PHYSICIAN

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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TEXAS
Health and Human
Services

PHYSICIAN

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31.1 Enrollment

Physicians, podiatrists, physician groups, and podiatry groups may enroll as Children with Special Healthcare Needs (CSHCN) Services Program providers by completing the provider enrollment application available through the Provider Enrollment and Management System (PEMS). Providers may also enroll or reenroll in the CSHCN Services Program online through PEMS. For assistance with the application process, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Option 2.

In this section the term "physician" means a doctor of medicine (MD), doctor of osteopathy (DO), or doctor of podiatric medicine (DPM).

Physicians must be actively enrolled as a Medicaid provider before enrolling in the CSHCN Services Program. "Actively enrolled" physicians are those that have filed claims for clients of the CSHCN Services Program or Texas Medicaid within the past 24 months, and that do not have any type of payment holds on their enrollment status. Physicians must be licensed by the Texas licensing board. Out-of-state physicians must meet all these conditions and be located in the United States, within 50 miles of the Texas state border.

Requests for medical services provided by an out-of-state provider more than 50 miles from the Texas state border must be submitted for consideration to TMHP at the address in Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities."

Refer to: Section 2.1.9, "Out-of-State Providers" in Chapter 2, "Provider Enrollment and Responsibilities" for more information about out-of-state services.

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC) Chapter 38, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

Section 2.1.5.1, "Types of Providers" in Chapter 2, "Provider Enrollment and Responsibilities" for additional information.

Section 3.1.4, "Services Provided Outside of Texas" in Chapter 3, "Client Benefits and Eligibility" for more detailed information about services provided outside of Texas.

31.1.1 Group Practices

Provider groups that are enrolled in Texas Medicaid can enroll in the CSHCN Services Program by completing an enrollment application. The CSHCN Services Program application must include the Medicaid group provider identifier and performing provider identifiers for all physicians in the group.

31.1.2 Changes in Provider Enrollment

If additions or changes occur in the provider's enrollment information after the enrollment process is completed, the provider must notify TMHP of the changes through PEMS.

Refer to: Section 2.1.2, "Changes in Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for additional information.

31.1.3 Substitute Physician

Physicians may bill for the services of a substitute physician who sees clients in the billing physician's practice under either a reciprocal or locum tenens arrangement.

A reciprocal arrangement is one in which a substitute physician covers for the billing physician on an occasional basis when the billing physician is unavailable to provide services. Reciprocal arrangements are limited to a continuous period no longer than 14 days and do not have to be in writing.

A *locum tenens* arrangement is one in which a substitute physician assumes the practice of a billing physician for a temporary period no longer than 90 days when the billing physician is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the Armed Forces. The locum tenens arrangement may be extended for a continuous period longer than 90 days if the billing physician's absence is due to being called or ordered to active duty as a member of a reserve component of the Armed Forces. *Locum tenens* arrangements must be in writing.

Substitute physicians are required to enroll with the CSHCN Services Program. Substitute physicians are also required to enroll with Texas Medicaid before enrolling in the CSHCN Services Program and cannot be on the Texas Medicaid provider exclusion list.

The billing provider's name, address, and national provider identifier must appear in Block 33 of the claim form. The name and mailing address of the substitute physician must be documented on the claim in Block 19, not Block 33. When a physician bills for a substitute physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a *locum tenens* arrangement.

31.2 Benefits, Limitations, and Authorization Requirements

Physician and podiatrist services include reasonable and medically necessary services that are ordered and performed by a physician or under the personal supervision of a physician and that are within the scope of practice of his or her profession, as defined by state law. The physician must examine the client, make a diagnosis, establish a plan of care, and document these tasks on the appropriate client medical records before submitting claims. Payment may be recouped if the documentation is not in the client's medical record.

To be payable by the CSHCN Services Program, services must be personally performed by the physician or by a qualified person working under the personal supervision of the physician. Personal supervision means that the physician must be in the building of the office or facility when and where the service is provided. Direct supervision means the physician must be physically present in the room at the time the service is provided.

If an attending physician provides personal and identifiable direction to interns or residents who are participating in the care of a CSHCN Services Program client in a teaching setting through an approved and accredited training program by the appropriate accreditation agencies, the attending physician's services are a benefit. For major surgical procedures and other complex and dangerous procedures or

situations, the attending physician must be physically present during the procedure or situation to provide personal and identifiable direction. Payment for services may be recouped if personal and identifiable direction is not provided or is not appropriately documented.

To demonstrate that personal and identifiable direction was provided, the attending physician must have:

- Reviewed the client's history and physical examination and personally examined the client within a reasonable period after the client's admission and before the client's discharge.
- Confirmed or revised the client's diagnosis.
- Determined the course of treatment to be followed.
- Provided appropriate supervision of the interns or residents.
- Entered the appropriate daily documentation of the tasks identified above in the client's medical record before the claim is submitted.

31.2.1 Authorization and Prior Authorization Requirements

Some services, as specified throughout this chapter, require authorization or prior authorization as a condition for reimbursement. Authorization and prior authorization is not a guarantee of payment.

- Authorization must occur no later than 95 days after the date of service.
- Prior authorization must be obtained before the service is provided.

Authorization requests received after the authorization deadline are denied.

The 95-day filing deadline is for all services that require authorization (not *prior* authorization), including extensions and emergency situations.

Before submitting an authorization or prior authorization request, the provider must verify the client's eligibility. Any service provided while the client is not eligible cannot be reimbursed. Providers are responsible for knowing which services require authorization or prior authorization.

All requests for prior authorizations or authorizations must be submitted in writing on the CSHCN Services Program-approved authorization and prior authorization forms. Forms are located on the Forms page of the TMHP website. Providers may fax their authorization or prior authorization requests to the TMHP-CSHCN Services Program Authorization Department at 1-512-514-4222. This fax number is only for authorization or prior authorization requests.

Fax transmittal confirmations are not accepted as proof of timely authorization or prior authorization submission.

Requests to extend the authorization deadline are not considered except in cases involving retroactive eligibility.

Exception: *For clients that receive retroactive eligibility, the authorization and prior authorization requirement may be waived if the client's eligibility had not been determined by the time TMHP received the request. Claims for these services must be received within 95 days of the eligibility add date and must include a completed request for authorization/prior authorization, along with all other applicable documentation.*

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for additional information.

Section 4.3.1, "Services that Require Authorization" in Chapter 4, "Prior Authorizations and Authorizations" for a list of some of the services requiring authorization.

Section 4.4.1, "Services that Require Prior Authorization" in Chapter 4, "Prior Authorizations and Authorizations" for a list of some of the services requiring prior authorization.

31.2.2 Aerosol Treatments/Inhalation Therapy

Aerosol therapy is a benefit of the CSHCN Services Program. Continuous inhalation treatment with aerosol medication for acute airway obstruction (procedure codes 94644 and 94645) is a benefit of the CSHCN Services Program.

On physician claims, nebulizers and metered-dose inhaler treatments must be billed with procedure code 94640.

Pentamidine aerosol treatment (procedure codes 94642 and J2545) is a benefit of the CSHCN Services Program for diagnosis codes B20, D8481, D84821, D84822, and D8489 for the treatment of pneumocystis carinii.

Procedure code J7605 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J705	J708	J709	J9801	J9809	Q334	R051
R052	R053	R054	R058	R059	Z7182		

Procedure code J7608 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J8281	J8282	J9801	J9809	Q334
R051	R052	R053	R058	R059	Z7182		

Procedure codes J7622, J7631, J7639, J7644, and J7682 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J9801	J9809	Q334	R051	R052
R053	R054	R058	R059	Z7182			

Procedure code J7626 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J9801	J9809	Q334	R051	R052
R053	R054	R058	R059	Z7182			

Procedure code J7633 may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes							
A150	E840	J09X1	J09X2	J09X9	J1000	J1001	J1008
J101	J1100	J1108	J111	J121	J15212	J188	J189
J210	J211	J218	J398	J410	J411	J418	J42
J430	J431	J432	J438	J439	J440	J441	J449
J4520	J4521	J4522	J4530	J4531	J4532	J4540	J4541
J4542	J4550	J4551	J4552	J45901	J45902	J45909	J45990

Diagnosis Codes							
J45991	J45998	J470	J471	J479	J60	J61	J620
J628	J630	J631	J632	J633	J634	J635	J64
J660	J661	J662	J668	J670	J671	J672	J673
J674	J675	J676	J677	J678	J679	J680	J681
J682	J683	J684	J689	J690	J691	J698	J700
J701	J708	J709	J9801	J9809	Q334	Z7182	

31.2.3 Allergy Services

Allergy testing and desensitization are benefits of the CSHCN Services Program.

Providers must use the following procedure codes to bill for allergy testing:

Procedure Codes									
86001	86003	86005	86008	86486	95004	95017	95018	95024	95027
95028	95076	95180	95199						

Allergy blood testing (procedure codes 86001, 86003, 86005, and 86008) are a benefit of the CSHCN Services Program under the following circumstances:

- The client is unable to discontinue medications
- An allergy skin test is inappropriate for the client because of the following reasons:
  - The client is pediatric
  - The client is disabled
  - The client suffers from a skin condition such as dermatitis

Procedure code 86001 is limited to 20 allergens per rolling year, any provider. Procedure codes 86003 and 86008 are limited to 30 allergens per rolling year, any provider. Procedure code 86005 is limited to 4 screenings per rolling year, same provider.

Providers must indicate the number of allergens tested in the Units field in Block 24G of the CMS-1500 paper claim form. If the number of tests is not indicated in this field, payment is made for only one test.

31.2.3.1 Collagen Skin Tests

Collagen skin tests are a benefit of the CSHCN Services Program and may be reimbursed using procedure code Q3031.

Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure which utilizes collagen.

31.2.3.2 Prior Authorization Requirements

Allergy services generally do not require prior authorization; however, prior authorization is required for unlisted procedure code 95199 and when benefit limitations are exceeded for procedure codes 86001, 86003, 86005, and 86008.

Every effort should be made to use the appropriate Healthcare Common Procedure Coding System (HCPCS) or Current Procedural terminology (CPT) procedure code which describes the procedure being performed. If a procedure code does not exist to describe the service performed, procedure code 95199 should be submitted with appropriate documentation to assist in determining coverage. The documentation submitted must include all of the following:

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

Requests for prior authorization of procedure codes 86001, 86003, 86005, and 86008 must be submitted with documentation of medical necessity and include all of the following:

- Results of any previous treatment
- Documentation indicating that the client's treatment could not be completed within the policy limits for the requested procedures
- Client diagnosis and conditions that support the medical necessity for the additional procedures requested
- Explanation of client outcomes that the requested procedures will achieve

Prior authorization requests must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request Form.

31.2.4 Ambulatory Blood Pressure Monitoring

Blood pressure monitoring by either self-measured blood pressure monitoring or ambulatory blood pressure monitoring are benefits of the CSHCN Services Program when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are a benefit for the initial diagnosis of hypertension and should not be used for maintenance monitoring. Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for the evaluation of one of the following conditions:

- White coat hypertension, which includes all of the following:
  - A clinic or office blood pressure measurement greater than 140/90 mm Hg on at least three separate clinic or office visits with two separate measurements made at each visit
  - At least two documented separate blood pressure measurements taken outside the clinic or office, which are less than 140/90 mm Hg
  - No evidence of end-organ damage
- Resistant hypertension
- Evaluation of hypotensive symptoms as a response to hypertension medications

- Nocturnal angina
- Episodic hypertension
- Evaluation of syncope

Providers must document that the self-measured blood pressure monitoring and ambulatory blood pressure monitoring was performed for at least 24 hours.

Providers must use procedure codes 93784, 93786, 93788, and 93790 when billing for ambulatory blood pressure monitoring.

Ambulatory blood pressure monitoring is limited to two services per lifetime, any provider. Claims that exceed the limitation of two services per lifetime may be considered for reimbursement when documentation of medical necessity is submitted with the claim.

Self-measured blood pressure monitoring procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings - excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs - day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education
- Client purchase or receipt of new blood pressure device

Self-measured blood pressure monitoring procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

Only one method of blood pressure monitoring (self-measured or ambulatory) may be reimbursed within a rolling 12-month period. Self-measured blood pressure monitoring submitted within the same rolling 12-month period as ambulatory blood pressure monitoring will be denied.

31.2.5 Anesthesia Services

Anesthesia services are a benefit of the CSHCN Services Program and may be reimbursed to anesthesiologists, certified registered nurse anesthetists (CRNAs), anesthesiologist assistants (AA), and other qualified professionals.

Anesthesia must be administered by an anesthesia practitioner. An anesthesia practitioner is defined as the following:

- An anesthesiologist performing the anesthesia service alone or medically directs a CRNA, AA, or other qualified professional
- A CRNA who is not medically directed
- An AA performing delegated services
- A qualified professional as identified by the Texas Medical Board performing delegated services

Authorization is not required for anesthesia services. Specific surgical procedures, however, may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon are denied.

