedure Codes - Informational		
4256F	0075T	0076T

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, revised, and discontinued modifiers:

New Modifiers		
XE	XS	
Revised Modifiers		
PO	XP	XU

New modifiers are effective for dates of service on or after January 1, 2015. Providers may contact the appropriate copyright holder to obtain modifier descriptions. ■

PRIOR 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:

- Current *Texas Medicaid Provider Procedures Manual*
- Current *CSHCN Services Program Provider Manual*
- Articles published on the Texas Medicaid & Healthcare Partnership (TMHP) web page at www.tmhp.com

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 autho-