For time-based anesthesiology procedure codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

The anesthesiologist who medically directs the CRNA, AA, or other qualified professional must document the same time that the CRNA, AA, or other qualified professional documents.

Time units are determined on the basis of one time unit for each 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

Anesthesia services for obstetrical or family planning procedures are not a benefit of the CSHCN Services Program.

Local, regional, or general anesthesia provided by a surgeon is not a separately payable benefit of the CSHCN Services Program when performed by the operating surgeon. If anesthesia services are provided and modifier 47 is used, the services are included in the global fee for the surgical procedure.

31.2.5.1 Medical Direction

Personal medical direction of an anesthesia practitioner (CRNA, AA, or other qualified professional) by an anesthesiologist is a benefit of the CSHCN Services Program if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.

Exception: *Anesthesiologists may simultaneously supervise more than a combination of four CRNAs, AAs, or other qualified professionals, as defined by the Texas Medical Board under emergency circumstances.*

- The anesthesiologist is physically present in the operating suite.

Medical direction is a covered service only if all of the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical and key portions of the anesthesia plan, including induction and emergence, if applicable.
- The anesthesiologist must ensure that a qualified professional, including anesthesiologist assistants, can perform any procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at frequent intervals.
- The anesthesiologist must provide direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.
- The anesthesiologist provides indicated postanesthesia care.
- The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist directing the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:
    - Address an emergency of short duration in the immediate area.
    - Administer an epidural or caudal anesthetic to ease labor pain for a client who is not enrolled in the CSHCN Services Program.

- Provide periodic, rather than continuous, monitoring of an obstetrical client who is not enrolled in the CSHCN Services Program.
- Receive clients entering the operating suite for the next surgery.
- Check or discharge clients in the recovery room.
- Handle scheduling matters.

An anesthesiologist may medically direct up to four concurrent anesthesia procedures. Concurrent medical direction refers to involvement of the anesthesiologist in directing two, three, or four current anesthesia procedures.

Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a CSHCN Services Program client. For example, if three procedures are medically directed but only two involve CSHCN Services Program clients, the CSHCN Services Program claims should be billed as concurrent medical direction of three procedures.

The following information must be available to the state upon request and is subject to retrospective review:

- The name of each CRNA, AA, and other qualified professional concurrently being medically directed or supervised and a description of the procedure that was performed must be documented and maintained on file.
- Signatures of the anesthesiologist, CRNAs, AAs, or other qualified professionals involved in administering anesthesia services must be documented in the client's medical record.
- For medical direction, the anesthesiologist must document in the client's medical record that he or she:
  - Performed the pre-anesthetic exam and evaluation.
  - Provided the indicated post-anesthesia care.
  - Was present during the critical and key portions of the anesthesia procedure including, if applicable, induction and emergence.
  - Was present during the anesthesia procedure to monitor the client's status.

31.2.5.2 Monitored Anesthesia Care

Monitored anesthesia care may include any of the following:

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

31.2.5.3 Anesthesia Modifiers

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

When an anesthesia procedure is billed without the appropriate reimbursement modifiers, or is billed with modifier combinations other than those listed in this section, the claim is denied.

A claim billed with a modifier indicating that the anesthesia was not medically directed or medically supervised (modifier AD, QK, QX, or QY) is denied if a previous claim has been billed with a modifier indicating the service was personally performed (modifier AA or QZ) and is reimbursed for the same client, date of service, and procedure code.

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

31.2.5.3.1 State-Defined Modifiers

Modifiers U1 (indicating one anesthesia claim is expected) and U2 (indicating two anesthesia claims are expected) are state-defined modifiers that may be billed by an anesthesiologist, CRNA, AA, or other qualified professional.

Modifier U3 indicates that the anesthesia was performed with dental services.

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

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

31.2.5.3.2 Anesthesiologist Services and Modifier Combinations

When a single claim per client is billed by the anesthesiologist for personally performing the anesthesia service, the AA and U1 modifier combination must be billed together.

Anesthesiologists may be reimbursed for medical direction of anesthesia practitioners by using one of the following modifier combinations:

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
Anesthesiologist Providing Medical Direction or Medical Supervision to Other Qualified Professionals		
QY and U1	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one CRNA, AA, or other qualified professional, the QY + U1 modifier combination must be billed together if the CRNA, AA, or qualified professional are a part of a clinic/group.	Only the anesthesiologist
QK and U1	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals.	Only the anesthesiologist

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
AA, U1, and GC	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one resident physician.	Only the anesthesiologist
AD and U1 (emergency circumstances only)	When a single claim per client is billed by the anesthesiologist for medically supervising anesthesia services provided by more than four concurrent procedures that are provided by a CRNA, AA, or other qualified professional. The AD modifier must be used in emergency circumstances only and limited to 6 units (90 minutes maximum) per case for each occurrence requiring supervision of five or more concurrent procedures.	Only the anesthesiologist
Anesthesiologist Providing Medical Direction or Medical Supervision of CRNAs or AAs		
QY and U2	When two claims per client are billed, one by the medically directing anesthesiologist and one by the CRNA, AA, or other qualified professional.	Both the anesthesiologist and CRNA, AA, or other qualified professional
QK and U2	When two claims per client are billed for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNA(s), AA(s), or other qualified professionals.	Both the anesthesiologist and CRNA(s), AA(s), or other qualified professional
AD and U2 (emergency circumstances only)	When two claims per client are billed for medically supervising more than four concurrent anesthesia procedures provided by CRNA(s), AA(s), or other qualified professionals. The AD modifier must be used in emergency circumstances only and limited to 6 units (90 minutes maximum) per case for each occurrence requireing supervision of five or more concurrent procedures.	Both the anesthesiologist and CRNA(s), AA(s), or other qualified professional

31.2.5.3.3 CRNA, AA, or Other Qualified Professional Services

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

Modifiers QX and U2 must be submitted by a CRNA, AA, or other qualified professional who provided services under the medical direction of an anesthesiologist.

31.2.5.3.4 Monitored Anesthesia Care

Anesthesiologists, CRNAs, AAs, or other qualified professionals may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier, and must be billed with any combination of pricing modifiers for reimbursement.

31.2.5.4 Dental General Anesthesia

Procedure code 00170 with modifier U3 should be used when billing for the appropriate reimbursement of dental general anesthesia.

Refer to: Chapter 14, "Dental" for more information about dental services.

31.2.5.5 Epidural and Subarachnoid Infusion (Not including Labor and Delivery)

Epidural and subarachnoid infusion for pain management may be reimbursed for acute, chronic, and postoperative pain management.

Procedure code 01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure. If procedure code 01996 is billed longer than 30 days medical necessity documentation is required. Cancer diagnoses are excluded from the 30-day limitation.

31.2.5.6 Reimbursement

To be reimbursed, providers of anesthesia services must include the following on submitted claims:

- Appropriate national anesthesia procedure codes
- Correct modifier(s)
- Name of the anesthesiologist, CRNA, or medically directed AA administering the anesthesia
- Exact amount of face-to-face time with the client

If procedure code 01996 is used, it must be reported as a medical service rather than an anesthesia service.

The anesthesiologist's reimbursement for medical direction of CRNAs, AAs, and other qualified professionals is 50 percent of the maximum allowable fee.

The CRNA's or AA's reimbursement for performing an anesthesia service when supervised by a physician other than an anesthesiologist is 92 percent of the maximum allowable fee.

A CRNA or AA under the supervision of an anesthesiologist may be reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

Refer to: Chapter 12, "Certified Registered Nurse Anesthetist (CRNA)" for more information on CRNA services.

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

Procedure codes 99100, 99116, 99135, and 99140 are qualifying circumstances that impact the character of the anesthesia services provided. These procedures are not payable alone, but are payable in addition to the anesthesia service. Documentation supporting the medical necessity for use of these procedure codes may be subject to retrospective review.

31.2.5.7 Conversion Factor

A conversion factor is the multiplier that transforms relative value into payment amounts. There is a standard conversion factor for anesthesia services that can be obtained from the online fee lookup on the TMHP website at www.tmhp.com.

31.2.5.8 Time-Based Fees

Reimbursement of time-based anesthesia services is defined as [(Minutes/15) + Relative Value Units (RVUs)] x Conversion Factor = Anesthesia Reimbursement. It is derived from the following steps:

1) Divide the total anesthesia time in minutes (the time of all procedures performed, directed or supervised) by 15.

   Add the RVUs for the procedure performed (use the procedure with the highest RVUs when multiple procedures are performed at the same time).

   Multiply this sum by the appropriate conversion factor.

Reimbursement of time-based fees requires documentation of exact time in minutes of face-to-face time with the client.

If anesthesia services are performed for two surgical procedures at separate times during the same date of service, both may be reimbursed based on the documentation submitted with the claim.

31.2.6 Audiometry/Hearing Services

The CSHCN Services Program may reimburse appropriately-enrolled providers for audiometry and other hearing services.

Authorization is not required for hearing services provided by physicians.

Refer to: Chapter 20, "Hearing Services" for more information about hearing services.

CSHCN Services Program clients who are 17 years of age or older, legal residents of the state of Texas, and are employable, may be eligible for assistance from the Health and Human Services Commission (HHSC). The CSHCN Services Program is the payer of last resort and may request that clients meeting these requirements apply to HHSC.

31.2.7 Augmentative Communication Devices (ACDs)

The purchase, rental, replacement, modification, and repair of ACDs that function independently of any other technology (i.e., may not rely on a computer in any way) are benefits of the CSHCN Services Program when medically necessary.

Refer to: Chapter 10, "Augmentative Communication Devices (ACDs)."

31.2.8 Biofeedback Services

Biofeedback is a form of therapy in which a physiologic activity is monitored, amplified, and conveyed by visual or acoustic signals. Procedure codes 90901, 90912 and 90913 may be benefits of the CSHCN Services Program for biofeedback services.

The CSHCN Services Program will cover biofeedback services with prior authorization for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence (i.e., stress, urge, overflow, mixed)
- Fecal incontinence

Procedure codes 90901, 90912 and 90913 are limited to one procedure code for each date of service by any provider to include all modalities of the services performed during a specific session regardless of the number of modalities performed.

Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

31.2.8.1 Medical Record Documentation

The physician must provide correct and complete information including documentation establishing medical necessity of the service requested, which must remain in the client's medical record and maintain the record of the performing staff member(s') certification. Claims may be subject to retrospective review.

31.2.8.2 Provider Certification

Biofeedback services must be performed by a staff member who is certified by Biofeedback Certification International Alliance (BCIA). The accepted certification types are:

Certification Type	Description
General biofeedback certification (BCB)	Professionals certified in general biofeedback covering all modalities such as SEMG, Thermal, GSR, HRV, and an overview of neurofeedback.
Pelvic muscle dysfunction biofeedback certification (BCB-PMD)	Professionals certified to use SEMG biofeedback to treat elimination disorders including incontinence and pelvic pain.

31.2.8.3 Authorization Requirements

Prior authorization is required for biofeedback services. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request Form.

The number of sessions prior authorized will not exceed a total of 12 sessions and will not exceed a total duration of 12 weeks. The following documentation must be submitted for consideration of prior authorization:

- Failure of pharmacotherapy and behavioral training
- Evidence of dyssynergic or non-relaxing detrusor/voluntary sphincter activity based on urodynamic evaluation to include urinary flow testing and complex cystometry
- The client has agreed to actively participate in the biofeedback sessions
- Diagnosis of fecal, stress, urge, overflow, or a mix of stress and urge incontinence
- Medical records indicate that the physician has excluded any underlying medical conditions that could be causing the problem
- For clients who are 21 years of age or older with a diagnosis of stress, urge, overflow, or a mix of stress and urge incontinence, the medical records must indicate failed pelvic muscle exercise (PME) service

  Note: *A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing 4 weeks of PME exercises.*

After completion of the initial biofeedback treatment course, prior authorization may be considered for a total of 6 follow-up sessions not to exceed 3 sessions per week and total duration not to exceed 8 weeks. Prior authorization documentation submitted must be for the same condition as the original request, must include each original symptom, and how the symptom has objectively improved. The documentation may include, but is not limited to:

- For urinary incontinence, the biofeedback therapy should result in improvement of continence scores. There should be a decrease in high-grade stress incontinence, nocturnal enuresis, and loss of urine during activity. For clients who are 21 years of age and older, the pelvic floor muscle contraction strength should improve with the ability to hold the contractions longer and to increase repetitions.

- For fecal incontinence, the biofeedback therapy should result in improvement of continence scores. Squeeze and anal pressures, squeeze duration, and for clients who are 21 years of age and older, pelvic floor muscle contraction strength should show improvement.

Total authorized sessions for any combination of procedure codes 90901, 90912 and 90913, including the 12 initial sessions and 6 follow-up sessions, will not exceed 18 sessions for urinary or fecal incontinence conditions.

31.2.8.4 Noncovered Services

Neurofeedback (i.e., EEG biofeedback) is not a benefit of the CSHCN Services Program.

31.2.9 Bone Growth Stimulators

Internal (implanted) or external (not implanted) bone growth (osteogenic) stimulators are a benefit of the CSHCN Services Program.

Electromagnetic bone growth stimulators promote healthy bone growth and repair by low intensity electrical stimulation. Electrical stimulation is provided by implanting low-voltage electrodes within the tissue surrounding the bone (internal) or by external placement of a device which transmits low-voltage currents through the soft tissue to the bone (external).

Ultrasonic bone growth stimulators promote healthy bone growth and repair through low-intensity pulsed ultrasound waves.

Bone growth stimulators are a benefit for skeletally mature individuals only.

Bone growth stimulation (procedure codes 20974, 20975, and 20979) is limited to one service every six months. Bone growth stimulation for a second fracture that occurs during the six-month limitation period may be considered on appeal with documentation of medical necessity that supports that the criteria have been met for the second fracture.

Refer to: Section 31.2.9.1, "Prior Authorization Requirements for Bone Growth Stimulators" in this chapter for information about prior authorization requirements for procedure codes 20974, 20975, and 20979.

Due to the short life of the equipment, osteogenic stimulators are purchased.

An ultrasonic bone growth stimulator may not be reimbursed concurrently with other noninvasive bone growth stimulation devices.

Monitoring the effectiveness of bone growth stimulation treatment should be billed as the appropriate evaluation and management (E/M) code.

Physician services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Durable medical equipment (DME) may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.9.1 Prior Authorization Requirements for Bone Growth Stimulators

Prior authorization is required for bone growth stimulator devices. Inpatient admissions require prior authorization. Ambulatory or day surgery requires authorization.

Prior authorization requests for bone stimulator devices must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

A completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form prescribing the DME or medical supplies must be signed and dated by the prescribing physician familiar with the client prior to requesting authorization. All signatures

must be current, stamped signatures will not be accepted. The completed CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form must be maintained by the requesting provider and the prescribing physician.

To avoid unnecessary authorization denials, the physician must provide correct and complete information, including documentation for medical necessity of the DME or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the bone growth stimulator.

Documentation that supports medical necessity for a bone growth stimulator device must be maintained by the ordering physician and requesting provider in the client's medical record and is subject to retrospective review.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

The manufacturer will replace the bone growth stimulator device during the course of treatment should the device become nonfunctional. Repairs to purchased equipment will not be prior authorized. All repairs are considered part of the purchase price.

A new bone growth stimulator may be considered for prior authorization with documentation that supports treatment of a different fracture site when the criteria listed in the following sections are met.

31.2.9.1.1 Low-Intensity Ultrasound Bone Growth Stimulators

Documentation of the following is required for prior authorization of the external, low-intensity ultrasound bone growth stimulator device (procedure code E0760):

- Nonunion of a fracture other than the skull or vertebrae in a skeletally mature person, documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days each, including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs
- The fracture is not tumor-related
- The fracture is not fresh (less than 7 days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture)

31.2.9.1.2 Non-Invasive Bone Growth Stimulators

Documentation of the following is required for prior authorization of the external, electromagnetic bone stimulator device (procedure code E0747):

- At least one of the following conditions:
  - Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for 3 months or longer despite appropriate fracture care.
  - Delayed unions of fractures of failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures).
- Serial radiographs have confirmed that no progressive signs of healing have occurred.
- The fractured gap is 1 cm or less.
- The individual can be adequately immobilized and is likely to comply with nonweight bearing restrictions.

Documentation of one of the following is required for prior authorization of the external, electromagnetic bone stimulator device for spinal application (procedure code E0748):

- One or more failed fusions
- Grade II or worse spondylolisthesis
- A multiple level fusion with extensive bone grafting is required
- Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous fusion surgery, previous disc surgery, or gross instability

31.2.9.1.3 Invasive Bone Growth Stimulators

Documentation of one of the following is required for prior authorization of the surgically implanted osteogenesis stimulator device (procedure code E0749):

- Nonunion of long bone fractures (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, and metacarpal, metatarsal, carpal, and tarsal bones). Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator. Serial radiographs must include a minimum of 2 sets of radiographs separated by a minimum of 90 days. Each set of radiographs must include multiple views of the fracture site.
- Failed fusion of a joint other than the spine when a minimum of three months has elapsed since the joint fusion was performed.
- Congenital pseudoarthrosis.
- An adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to previously failed spinal fusion at the same site.
- An adjunct to multiple-level fusion. A multiple level fusion involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

31.2.9.2 Authorization Requirements for Bone Growth Stimulation

Authorization is required for bone growth stimulation professional services (procedure codes 20974, 20975, and 20979). Providers must submit documentation of medical necessity, which includes the appropriate clinical indications for a low-intensity ultrasound, non-invasive, or invasive device, as defined in section Section 31.2.9.1, "Prior Authorization Requirements for Bone Growth Stimulators" in this chapter.

Authorization requests for bone growth stimulation must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form.

Refer to: Section 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization requirements.

31.2.10 Casting

The CSHCN Services Program may reimburse the application of casts, splinting, and strapping in addition to an E/M procedure code when no surgery is performed. Casting, splinting and strapping are subject to global surgery fee guidelines.

Supplies used for casting, splinting, and strapping are not reimbursed separately.

Procedure codes 29450 and 29750 are benefits for the following diagnosis codes:

Diagnosis Codes							
M21541	M21542	M21549	Q662	Q6651	Q6652	Q666	Q6681

Diagnosis Codes	
Q6682	Q6689

The following procedure codes may be reimbursed for surgery when billing for casting, splinting, or strapping services:

Procedure Codes									
Body and upper extremity casts									
29000	29010	29015	29035	29040	29044	29046	29049	29055	29058
29065	29075	29085	29086						
Body and upper extremity splints									
29105	29125	29126	29130	29131					
Body and upper extremity strapping									
29200	29240	29260	29280	29799					
Lower extremity casts									
29305	29325	29345	29355	29358	29365	29405	29425	29435	29440
29445	29580								
Lower extremity splints									
29505	29515								
Lower extremity strapping									
29520	29530	29540	29550						
Cast removal or repair									
29700	29705	29710	29720	29730	29740				

31.2.11 Chemotherapy

Chemotherapy services are a benefit of the CSHCN Services Program when they are provided by a physician or under the supervision of a physician.

Note: *Authorization is not required for administration of chemotherapy.*

Providers billing for chemotherapy administration may be reimbursed by using the appropriate procedure codes shown in the following table:

Procedure Codes									
95991	96401	96402	96405	96406	96409	96411	96413	96415	96416
96417	96420	96422	96423	96425	96440	96446	96450	96521	96522
96523	96542	96549	G0498						

For the first 15 minutes through the first hour of chemotherapy infusion, procedure code 96409 or 96413 must be used for a single or initial chemotherapeutic medication. Procedure code 96411 must be used for each additional chemotherapeutic medication given and must be billed with procedure code 96401, 96402, 96409, 96413, or 96416.

Procedure code 96415 must be used for each additional hour beyond the initial hour and must be used in conjunction with procedure code 96409, 96413, or 96416.

Procedure code 96416 will be denied if billed with procedure code G0498 on the same date of service, any provider.

Procedure code 96417 must be used for each subsequent infusion up to 1 hour and must be used in conjunction with procedure code 96409, 96413, or 96416 on the same day, by the same provider. Procedure code 96415 must be used for each additional hour.

Procedure codes 96416 and 96425 must be used when initiating an infusion that will take more than 8 hours and requires using an implanted pump or a portable pump.

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

The chemotherapy administration procedure codes listed above include charges for intravenous (IV) solutions (such as saline, dextrose and water, Ringer's solution, etc.) and IV equipment (administration sets, needles, extension tubing, etc.).

The chemotherapy administration procedure codes 96440 and 96450 include payment for the surgical procedure. Separate reimbursement for the surgical codes will not be allowed.

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

Chemotherapeutic drugs and other injections given in the course of chemotherapy may be reimbursed using the appropriate procedure code. The chemotherapeutic agents should be billed separately, including the name of the drug and actual amount administered for correct reimbursement.

Physicians providing a chemotherapy administration service as an inpatient service on the same day as an E/M service must bill using modifier 25 except for procedure code 99211. A different diagnosis is not required.

When a significant, separately identifiable E/M service is performed, the appropriate E/M code must be submitted with modifier 25 and the chemotherapy procedure code. A different diagnosis is not required for an E/M service provided on the same day. Documentation that supports a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Modifier 25 must be used to describe circumstances in which an office visit was provided at the same time as other separately identifiable services. This modifier may be appended to the E/M code when the services are rendered. Both services must be documented as distinct and documentation must be maintained in the client's medical record and made available upon request by the CSHCN Services Program.

Chemotherapy planning program (procedure code 99213, 99214, or 99215) may be reimbursed.

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

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.12 Clinician-Directed Care Coordination Services

Clinician (physician or APRN)-directed care coordination services are a benefit of the CSHCN Services Program.

Clinician-directed care coordination services are a benefit only when provided by a primary care clinician, specialist, or subspecialist who attests that he or she is providing the medical home for the client.

The medical home is defined as:

- A partnership between the child, the child's family, and the primary care provider (or place where the child receives care).

- A care delivery model that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

In providing a medical home for the client, the primary care clinician directs care coordination together with the child or youth and family. Care coordination is a family-centered process that links children or youths with special health needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

Clinician-directed care coordination services (face-to-face and non-face-to-face) must include the following activities, with permission of the client or family:

- Supervising the development and revision of a client's written care plan (a formal document or contained in the client's progress notes) in partnership with the client, family, and other agreed-upon contributors and sharing of this care plan with other providers, agencies, and organizations involved in the care of the client
- Coordinating care among multiple providers
- Maintaining a central record or database that contains all pertinent client medical information, including hospitalizations and specialty care
- Assisting the client and family in communicating clinical issues when a client is referred for a consultation or additional care
- Evaluating, interpreting, and managing consultant recommendations for the client and family in partnership and collaboration with consultants, other providers, the client, and the family

Clinician-directed care coordination services should also include supervision of development and revision of the client's emergency medical plan in partnership with the client, the family, and other providers to be used by emergency medical services (EMS) personnel, utility service companies, schools, other community agencies, and caregivers.

31.2.12.1 Face-to-Face Clinician-Directed Care Coordination Services

Face-to-face care coordination services are encompassed within the various levels of E/M services and prolonged services.

Providers should use the most appropriate face-to-face E/M procedure codes to bill for care coordination services.

When counseling or care coordination requires more than 50 percent of the client or family encounter (face-to-face time in the office or other outpatient setting, or floor or unit time in the hospital), then time may be considered the key or controlling factor to qualify for a particular level of E/M service.

Counseling is discussion with the client or family, concerning diagnostic studies or results, prognosis, risks and benefits, management options, importance of adhering to the treatment regimen, and client and family education.

An E/M procedure code for a face-to-face problem-focused care coordination visit may be billed on the same day as a preventive medicine visit. Modifiers must be used as appropriate for billing.

Any face-to-face inpatient or outpatient E/M procedure code that is a benefit of the CSHCN Services Program may be billed on the same day as any non-face-to-face clinician-directed care coordination (procedure codes 99367, 99374, 99375, 99377, and 99378), when the client requires significant, separately identifiable E/M service by the same physician on the same day. Modifiers must be used for appropriate billing.

31.2.12.2 Non-Face-to-Face Clinician-Directed Care Coordination Services

Non-face-to-face care coordination services include:

- Prolonged services (procedure codes 99358 and 99359)

- Medical team conferences (procedure code 99367)
- Care plan oversight/supervision (procedure codes 99374, 99375, 99377, and 99378)

Non-face-to-face specialist or subspecialist telephone consultations (procedure code 99499 with modifier U9) are a benefit for a specialist or subspecialist when the clinician providing the medical home contacts the specialist for advice or a referral and the consultation is at least 15 minutes in duration.

Telephone consultations are defined by the CSHCN Services Program as the process where the specialist or subspecialist receives a telephone call from the clinician providing the medical home. During the telephone call, the specialist or subspecialist assesses and manages the client's condition by providing advice or referral to a more appropriate provider.

Specifically, non-face-to-face clinician supervision of the development or revision of a client's care plan (care plan oversight services) may include the following activities. These services do not have to be contiguous:

- Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results ordered during or associated with a face-to-face encounter
- Telephone calls with other clinicians (not employed in the same practice), including specialists or subspecialists involved in the care of the client
- Telephone or face-to-face discussions with a pharmacist about pharmacological therapies (not just ordering a prescription)
- Medical decision making
- Activities to coordinate services (if the coordination activities require the skill of a clinician)
- Documentation of the services provided, including writing a note in the client chart describing services provided, decision making performed, and amount of time spent performing the countable services, including time spent by the physician working on the care plan after the nurse has conveyed pertinent information from agencies or facilities to the physician, including the start and stop times

The following activities are not covered as non-face-to-face clinician oversight/supervision of the development or revision of the client's care plan (care plan oversight services):

- Time that staff spends getting or filing charts, calling the home health agencies, clients, etc.
- Clinician telephone calls to a client or family, except when necessary to discuss changes in client's care plan
- Clinician time spent telephoning prescriptions to the pharmacist (not a physician service; does not require a physician to perform)
- Clinician time getting or filing the chart, dialing the telephone, or time on hold (these activities do not require clinician work or meaningfully contribute to the treatment of the illness or injury)
- Travel time
- Time spent preparing claims and for claims processing
- Initial interpretation or review of lab or study results that were ordered during, or associated with, a face-to-face encounter
- Services included as part of other E/M service
- Consults with health professionals not involved in the client's case

These services may be reimbursed for the clinician time involved in this coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

Clinician-directed care coordination services must be documented in the client's medical record. Documentation must support the services being billed and must include a record of the clinician's time spent performing specific care coordination activities, including start and stop times. The documentation should include a formal care plan and emergency services plan.

The supporting documentation maintained in the client's medical records must be dated and include the following components and requirements:

- A current medical summary containing key information about the client's health (e.g., conditions, complexity, medications, allergies, past surgical procedures, etc.)
- A current list of the main concerns, key strengths and assets, and the related current clinical information
- Planned actions or interventions to address the concerns and to sustain or build strength, with the expected outcomes
- Persons responsible
- Timeframes and due dates

The supporting documentation must be reviewed and updated every 6 months, or more frequently, as needed.

Client medical records are subject to retrospective review.

Payment is made for care coordination to a clinician providing postsurgical care during the postoperative period only if the care coordination is documented to be unrelated to the surgery.

31.2.12.2.1 Care Plan Oversight

Clinician-directed care plan oversight services may be billed with one of the procedure codes listed in the following table.

Clinician supervision of a client in the home or domiciliary or under the care of a home health agency or hospice (care plan oversight) may be billed with the following procedure codes:

Procedure Codes			
99374	99375	99377	99378

The clinician who bills for the care plan oversight must be the same clinician who signed the plan of care for the home health agency (procedure codes 99374 and 99375) or hospice (procedure codes 99377 and 99378).

Care plan oversight may be reimbursed for the clinician time involved in the coordination. The clinician billing the services must personally perform the services. Care coordination services delegated to or performed by others do not count towards care coordination reimbursement.

The following end-stage renal disease procedure codes apply to a full or partial month of services and are inclusive of all the clinicians supervision services described in care plan oversight (procedure codes 99374, 99375, 99377, and 99378):

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

Care plan oversight may not be reimbursed to the same clinician during the same month as end-stage renal disease services.

The clinician may not have a significant financial or contractual relationship with the home health agency as defined in 42 *Code of Federal Regulations* (CFR) 424.

The clinician may not be the medical director or employee of the hospice and may not furnish services under arrangements with the hospice (including volunteering).

31.2.12.2.2 Medical Team Conference

Medical conferences may be billed with procedure code 99367.

One medical team conference (procedure code 99367) may be reimbursed every 6 months when the coordinating clinician attests that he or she is providing the medical home for the client. The coordinating clinician may be the client's primary care physician or a specialist.

The medical team conference time must be documented in the client's record.

31.2.12.2.3 Non-Face-to-Face Specialist or Subspecialist Telephone Consultations

Non-face-to-face specialist or subspecialist telephone consultations may be billed with procedure code 99499 and modifier U9.

A specialist or subspecialist telephone consultation is limited to two every 6 months by the same provider.

The clinician providing the medical home must maintain the following documentation in the client's medical record:

- The start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name of the consulted specialist or subspecialist

The specialist or subspecialist must maintain documentation of the telephone consultation using the CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services Form or similar clinical record documentation. These records are subject to retrospective review. The supporting documentation must include, but is not limited to, the following:

- The client's name, date of birth, and CSHCN Services Program identification number
- The start and stop times indicating the consultation lasted at least 15 minutes
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment or laboratory services
- The name and telephone number of the referring clinician providing the medical home
- The specialist's or subspecialist's and referring clinician's National Provider Identifier (NPI) information

31.2.12.2.4 Non-Face-to-Face Prolonged Services

Non-face-to-face prolonged services may be billed with procedure codes 99358 and 99359.

The client must be an established client and must have had a face-to-face encounter at least once during the 6 months immediately preceding provision of the first non-face-to-face prolonged service.

Non-face-to-face prolonged services (procedure code 99358 or 99359) are limited to a maximum of 90 minutes, once per client, for the same provider.

Procedure code 99358 must be used to report the first hour of prolonged services. Prolonged services of less than 30 minutes duration are considered part of the physician E/M service being provided.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Procedure code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Procedure code 99359 must be billed for the same date of service by the same provider as procedure code 99358 or it will be denied.

Procedure codes 99358 and 99359 will be denied if billed on the same date of service as any of the following procedure codes:

Procedure Codes									
99202	99203	99204	99205	99212	99213	99214	99215	99221	99222
99223	99231	99232	99233	99234	99235	99236	99242	99243	99244
99245	99252	99253	99254	99255	99281	99282	99283	99284	99285
99304	99305	99306	99307	99308	99309	99310	99341	99342	99344
99345	99347	99348	99349	99350	99417	99418			

31.2.12.2.5 Authorization for Non-Face-to-Face Clinician-Directed Care Coordination Services

Authorization is required for non-face-to-face clinician-directed care coordination services. A CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services form, and the required documentation must be submitted.

Authorization of initial non-face-to-face clinician-directed care coordination services requires at least 1 covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the 6 months preceding the provision of the first non-face-to-face care coordination service.

Authorization for subsequent non-face-to-face clinician-directed care coordination services requires at least 1 covered face-to-face inpatient or outpatient E/M visit by the clinician directing the care coordination during the previous 12 months, or more frequently as indicated by the client's condition.

Authorization of medical team conferences (procedure code 99367) is limited to once every 6 months. Additional medical team conferences may be considered with documentation of a change in the client's medical home.

Authorization of non-face-to-face prolonged services (procedure codes 99358 and 99359) is limited to a maximum of 90 minutes once per client, per provider. Additional prolonged non-face-to-face services may be authorized (with documentation) if there is one of the following significant changes in the client's clinical condition:

- The client will soon be, or has recently been, discharged from a prolonged and complicated hospitalization requiring coordination of complex care with multiple providers in order for the client to be adequately cared for in the home.
- Documentation of recent trauma resulting in new medical complications that require complex interdisciplinary care.
- The client has a new diagnosis of a medically complex condition requiring additional interdisciplinary care with additional specialists.

Authorization of care plan oversight or supervision (procedure codes 99374, 99375, 99377, and 99378) is limited to one service a month in a 6-month authorization period.

In order for authorization to be considered, the client must require complex and multidisciplinary care modalities involving regular clinician development or revision of care plans, review of subsequent reports of client status, and review of related laboratory and other studies, such as:

- Medically complex health care: Health care provided by a clinician that requires coordination of various treatment modalities or a multidisciplinary approach due to the client's moderate or severe health condition, physical or functional limitations, or health risk factors.
- Multidisciplinary health care: The coordination of clinician-ordered medically necessary health care that requires the collaboration of two or more medical, educational, social, developmental, or other professionals in order to properly devise and implement the clinician-developed plan of medical care. For CSHCN Services Program coverage, multidisciplinary health care must include medically necessary services provided by program-enrolled clinical providers. Development and implementation of the plan of medical care may, in addition, need to take into account other related care provided by nonclinical providers as required to address the overall health needs of a client.

Documentation of the following components must be submitted with the authorization form to obtain an initial authorization or renewal:

- A current medical summary, containing key information about the client's health (e.g., conditions, complexity, medications, allergies, past surgical procedures)
- A current list of the main concerns as well as key strengths and assets, and the related current clinical information
- Planned action steps or interventions to address the concerns and to sustain or build strengths, with the expected outcomes
- Persons responsible
- Timeframes or due dates

The supporting documentation can be in the form of the following:

- Formal written care plan
- Progress note detailing the care coordination planning
- Letter of medical necessity detailing the care plan oversight and care coordination

Authorization is limited to a maximum of 6 months. Subsequent periods of authorization require submission of a new request with documentation supporting medical necessity for ongoing services.

Non-face-to-face specialist or subspecialist telephone consultations do not require authorization.

31.2.13 Cochlear Implants

Cochlear implants and auditory rehabilitation are benefits for CSHCN Services Program clients.

Refer to: Section 20.3.2, "Cochlear Implants" in Chapter 20, "Hearing Services" for more information about cochlear implants.

31.2.14 Colon Capsule Endoscopy

Colon capsule endoscopy (procedure code 91113) is a benefit of the CSHCN Services Program and limited to the following diagnosis codes:

Diagnosis Codes					
K635	K921	K922	R195	Z5309	Z538

31.2.15 Colorectal Cancer Screening

Procedure codes 74263, 81528, 82270 (CLIA waived test), G0104, G0105, G0121, and G0328 (with modifier QW) are benefits of the CSHCN Services Program. An additional screening may be considered on appeal with documentation that indicates the provider was unable to obtain the previous screening results from a different provider or the provider was new to treating the client and was not aware the client had already received colorectal cancer screening.

Procedure code 81528 may be reimbursed once every 3 years for clients who are 45 years of age or older. Procedure code G0104 may be reimbursed once every 5 years, or as recognized by the ACS or the U.S. Preventive Services Task Force (USPSTF). Procedure code G0121 may be reimbursed once every 10 rolling years.

Refer to: Chapter 25, "Enrollment" for additional information about laboratory cancer screening or pathology procedures.

High-risk individuals include clients with one or more of the following factors:

- A close relative who has had colorectal cancer or an adenomatous polyp

  Note: *"Relative" means close blood relatives, including first-degree male or female relatives (parents, siblings, or children), second-degree relatives (aunts, uncles, grandparents, nieces, nephews), and third-degree relatives (first cousins, great grandparents) who are on the same side of the family as the client.*

- Family history of familial adenomatous polyposis
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of colorectal cancer
- Personal history of adenomatous polyps
- Personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis

During the course of a screening flexible sigmoidoscopy, if a lesion or growth is detected that results in a biopsy or removal of the growth, an appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be reported.

During the course of a screening colonoscopy, if a lesion or growth is detected that results in a biopsy or removal of the growth, the procedure code for a colonoscopy with biopsy or removal of lesion should be reported.

31.2.16 Critical Care Services

Critical care is a benefit of the CSHCN Services Program. Authorization is not required for these services.

Critical care is the care of a critically ill client who requires constant physician attention. Critical care involves high-complexity decision making to access, manipulate, and support vital system functions. If the physician is not at bedside, he or she must be immediately available to the client. The physician must devote his or her full attention to the client and therefore, cannot render E/M services to any other client during the same period of time. Critical care is usually given in a critical care area, such as a coronary care unit, respiratory care unit, intensive care unit, pediatric intensive care unit, neonatal intensive care unit, or emergency department care facility.

Noncritical intensive care is a benefit for infants who are very low birth weight, low birth weight, or normal weight and do not meet the definition of critically ill but continue to require intensive observation, frequent interventions, and other intensive services only available in the intensive care setting.

Neonatal critical care is the comprehensive care of the critically ill neonate. The neonatal period is defined as the period from birth through the 28th day of life. Neonatal critical care codes are comprehensive per diem (daily) care codes for providers personally delivering or supervising the delivery of care of the critically ill neonate as an inpatient.

Newborn resuscitation is a benefit for high-risk newborns who require resuscitation.

In accordance with CPT, critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the client, provided that the client's condition continues to require the level of physician attention as described above.

31.2.16.1 General Limitations

Services for a client who is not, or is no longer, critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes, such as continuing intensive care (procedure codes 99478, 99479, and 99480) or subsequent hospital care (procedure codes 99231, 99232, and 99233).

Neonatal critical care (procedure codes 99468 and 99469), pediatric critical care (procedure codes 99471, 99472, 99475, and 99476), and the initial critical care (procedure code 99291) are limited to once per day for the same provider. Subsequent critical care (procedure code 99292) is each additional 30 minutes beyond the first 74 minutes of critical care, and is limited to a quantity of 6 units (3 hours) per day.

Neonatal and pediatric critical care (procedure codes 99468, 99469, 99471, 99472, 99475, and 99476) and continuing intensive care services (procedure codes 99478, 99479, and 99480) are inpatient, per-day charges and only billable once per day by any provider. No other inpatient E/M services may be reimbursed on the same day when billed by the same provider.

When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) should be used.

If the same physician provides critical care for a neonatal or pediatric client in both the outpatient and inpatient settings on the same day, the provider should report only the appropriate inpatient neonatal or pediatric critical care service (procedure codes 99468, 99469, 99471, 99472, 99475, and 99476).

E/M services provided on the same day by the same provider as surgical procedures that meet the definition of separately identifiable and above and beyond usual preoperative and postoperative care may be billed with modifier 25. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request.

Critical care (procedure codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476) is only billable by the provider rendering the critical care service while the client is critically ill. While providers from various specialties (e.g., cardiology or neurology) may be consulted to render an opinion or assist in the management of a particular portion of the care, only the provider managing the care of the critically ill client during a life threatening crisis may bill the critical care.

If a second physician provides critical care services on the same day at a separate and distinct time, the physician should report the appropriate time-based critical care service (procedure code 99291 or 99292).

Critical care totaling less than 30 minutes in duration on a given date should be reported with the appropriate E/M procedure code.

Actual time spent with the individual client should be recorded in the client's record and reflect the time billed on the claim. The time that can be reported as critical care is the time spent engaged in work directly related to the individual client's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

The time spent in the following activities may not be included in the time reported as critical care:

- Activities that occur outside of the unit or off the floor because the physician is not immediately available to the client
- Activities that do not directly contribute to the treatment of the client even if they are performed in the critical care unit
- Performing separately reportable procedures or services

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

APRNs, physician assistants, and CRNAs may be reimbursed the lower of the billed amount or 92 percent of the amount allowed by Texas Medicaid for physicians for the same service.

31.2.16.2 Critical Care Services

Procedure codes 99291 and 99292 are used to identify critical care services provided to clients who are 6 years of age or older.

Procedure code 99291 should be used per day for the first 30 to 74 minutes of critical care even if the time spent by the physician is not continuous on that day.

Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room) which does not result in admission, must be billed using procedure codes 99291 and 99292.

If outpatient critical care (procedure codes 99291 and 99292) is provided to a client at a distinctly separate time than another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

If critical care (procedure code 99291) is provided by different physicians that meet the initial 30-minute time requirement, and the care is provided at separate distinct times, the initial provider's claim may be reimbursed. The second provider's claim will be denied but may be considered on appeal. The time spent by each physician cannot overlap (i.e., two physicians cannot bill critical care for care delivered at the same time). Supporting medical record documentation must be provided by the second physician that includes the time in which the critical care was rendered. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill client during the life-threatening crisis.

If the provider's time exceeds the 74-minute time threshold for procedure code 99291, procedure code 99292 may be billed in addition to procedure code 99291 for each additional 30 minutes.

Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider's group practice.

Procedure code 99292 is limited to six units per day (3 hours), any provider. If the number of units is not stated on the claim, only a quantity of one will be allowed.

Retrospective review may be performed to ensure the documentation supports the medical necessity of the service and any modifier used when billing the claim.

31.2.16.3 Pediatric Critical Care

Procedure codes 99471, 99472, 99475, and 99476 are used to identify pediatric critical care services provided to clients who are 29 days through 24 months of age.

Pediatric critical care services are comprehensive per diem (daily) care procedure codes for providers personally delivering or supervising the delivery of care of the critically ill infant or child.

Inpatient pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge.

31.2.16.4 Neonatal Critical Care

Procedure codes 99468 and 99469 are used to identify neonatal critical care services provided to clients who are 28 days of age or younger.

Procedure code 99468 is used for the first day of admission for a critically ill neonate, 28 days of age or younger, and may be reimbursed once per day, any provider.

Procedure code 99468 must be billed for the initial day of neonatal critical care irrespective of the time that the provider spends with the client.

Procedure code 99469 must be billed for subsequent neonatal critical care per day, irrespective of the time that the provider spends directing the care of the critically ill neonate or infant that is 28 days of age or younger.

Procedure code 99469 may be reimbursed once per day, any provider.

After the neonate is no longer considered critically ill, the E/M procedure codes for subsequent hospital care (procedure codes 99231, 99232, and 99233) or subsequent intensive care (procedure codes 99478, 99479, and 99480) must be used.

If the infant remains in critical care after the 28th day of age, on the 29th day of age, the provider must bill pediatric critical care codes (procedure codes 99471 and 99472).

Neonatal intensive or critical care procedure codes 99468, 99469, 99477, 99478, 99479, and 99480 are inpatient, per day charges and only billable once per day by any provider.

31.2.16.5 Intensive Care (Noncritical) Services

Initial hospital care provided to neonates who require intensive observation, frequent interventions, and other intensive services may be billed using procedure code 99477. Subsequent intensive care provided to very low birth weight, low birth weight, and normal weight infants who do not meet the definition of critically ill but continue to require intensive observation, frequent interventions, and other intensive services only available in the intensive care setting, may be billed using procedure codes 99478, 99479, and 99480.

31.2.16.6 Newborn Resuscitation

Newborn resuscitation may be billed using procedure code 99465.

Procedure code 99465 may be reimbursed for clients birth through 28 days of age. For cardiopulmonary resuscitation performed on clients 29 days of age or older, providers must bill procedure code 92950. Procedure code 92950 may be billed on the same day as critical care (procedure codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476) when reported as a separately identifiable procedure.

Procedure code 99465 must be used by the provider who performs the resuscitation.

31.2.17 Echoencephalography

Procedure code 76506 is a benefit of the CSHCN Services Program with the following diagnosis codes:

Diagnosis Codes							
A066	A170	A171	A1781	A1782	A1789	C410	C6961
C6962	C700	C710	C711	C712	C713	C714	C715
C716	C717	C718	C719	C7221	C7222	C7231	C7232
C7241	C7242	C7259	C729	C751	C752	C768	C7931
C7932	C7940	C7949	C7951	C7952	C7989	D075	D098
D164	D3161	D3162	D320	D329	D330	D331	D332

Diagnosis Codes							
D333	D3500	D3501	D3502	D420	D421	D429	D432
D433	D434	D438	D439	D47Z1	D47Z2	D480	D487
D492	D496	D497	F0390	F03911	F03918	F0392	F0393
F0394	G060	G062	G07	G08	G132	G138	G232
G233	G300	G301	G308	G309	G3101	G3109	G311
G312	G3180	G3183	G3184	G3185	G3186	G3187	G3189
G319	G910	G911	G912	G930	G932	G9340	G9341
G9342	G9343	G9344	G9345	G9349	G935	G936	G937
G9381	G9389	G939	G94	G988	G998	H35361	H4600
H4601	H4602	H4603	H4610	H4611	H4612	H4613	H462
H463	H468	H469	H47011	H47012	H47013	H47019	H47021
H47022	H47023	H47029	H47031	H47032	H47033	H47039	H47091
H47092	H47093	H47099	H4710	H4711	H4712	H4713	H47141
H47142	H47143	H47149	H4720	H47211	H47212	H47213	H47219
H4722	H47231	H47232	H47233	H47239	H47291	H47292	H47293
H47299	H47311	H47312	H47313	H47319	H47321	H47322	H47323
H47329	H47331	H47332	H47333	H47339	H47391	H47392	H47393
H47399	H4741	H4742	H4743	H4749	H47511	H47512	H47519
H47521	H47522	H47529	H47531	H47532	H47539	H47611	H47612
H47619	H47621	H47622	H47629	H47631	H47632	H47639	H47641
H47642	H47649	I6000	I6001	I6002	I6010	I6011	I6012
I602	I6030	I6031	I6032	I604	I6050	I6051	I6052
I606	I607	I608	I609	I610	I611	I612	I613
I614	I615	I616	I618	I619	I6200	I6201	I6202
I6203	I621	I629	I6330	I63311	I63312	I63319	I63321
I63322	I63323	I63329	I63331	I63332	I63333	I63339	I6339
I6340	I63411	I63412	I63419	I63421	I63422	I63429	I63431
I63432	I63439	I6349	I6350	I63511	I63512	I63513	I63519
I63521	I63522	I63523	I63529	I63531	I63532	I63533	I63539
I63543	I6381	I6389	I6601	I6602	I6603	I6609	I6611
I6612	I6613	I6619	I6621	I6622	I6623	I6629	I668
I669	I671	I6781	I6782	I6783	I67850	I67858	I6789
I680	I69098	I6921	I69210	I69211	I69212	I69213	I69214
I69215	I69218	I69219	I69220	I69221	I69222	I69223	I69269
I69290	I69291	I69292	I69293	I69298	O99411	O99412	O99413
O99419	O9942	O9943	P0082	P0700	P0701	P0702	P0703
P0710	P0714	P0715	P0716	P0717	P100	P101	P102
P103	P104	P108	P109	P112	P119	P120	P121
P122	P123	P124	P1281	P1289	P129	P150	P151
P152	P153	P154	P155	P156	P158	P352	P370

Diagnosis Codes							
P371	P372	P373	P374	P378	P520	P521	P5221
P5222	P523	P524	P525	P526	P528	P529	P90
P912	P91811	P91819	P91821	P91822	P91823	P91829	P9188
Q010	Q011	Q012	Q018	Q02	Q030	Q031	Q038
Q040	Q041	Q042	Q045	Q046	Q048	Q050	Q051
Q052	Q054	Q0701	Q0702	Q0703	Q282	Q283	R220
R221	R5600	R569	S0190XA	S0190XD	S0190XS	S060X0A	S060X0D
S060X0S	S060X1A	S060X1D	S060X1S	S060X9A	S060X9D	S060X9S	S060XAA
S060XAD	S060XAS	S061X0A	S061X0D	S061X0S	S061X1A	S061X1D	S061X1S
S061X2A	S061X2D	S061X2S	S061X3A	S061X3D	S061X3S	S061X4A	S061X4D
S061X4S	S061X5A	S061X5D	S061X5S	S061X6A	S061X6D	S061X6S	S061X7A
S061X8A	S061X9A	S061X9D	S061X9S	S061XAA	S061XAD	S061XAS	S06305A
S06305D	S06305S	S06306A	S06306D	S06306S	S06307A	S06308A	S0630AA
S0630AD	S0630AS	S06310A	S06310D	S06310S	S06311A	S06311D	S06311S
S06312A	S06312D	S06312S	S06313A	S06313D	S06313S	S06314A	S06314D
S06314S	S06315A	S06315D	S06315S	S06316A	S06316D	S06316S	S06317A
S06318A	S06319A	S06319D	S06319S	S0631AA	S0631AD	S0631AS	S06320A
S06320D	S06320S	S06321A	S06321D	S06321S	S06322A	S06322D	S06322S
S06323A	S06323D	S06323S	S06324A	S06324D	S06324S	S06325A	S06325D
S06325S	S06326A	S06326D	S06326S	S06327A	S06328A	S06329A	S06329D
S06329S	S0632AA	S0632AD	S0632AS	S06330A	S06330D	S06330S	S06331A
S06331D	S06331S	S06332A	S06332D	S06332S	S06333A	S06333D	S06333S
S06334A	S06334D	S06334S	S06335A	S06335D	S06335S	S06336A	S06336D
S06336S	S06337A	S06338A	S06339A	S06339D	S06339S	S0633AA	S0633AD
S0633AS	S06340A	S06340D	S06340S	S06341A	S06341D	S06341S	S06342A
S06342D	S06342S	S06343A	S06343D	S06343S	S06344A	S06344D	S06344S
S06349A	S06349D	S06349S	S06350A	S06346D	S06346S	S06347A	S06348A
S06349A	S06349D	S06349S	S0634AA	S0634AD	S0634AS	S06350A	S06350D
S06350S	S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A
S06353D	S06353S	S06354A	S06354D	S06354S	S06355A	S06355D	S06355S
S06356A	S06356D	S06356S	S06357A	S06358A	S06359A	S06359D	S06359S
S0635AA	S0635AD	S0635AS	S06360A	S06360D	S06360S	S06361A	S06361D
S06361S	S06362A	S06362D	S06362S	S06363A	S06363D	S06363S	S06364A
S06364D	S06364S	S06365A	S06365D	S06365S	S06366A	S06366D	S06366S
S06367A	S06368A	S06369A	S06369D	S06369S	S06370A	S06370D	S06370S
S06371A	S06371D	S06371S	S06372A	S06372D	S06372S	S06373A	S06373D
S06373S	S06374A	S06374D	S06374S	S06375A	S06375D	S06375S	S06376A
S06376D	S06376S	S06377A	S06378A	S06379A	S06379D	S06379S	S0637AA
S0637AD	S0637AS	S06380A	S06380D	S06380S	S06381A	S06381D	S06381S
S06382A	S06382D	S06382S	S06383A	S06383D	S06383S	S06384A	S06384D

Diagnosis Codes							
S06384S	S06385A	S06385D	S06385S	S06386A	S06386D	S06386S	S06387A
S06388A	S06389A	S06389D	S06389S	S0638AA	S0638AD	S0638AS	S064X0A
S064X0D	S064X0S	S064X1A	S064X1D	S064X1S	S064X2A	S064X2D	S064X2S
S064X3A	S064X3D	S064X3S	S064X4A	S064X4D	S064X4S	S064X5A	S064X5D
S064X5S	S064X6A	S064X6D	S064X6S	S064X7A	S064X8A	S064X9A	S064X9D
S064X9S	S064XAA	S064XAD	S064XAS	S065X0A	S065X0D	S065X0S	S065X1A
S065X1D	S065X1S	S065X2A	S065X2D	S065X2S	S065X3A	S065X3D	S065X3S
S065X4A	S065X4D	S065X4S	S065X5A	S065X5D	S065X5S	S065X6A	S065X6D
S065X6S	S065X7A	S065X8A	S065X9A	S065X9D	S065X9S	S065XAA	S065XAD
S065XAS	S066X0A	S066X0D	S066X0S	S066X1A	S066X1D	S066X1S	S066X2A
S066X2D	S066X2S	S066X3A	S066X3D	S066X3S	S066X4A	S066X4D	S066X4S
S066X5A	S066X5D	S066X5S	S066X6A	S066X6D	S066X6S	S066X7A	S066X8A
S066X9A	S066X9D	S066X9S	S066XAA	S066XAD	S066XAS	S06890A	S06890D
S06890S	S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A
S06893D	S06893S	S06894A	S06894D	S06894S	S06895A	S06895D	S06895S
S06896A	S06896D	S06896S	S06897A	S06898A	S06899A	S06899D	S06899S
S0689AA	S0689AD	S0689AS	S069X0A	S069X0D	S069X0S	S069X1A	S069X1D
S069X1S	S069X2A	S069X2D	S069X2S	S069X3A	S069X3D	S069X3S	S069X4A
S069X4D	S069X4S	S069X5A	S069X5D	S069X5S	S069X6A	S069X6D	S069X6S
S069X7A	S069X8A	S069X9A	S069X9D	S069X9S	S069XAA	S069XAD	S069XAS
S06A0XA	S06A0XD	S06A0XS	S06A1XA	S06A1XD	S06A1XS	S0990xA	S0990xD
S0990xS							

31.2.17.1 Ambulatory Electroencephalogram

Ambulatory electroencephalographic monitoring is a benefit of the CSHCN Services Program with the following diagnosis codes:

Diagnosis Codes							
F05	F060	F0670	F0671	F068	G253	G40001	G40009
G40011	G40019	G40101	G40109	G40111	G40119	G40201	G40209
G40211	G40219	G40301	G40309	G40311	G40319	G40401	G40409
G40411	G40419	G40501	G40509	G40801	G40802	G40803	G40804
G40811	G40812	G40813	G40814	G40841	G40842	G40843	G40844
G4089	G40901	G40909	G40911	G40919	G40A11	G40A19	G40B01
G40B09	G40B11	G40B19	G40C01	G40C09	G40C11	G40C19	G912
G9381	G9389	P912	R561	R569	Z85020	Z85030	Z85040
Z85060	Z85110	Z85230	Z85520	Z85821	Z85841	Z85848	Z86011
Z8669	Z87728	Z87798					

Procedure codes must be used when billing for ambulatory electroencephalograms:

Procedure Codes									
95700	95705	95706	95707	95708	95709	95710	95711	95712	95713
95714	95715	95716	95717	95718	95719	95720	95721	95722	95723
95724	95725	95726	95957						

Authorization is not required for the diagnoses listed above. All other diagnoses require authorization and documentation of medical necessity. Documentation should include the diagnosis and the specific rationale for the request. Claims for ambulatory electroencephalographic monitoring are considered for payment on appeal for diagnoses other than those listed above or if the frequency of testing exceeds the limitation.

Ambulatory electroencephalograms are limited to three every 6 months, per client, same provider. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid for the procedure.

31.2.18 Evaluation and Management (E/M) Services

E/M services are benefits of the CSHCN Services Program. When selecting the level of service provided, providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS.

Covered professional services provided by physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. This manual may not list all E/M procedure codes that may be reimbursed by the CSHCN Services Program.

31.2.18.1 New or Established Patient Visits

Home/residence services are those services that are provided in a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship), assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.

New patient visits will be allowed every 3 years for physician E/M services, per client, per provider.

A new patient is defined by the American Medical Association (AMA) as one who has not received any professional services from a physician or physician within the same group practice, of the same specialty, within the past 3 years. An established patient is one who has received professional services from a physician or physician within the same group practice, of the same specialty, within the last 3 years.

Providers may use procedure codes 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office, or in an outpatient or other ambulatory facility.

Providers may use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office, outpatient, or other ambulatory facility during regularly scheduled evening, weekend, holiday, or standard office hours.

Providers may use procedure codes 99341, 99342, 99344, and 99345 when billing for new patient services provided in the home/residence setting.

Providers may use procedure codes 99347, 99348, 99349, and 99350 when billing for established patient services provided in the home/residence setting.

A subsequent home/residence visit (procedure codes 99347, 99348, 99349, and 99350) billed on the same day as a new patient home/residence visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure billed on the same day, regardless of the diagnosis.

Subsequent home/residence evaluation and management procedure codes are limited to one per day regardless of diagnosis.

Office visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same day as a planned procedure (minor or extensive), are included in the cost of the procedure and are not separately reimbursed.

Modifier 25 may be used to identify a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded. The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

31.2.18.2 Inpatient Professional Services

31.2.18.2.1 Initial and Subsequent Hospital Care (Nonintensive Care)

Initial or subsequent hospital visits (procedure codes 99221, 99222, 99223, 99231, 99232, and 99233), observation (procedure codes 99234, 99235, and 99236), and discharge (procedure codes 99238 and 99239) are limited to one per day for the same provider.

If a subsequent inpatient/observation hospital visit (procedure codes 99231, 99232, and 99233) following admission is billed on the same day by the same provider as an emergency department visit (procedure codes 99281, 99282, 99283, 99284, and 99285), an office visit (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or an outpatient consultation (procedure codes 99242, 99243, 99244, and 99245), the subsequent hospital visit will be paid and the other visits will be denied.

One initial inpatient/observation consultation (procedure code 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period. Any subsequent consultation that is billed as an initial consultation during this time period will be denied.

A subsequent inpatient/observation hospital visit (procedure codes 99231, 99232, and 99233) may be reimbursed on the same day to the same provider when critical care services (procedure codes 99291 and 99292) are billed.

E/M services provided in a hospital setting following a major procedure, provided by the same provider or in direct follow-up for postsurgical care, are included in the surgeon's global surgical fee and are denied as included in another procedure.

A physician who did not perform the surgery and provides postoperative surgical care in the time frame that is included in the global surgical fee must bill with modifier 55. This may only be done when the surgeon submits a charge for surgical care only and there is an agreement between the physicians and the surgeon to split the care of the client.

31.2.18.2.2 Hospital Discharge Day Management

Discharge management (procedure codes 99238 and 99239) billed on the same date of service as the admission by the same provider will be denied.

Discharge management (procedure codes 99238 and 99239) billed on the same date of service as an emergency room visit by the same provider is denied, but may be considered for reimbursement upon appeal, if provided at a separate time.

Only one discharge management service will be considered for reimbursement per day. Subsequent hospital visits billed on the same day as discharge management, by the same provider, will be denied.

Initial/observation or subsequent hospital visit (procedure codes 99221, 99222, and 99223) billed on the same day as hospital discharge day management (procedure code 99238) is denied as part of another procedure billed on the same day.

31.2.18.2.3 Concurrent Inpatient Care

Concurrent care exists when services are provided to a client by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the client in accordance with accepted standards of good medical practice.

Concurrent care will not be paid to providers of the same specialty for the same or related diagnoses. Diagnoses are considered to be related when up to six digits of the primary diagnosis codes match. Denied concurrent care may be considered on an appeal basis when accompanied by documentation of medical necessity.

Concurrent care may be considered for reimbursement to providers of different specialties when providing services for unrelated diagnoses involving different organ systems.

31.2.18.3 Emergency Services

An emergency medical condition is defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that if not immediately treated must reasonably be expected to result in one of the following outcomes:

- Placing the client's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who require immediate medical attention. The facility must be available to provide services 24 hours a day, 7 days a week.

31.2.18.3.1 Hospital-Based Emergency Department Professional Services

Physicians may use procedure codes 99281, 99282, 99283, 99284, and 99285 to bill for services provided in the hospital-based emergency department. Office-based physicians may also use procedure codes 99202, 99203, 99204, and 99205 for new patients or procedure codes 99211, 99212, 99213, 99214, and 99215 for established patients, to bill for services provided in the office or in a hospital-based emergency department. These procedure codes are also appropriate for a physician who is attending a client in an outpatient observation room setting for less than 6 hours. Document the time for multiple visits in Block 24K of the CMS-1500 paper claim form.

Emergency department visits include the components of a diagnostic examination such as a pelvic or rectal examination. These components should not be billed with an unlisted procedure code in addition to the procedure code for the visit. These components are considered part of the examination and no separate reimbursement may be provided.

Multiple emergency department visits on the same day and billed by the same provider must have the times for each visit documented on the claim form. More than one visit on the same day can also be indicated by adding the appropriate modifier to the claim form. Medical documentation is required to support this charge.

Emergency department visits may be paid to different providers on the same day, when medically necessary, regardless of specialty and diagnosis.

Separate charges are allowed for emergency department treatment room and minor surgery or diagnostic procedures billed on the same day. Use the appropriate procedure code from the CPT manual.

Payment for an additional emergency department visit by an anesthesiologist following a surgical procedure is denied as part of the global anesthesia payment (base plus time). A distinct and separate diagnosis beyond the diagnosis for which the global anesthesia services were provided should be documented in order for payment to be considered on an appeal basis.

If an emergency department visit (procedure codes 99281, 99282, 99283, 99284, and 99285) is billed on the same day, by the same provider, as an office visit (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215), or outpatient consultation (procedure codes 99242, 99243, 99244, and 99245), the emergency department visit may be considered for reimbursement and the office or consultation visit is denied.

Emergency department visits (procedure codes 99281, 99282, 99283, 99284, and 99285) are denied when billed on the same day as an inpatient/observation service (procedure codes 99238 and 99239) by the same provider.

Binocular microscopy (procedure code 92504) and noninvasive ear or pulse oximetry for oxygen (procedure code 94760) will be denied when billed on the same day, by the same provider, as emergency department visit (procedure code 99281, 99282, 99283, 99284, or 99285).

31.2.18.4 Consultations

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. To be billed as such, a consultation must consist of the following:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.
- There must be correspondence from the consulting provider back to the referring provider indicating the medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary. If treatment is initiated and the client returns for follow up care, an established patient visit should be billed. If the purpose of the referral is to transfer care, a consultation may not be billed.

The medical records maintained by both the referring and consulting providers must identify their counterpart and reason for consultation.

Consultations may be billed using the following procedure codes:

Procedure Codes							
99242	99243	99244	99245	99252	99253	99254	99255

Office or outpatient consultations will be limited to one consultation every six-month period by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this time period will be denied.

31.2.18.5 Services Outside of Business Hours

The CSHCN Services Program limits reimbursement for after hours charges (procedure codes 99050, 99056, and 99060) to office-based providers rendering services after routine office hours or on an emergency basis.

An office-based provider may bill an after hours charge in addition to a visit for providing services after routine office hours. After hours charges may be billed when the provider's clinical judgment deems it medically necessary to interrupt the routine schedule to care for a client with an emergent condition. A provider's routine office hours are those hours posted at the physician's office as the usual office hours. The CSHCN Services Program may reimburse office-based physicians when any of the following exists:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours.
- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.
- After-hours procedure codes are limited to one per day, same provider.

Procedure codes 99050, 99056, and 99060 are not reimbursed separately to emergency department-based physicians or emergency department-based groups.

31.2.18.6 Prolonged Physician Services

Prolonged services may be provided in an office, outpatient, or inpatient setting and involves direct (face-to-face) client contact that is beyond the usual service and exceeds the time threshold of the E/M procedure code (listed in the table below) being billed on that day:

Procedure Codes								
99205	99215	99223	99233	99236	99245	99255	99345	99350

Prolonged services of less than 30 minutes duration should not be reported separately.

Procedure code 99417 should only be used when an outpatient evaluation and management service has been selected using time alone as the basis, and only after the minimum time required to report the addition to the code of the outpatient evaluation and management service has been exceeded by 15 minutes.

Procedure codes 99417 and 99418 are limited to 4 units (1 hour) per day and should not be used to report an additional time increment of less than 15 minutes.

Procedure code 99418 is only used when inpatient or observation evaluation and management service has been selected using time alone as the basis and only after the minimum time required to report the addition to the code of the inpatient and observation evaluation and management service has been exceeded by 15 minutes.

31.2.18.7 Observation Room Services

When a client's status changes from observation to inpatient, the date of inpatient admission is the date the client was admitted to the hospital as an inpatient. Charges are to be billed as specified in Section 24.4, "Outpatient Services" in Chapter 24, "Hospital."

Inpatient/observation care discharge day management (procedure codes 99238 and 99239) may be used to report services provided to a client upon discharge from "observation status" if the discharge date differs from the initial date of admission.

The following limitations apply to these procedure codes:

- Procedure codes 99211, 99212, 99213, 99214, 99215, 99221, 99222, and 99223 are denied if billed on the same day as procedure codes 99238 and 99239 by the same provider.
- If a physician inpatient/observation visit (procedure codes 99221, 99222, 99234, 99235, 99238, and 99239) is billed on the same day as prolonged services (procedure codes 99417 and 99418) by the same provider, the prolonged services are denied as part of another procedure on the same day.

- If procedure codes 99234, 99235, and 99236 are billed on the same day as a subsequent hospital visit (procedure codes 99231, 99232, and 99233) by the same provider, the subsequent visit is denied.
- If procedure codes 99234, 99235, and 99236 are billed on the same day as a consultation by the same provider, the consultation is paid and the physician inpatient hospital observation is denied.
- If a chemotherapy planning program (procedure codes 99213, 99214, or 99215) and physician outpatient hospital observation are billed on the same day by the same provider, the chemotherapy planning is paid and the physician outpatient hospital observation will be denied.
- Procedure codes 99234, 99235, and 99236 are not payable on the same day as procedure codes 99238 and 99239.
- Procedure codes 99234, 99235, and 99236 are subject to the global surgical fee pre-/postcare days assigned to certain surgical procedures.
- E/M services provided at any place of service (POS) other than an inpatient hospital and billed on the same day as a physician observation visit by the same provider are denied.
- If dialysis treatment and physician observation visits are billed the same day by the same provider, same specialty (other than nephrology and internal medicine specialists), the dialysis treatment may be paid and the physician observation visit is denied.

31.2.18.8 Preventive Care Services

The CSHCN Services Program may reimburse for preventive health-care services. Providers should submit claims with the following E/M procedure codes and include the appropriate diagnosis code. Diagnosis code Z00121 or Z00129 should be used for children's preventive care medical checkups. Diagnosis code Z0000 or Z0001 should be used for an adult preventive care medical checkup.

Procedure Codes									
99381	99382	99383	99384	99385	99386	99387	99391	99392	99393
99394	99395	99396	99397						

Providers may be reimbursed for an acute care visit on the same day as a preventive care visit. The acute care visit should be billed as an established patient visit. Modifier 25 must be used to describe circumstances in which a visit was provided at the same time as other separately identifiable services (e.g., preventive visits, minor procedure). Both services must be documented as distinct, and documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request. This modifier must be appended to the evaluation procedure code when the services rendered are distinct, provided for different diagnosis, or are performed for different reasons.

When the client visit is only for immunization, a preventive care visit will not be reimbursed. The administration fee and any vaccine or toxoid not obtained through Texas Vaccines for Children (TVFC) may be reimbursed when diagnosis code Z23 and the appropriate procedure code referencing an immunization is submitted with the claim.

Vaccinations, vaccine administration procedure codes, and laboratory services may be billed in addition to the preventive care E/M procedure code. Providers must append modifier 25 to one of the preventive care E/M procedure codes listed in the table above to identify a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the vaccine administration.

The CSHCN Services Program reimburses for only one preventive health visit per day per client for any provider. The program does not cover family planning services and inpatient newborn examinations.

Preventive care medical checkups are not a benefit of a telemedicine or telehealth service.

31.2.18.9 Preventive Care Medical Checkups and Developmental Testing

When a new patient acute care E/M visit is billed for the same date of service as a new patient preventive care medical checkup, both new patient services may be reimbursed when billed by the same provider if that provider has not billed other acute care E/M visits or preventive care medical checkups for the client in the preceding 3 years.

Modifier 25 must be used to describe circumstances in which an acute care E/M visit was provided at the same time as a preventive care medical checkup. This modifier must be appended to the E/M procedure code when the services are distinct and provided for a different diagnosis. An appropriate level E/M procedure code must be billed with the diagnosis supporting the acute care claim.

If the provider or provider group has billed for a new patient preventive care medical checkup within the past 3 years, subsequent preventive care medical checkups and acute care visits billed as new patient services will be denied when billed by the same provider. Another new checkup will only be allowed when the client has not received any professional services from the same provider or another provider who belongs to the same group practice in the past 3 years, because subsequent acute care visits after the initial new patient preventive care medical checkup continue the established relationship with the provider. Subsequent preventive care medical checkups and acute care visits after the initial new patient preventive care medical checkup continue the established relationship with the provider.

31.2.18.9.1 Laboratory Tests

Documented laboratory results obtained prior to the current medical checkup may be used as follows to complete the laboratory testing requirement:

- Results obtained within 30 days before the current medical checkup for clients who are 2 years of age and younger
- Results obtained within 90 days before the current medical checkup for clients who are 3 years of age and older

Documentation must include the date of service and one of the following:

- A clear reference to the previous visit by the same provider
- Results obtained from a different provider

31.2.18.9.2 Medical Checkup Follow-up Visit

A follow-up checkup is a visit that is scheduled to complete checkup components that could not be completed at the original medical checkup due to circumstances beyond the provider's control. If the parent or guardian did not give consent for a missing component, a follow-up visit is not necessary. The most appropriate procedure code for the follow-up visit will be determined by the components that could not be completed during the original medical checkup.

Procedure code 99211 may be submitted for a follow-up visit that includes a separately identifiable evaluation and management (E/M) component. When the follow-up visit does not include a separately identifiable E/M component, the following procedure codes must be used instead of procedure code 99211:

- Developmental testing (procedure code 96110) and autism screening (procedure code 96110 with modifier U6)
- Hearing screening (procedure code 92551)
- Immunization administration (procedure codes 90460 and 90461)

If a separately identifiable E/M component is required before completing one of the above checkup components, claims for the follow-up visit (procedure code 99211) and the checkup component may be submitted.

31.2.18.9.3 Denied Medical Checkups

Providers may be reimbursed for denied medical checkups through the appeal process when all of the following criteria are met for clients who are birth through 3 years of age:

- The client changed to a new provider in a new practice.
- The previous provider billed the maximum number of checkups in the procedure code age range for that client.
- The new provider's claim was denied for exceeding periodicity.

Note: *In addition to the criteria listed above, at least 1 year must have elapsed since the last checkup for clients who are 3 years of age or older.*

31.2.18.9.4 Developmental Screening and Testing

Developmental screening and testing may be a benefit when the services are provided during a preventive care medical checkup in accordance with accepted guidelines or when a parent expresses concern with a client's developmental progress. If the developmental screening was not completed during a previous checkup, or if the provider is seeing the client for the first time at a checkup for birth through 6 years of age, a standardized developmental screening must be completed.

Standardized developmental screening and testing may also be a benefit when they are performed outside of a preventive care medical checkup.

Clients with abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age with suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) as soon as possible, but no longer than 7 days after identification, even if the client is referred to an appropriate provider for further testing.

31.2.18.9.5 Developmental Screening

Developmental screening (procedure code 96110) is a required component of each checkup for clients who are birth through 6 years of age. Procedure code 96110 is a benefit when performed by an APRN or physician in the office, home, or outpatient hospital setting.

Providers must submit modifier U6 with procedure code 96110 to bill for autism screening. Autism screening is required at 18 and 24 months of age.

If the provider administers a standardized developmental screening at an additional checkup, the provider must document the rationale for the additional screen(s), which may be due to provider or parental concern. Retrospective review may be performed to ensure documentation supports medical necessity.

Additional parental or guardian consent may be required if online or web-based screening tools are used, which could result in client data being stored electronically in an outside database other than the provider's electronic medical record system, or if the data is used for purposes other than CSHCN Services Program screening. The provider should seek legal advice regarding the need for this consent.

Procedure code 96110, with or without modifier U6, must be billed with the appropriate E/M procedure code. Providers must use a standardized tool to complete the developmental screening. The CSHCN Services Program recognizes the following standardized tools:

- The Ages and Stages Questionnaire (ASQ), Ages and Stages Questionnaire: Social - Emotional (ASQ:SE)
- Parents' Evaluation of Developmental Status (PEDS)
- The Modified Checklist for Autism in Toddlers (M-CHAT)
- The Modified Checklist for Autism in Toddlers, Revised with Follow-up (M-CHAT - R/F)
- The Survey of Well-being of Young Children (SWYC)

A provider who chooses a standardized developmental screening tool different from those listed above must provide medical documentation that supports the use of the tool.

Developmental screening procedure code 96110 and autism screening procedure code 96110 with modifier U6 may be reported separately when provided as part of a medical checkup or follow up visit. Developmental screening and testing may also be billed with other office visits when medically necessary.

Procedure codes 96110 and 96110 with modifier U6 are each limited to once per day, same provider and will be denied unless a checkup, follow up visit or office visit is paid for the same date of service by the same provider. Providers may be reimbursed for both procedures on the same day.

Developmental screening, which is not expected to last longer than 30 minutes, is included in the limitation of 12 hours of behavioral health services per day, per provider. Physicians are not limited to the 12-hour limitation since they can delegate services and may submit claims in excess of 12 hours per day. The individuals delegated by a physician to perform these services are subject to the 12-hour limitation.

A Mini Mental State Examination is considered part of any E/M service and is not separately reimbursed.

31.2.18.9.6 Developmental Testing

Procedure codes 96112 and 96113, which consists of an extended evaluation, require the use of a standardized tool and are limited to clients who are birth through 20 years of age. Procedure codes 96112 and 96113 are a benefit when performed by an APRN, physician, or psychologist in the office, home, or outpatient hospital setting. Developmental testing is medically necessary when there is suspected developmental delay that is supported by the following clinical evidence:

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

The following procedure codes will be denied when billed on the same day as procedure codes 96112 and 96113:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Developmental testing procedure codes 96112 and 96113 are included in the system limitation of 12 hours of behavioral health services per day, per provider. Each additional 30 minutes may be reimbursed using add-on procedure code 96113. Retrospective review may be performed on billed hours and total hours worked per day since providers who perform developmental testing may possibly bill in excess of 12 hours per day. Providers must maintain clinical documentation in the client's medical record to support medical necessity.

Developmental testing that is performed when a development delay or change in the client's developmental status is not suspected would constitute developmental screening and is not covered. Providers may not bill clients for developmental testing that is considered developmental screening.

31.2.18.10 Preventive Care Medical Checkup Components

Referral to Establish a Dental Home

The American Academy of Pediatric Dentistry's (AAPD) definition of a dental home, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continu-

ously accessible, coordinated, and family-centered way. In Texas, establishment of a client's dental home begins at 6 months of age but no later than 12 months of age and includes referral to dental specialists when appropriate.

The provider must refer clients to establish a dental home beginning at 6 months of age or earlier if trauma or early childhood caries are identified. For established clients after the six-month medical checkup visit, the provider must confirm whether a dental home has been established and is on-going. If a dental home has not been established, the provider must make additional referrals at subsequent medical checkup visits until the parent or guardian confirms that a dental home has been established for the client. A parent or guardian of the client may self-refer for dental care at any age, including 12 months of age or younger.

31.2.18.10.1 Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV)

An intermediate oral evaluation with fluoride varnish application (procedure code 99429) is a benefit for clients 6 months of age through 35 months of age. Procedure code 99429 must be submitted with modifier U5, and diagnosis code Z00121 or Z00129.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup or an exception to the periodicity visit (procedure codes 99381, 99382, 99391, or 99392) and is limited to six services per lifetime by any provider.

An intermediate oral evaluation with fluoride varnish application is limited to preventive care medical checkup providers who have completed the required benefit education and who are certified by the DSHS Oral Health Program to perform an intermediate oral evaluation with fluoride varnish application.

The intermediate oral evaluation with fluoride varnish application add-on includes the following component:

- Intermediate oral evaluation
- Fluoride varnish application
- Dental anticipatory dental guidance to include:
  - The need for thorough daily oral hygiene practices
  - Education in potential gingival manifestations for clients with diabetes and clients under long-term medication therapy
  - Diet, nutrition, and food choices
  - Fluoride needs
  - Injury prevention
  - Antimicrobials, medications, and oral health
- Referral to a dentist to establish a dental home
- Additional dental anticipatory guidance if the client has no erupted teeth

Note: *A Texas Health Steps-certified oral evaluation and fluoride varnish (OEFV) provider must complete the intermediate oral evaluation but can delegate all other components.*

31.2.18.10.2 Mental Health Screening

Mental health screening is a benefit at each preventive care medical checkup when it is provided in accordance with accepted guidelines or when a parent expresses concern about the client's mental health.

Mental health screening using one of the following validated, standardized mental health screening tools recognized by the CSHCN Services Program is required once per calendar year, any provider for clients who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Patient Health Questionnaire (PHQ-9) Modified for Adolescents (PHQ-A [depression screen])
- Pediatric Symptom Checklist-17 (PSC-17)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance use])
- Rapid Assessment for Adolescent Preventive Services (RAAPS)

Providers may be reimbursed separately when using one of the required screening tools during a preventive care medical checkup.

Procedure code 96160 or 96161 must be submitted for the required mental health screening. Procedure codes 96160 and 96161 are a benefit for clients who are 12 through 18 years of age.

Mental health screening at other medical checkups does not require the use of a validated, standardized mental health screening tool.

Procedure code 96160 or 96161 must be submitted on the same date of service and by the same provider as procedure code 99384, 99385, 99394, or 99395. Procedure codes 96160 and 96161 are limited to once per calendar year, any provider.

Procedure codes 96160 and 96161 will not be reimbursed for the same client for any date of service.

The client's medical record must include documentation identifying the tool that was used, the screening results, and any referrals.

31.2.18.10.3 Postpartum Depression Screening

Postpartum depression screening is a benefit of the CSHCN Services Program. Procedure codes G8431 and G8540 may be reimbursed when billing for postpartum depression screening.

Postpartum depression screening must be submitted under the infant's Medicaid client number.

Procedure codes G8431 and G8510 must be submitted on the same claim, for the same date of service, by the same provider as the checkup or follow-up visit procedure codes below:

Procedure Codes				
99211	99381	99382	99391	99392

Providers may receive separate reimbursement for postpartum depression screening in addition to the infant's preventive care medical checkup or follow-up visit. The reimbursement amount for procedure codes G8431 and G8510 covers all postpartum depression screenings provided during the checkup or follow-up visit.

Only one procedure code, either G8431 or G8510, may be reimbursed per provider in the 12 months following the infant's birth.

Postpartum Depression Screening and Referral Services

The American Academy of Pediatrics (AAP) recommends the infant's provider screen mothers for postpartum depression. Postpartum depression is the most common form of postpartum mood disturbance. Screening mothers for postpartum depression is appropriate for the general postpartum population.

> ***Note:*** *Screening for postpartum depression during the infant's preventive care medical checkup is recommended, not required.*

Postpartum depression meets the same clinical criteria as major depressive disorder, with the main difference being onset during pregnancy or after delivery.

While postpartum depression is the most common form of postpartum mood disturbance, providers should be aware that other mood disorders that may arise during the postpartum period include anxiety and panic disorders, obsessive-compulsive disorder, and postpartum psychosis.

Postpartum psychosis is a much more severe form of postpartum depression accompanied by psychotic features. Postpartum psychosis is rare, typically develops in the first few days to weeks after delivery, and is a psychiatric emergency requiring immediate medical attention.

In addition to postpartum psychosis, immediate or emergent medical attention may be necessary when the risk of imminent harm or danger is present.

Screening Guidelines

Screening using a validated tool is required. At a minimum, screening should occur at least once during the postpartum period. Validated tools may include the following:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9

Screening alone is inadequate for improving clinical outcomes. A positive screening for postpartum depression requires the THSteps provider to develop a referral plan with the mother.

Positive Screenings: Referrals and Follow-Up

Providers must discuss the screening results with the mother, discuss the possibility of depression, and the impact depression may have on the mother, family, and health of the infant.

The provider and mother should discuss the mother's options so the provider can refer her to an appropriate provider. Screening and referral is not contingent upon the mother's Medicaid eligibility. When needed, referrals should be made regardless of the funding source, including referral to local mental health authorities and local behavioral health authorities.

Providers should refer the mother to a provider who can perform further evaluation and determine an appropriate course of treatment. Appropriate providers include, but are not limited to:

- Mental health clinicians
- The mother's primary care provider
- Obstetricians and gynecologists
- Family physicians

Community resources such as Local Mental Health Authorities (LMHAs)

Resources should be provided for support in the interim until the mother is able to access care.

Scheduling a return visit for the infant sooner than the next scheduled visit may be appropriate in some cases.

Prior Authorization Requirements

Screening for postpartum mood disorders at the checkup or follow up visit does not require prior authorization.

While recommended, screening for postpartum depression is not a compulsory requirement of the infant visit.

Documentation Requirements

Documentation in the infant's record must include the name of the screening tool used and date the screening was completed.

If the mother screens positive for depression, at a minimum, the provider must note that a referral plan was discussed with the mother and a referral to a provider was made. Providers may give the mother a copy of the completed screening tool to take with her to referral appointments.

Documentation should also include any health education or anticipatory guidance provided, along with the time period recommended for the infant's next appointment.

31.2.18.10.4 Sensory Screening

Providers may use test results from a different provider or a school vision and hearing screening program to replace the required visual acuity or hearing screening that requires the use of calibrated electronic equipment as long as the previous screening was performed within 12 months preceding the current medical checkup.

Procedure code 92551 may be reimbursed separately for a hearing screening (for hearing loss) with pure tone audiometric testing that is performed with the use of calibrated electronic equipment.

31.2.18.11 Teaching Physicians

Teaching physicians who provide E/M services may bill the CSHCN Services Program for lower- and mid-level E/M services (procedure codes 99202, 99203, 99211, 99212, and 99213) that are provided by residents if they meet the primary care exception under Medicare.

31.2.19 Evoked Response Tests and Neuromuscular Procedures

The following services are a benefit of the CSHCN Services Program:

- Autonomic function test (AFT)
- Electromyography (EMG)
- Nerve conduction studies (NCS)
- Evoked potential (EP) procedures
- Motion analysis (MAS) studies

All procedures must be medically indicated and testing must be performed using appropriate equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening, rather than diagnosis, are not benefits of the CSHCN Services Program.

Client medical records must clearly document the medical necessity for all procedures and must reflect the actual results of specific procedures. All client medical records are subject to retrospective review.

31.2.19.1 Autonomic Function Tests (AFTs)

AFTs are a benefit of the CSHCN Services Program when submitted with procedure codes 95921, 95922, 95923, and 95924. Prior authorization is not required for AFTs.

Procedure codes 95921, 95922, 95923, and 95924 are limited to once per date of service, by the same provider.

Autonomic disorders may be congenital or acquired (primary or secondary). Some of the conditions under which autonomic function testing may be appropriate include, but are not limited to, the following:

- Amyloid neuropathy
- Diabetic autonomic neuropathy
- Distal small fiber neuropathy
- Excessive sweating
- Gastrointestinal dysfunction
- Idiopathic neuropathy
- Irregular heart rate
- Multiple system atrophy
- Orthostatic symptoms
- Pure autonomic failure
- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)
- Sjogren's syndrome

31.2.19.2 Electromyography and Nerve Conduction Studies

EMG and NCS are a benefit of the CSHCN Services Program when billed with the following procedure codes:

EMG Procedure Codes									
51784	51785	95860	95861	95863	95864	95865	95866	95867	95868
95869	95870	95872	95875						

NCS Procedure Codes									
95885	95886	95887	95905	95907	95908	95909	95910	95911	95912
95913	95933	95937							

Prior authorization is not required for EMGs.

EMG and NCS are restricted to the following diagnosis codes:

Diagnosis Codes							
C701	C720	C721	D510	D511	D513	D518	D519
D538	E0842	E0942	E1041	E1042	E10610	E1141	E1142
E1144	E11610	E1342	E5111	E5112	E512	E518	E519
E52	E530	E531	E538	E550	E559	E560	E568
E610	E7281	E7289	E7841	E7849	E786	E851	E852
E853	E8581	E8582	E8589	E859	G120	G121	G1221
G1222	G1223	G1224	G1225	G1229	G128	G129	G130
G243	G2589	G260	G320	G360	G370	G375	G501
G510	G511	G512	G5131	G5132	G5133	G5139	G514
G518	G519	G522	G523	G527	G528	G540	G541

Diagnosis Codes							
G542	G543	G544	G545	G548	G549	G5601	G5602
G5603	G5611	G5612	G5613	G5621	G5622	G5623	G5631
G5632	G5633	G5641	G5642	G5643	G5681	G5682	G5683
G5691	G5692	G5693	G5701	G5702	G5703	G5711	G5712
G5713	G5721	G5722	G5723	G5731	G5732	G5733	G5741
G5742	G5743	G5751	G5752	G5753	G5761	G5762	G5763
G5771	G5772	G5773	G5781	G5782	G5783	G5791	G5792
G5793	G587	G588	G589	G590	G600	G601	G602
G603	G608	G609	G610	G6181	G6182	G6189	G619
G620	G621	G622	G6281	G6282	G629	G630	G650
G651	G652	G7000	G7001	G701	G702	G7081	G7089
G709	G7100	G7101	G7102	G7109	G7111	G7112	G7113
G7114	G7119	G7120	G7121	G71220	G71228	G7129	G713
G718	G719	G721	G722	G723	G7241	G7249	G7281
G7289	G729	G731	G733	G737	G800	G801	G802
G803	G804	G808	G809	G8311	G8312	G8313	G8314
G8321	G8322	G8323	G8324	G834	G8381	G8382	G8383
G8384	G8389	G839	G9009	G902	G904	G9050	G90511
G90512	G90513	G90519	G90521	G90522	G90523	G90529	G9059
G909	G950	G9511	G9519	G9520	G9529	G9581	G9589
G959	G990	G992	I776	I951	J3800	J3801	J3802
K5902	K5903	K5904	K5909	K592	K594	K624	K6289
M05411	M05412	M05421	M05422	M05431	M05432	M05441	M05442
M05451	M05452	M05461	M05462	M05471	M05472	M0549	M05511
M05512	M05521	M05522	M05531	M05532	M05541	M05542	M05551
M05552	M05561	M05562	M05571	M05572	M0559	M05711	M05712
M05721	M05722	M05731	M05732	M05741	M05742	M05751	M05752
M05761	M05762	M05769	M05771	M05772	M05779	M0579	M057A
M05811	M05812	M05821	M05822	M05831	M05832	M05841	M05842
M05851	M05852	M05861	M05862	M05871	M05872	M0589	M058A
M05A	M06011	M06012	M06021	M06022	M06031	M06032	M06041
M06042	M06051	M06052	M06061	M06062	M06071	M06072	M0608
M0609	M060A	M06811	M06812	M06821	M06822	M06831	M06832
M06841	M06842	M06852	M06861	M06862	M06871	M06872	M0688
M0689	M068A	M069	M21271	M21272	M21331	M21332	M21511
M21512	M216X1	M216X2	M21831	M21832	M21931	M21932	M320
M3210	M3211	M3212	M3213	M3214	M3215	M3219	M328
M329	M3300	M3301	M3302	M3309	M3310	M3311	M3312
M3319	M3320	M3321	M3322	M3329	M3390	M3391	M3392
M3399	M340	M341	M342	M3481	M3482	M3483	M3489

Diagnosis Codes							
M3500	M3501	M3502	M3503	M3504	M3505	M3506	M3507
M3508	M3509	M350A	M350B	M350C	M3581	M3589	M360
M4321	M4322	M4323	M4324	M4325	M4326	M4327	M4328
M436	M438X9	M4644	M4645	M4646	M4647	M4711	M4712
M4713	M4714	M4715	M4716	M4721	M4722	M4723	M4724
M4725	M4726	M4727	M4728	M47811	M47812	M47813	M47814
M47815	M47816	M47817	M47818	M47891	M47892	M47893	M47894
M47895	M47896	M47897	M47898	M4801	M4802	M4803	M4804
M4805	M48062	M4807	M4808	M5000	M5001	M50020	M50021
M50022	M50023	M5003	M5011	M50120	M50121	M50122	M50123
M5013	M5020	M5021	M50220	M50221	M50222	M50223	M5023
M5030	M5031	M50320	M50321	M50322	M50323	M5033	M5080
M5081	M50820	M50821	M50822	M50823	M5083	M5091	M50920
M50921	M50922	M50923	M5093	M5104	M5105	M5106	M5124
M5125	M5126	M5127	M5134	M5135	M51360	M51361	M51362
M51369	M51370	M51371	M51372	M51379	M5184	M5185	M5186
M5187	M5410	M5411	M5412	M5413	M5414	M5415	M5416
M5417	M5431	M5432	M5450	M5451	M5459	M546	M5489
M60011	M60012	M60021	M60022	M60031	M60032	M60041	M60042
M60044	M60045	M60046	M60051	M60052	M60061	M60062	M60070
M60071	M60073	M60074	M60076	M60077	M6008	M6009	M60111
M60112	M60121	M60122	M60131	M60132	M60141	M60142	M60151
M60152	M60161	M60162	M60171	M60172	M6018	M6019	M6090
M6250	M62511	M62512	M62519	M62521	M62522	M62529	M62531
M62532	M62539	M62541	M62542	M62549	M62551	M62552	M62559
M62561	M62562	M62569	M62571	M62572	M62579	M6258	M6259
M625A0	M625A1	M625A2	M625A9	M6281	M6284	M6285	M629
M7910	M7911	M7912	M7918	M792	M79601	M79602	M79604
M79605	M79621	M79622	M79631	M79632	M79641	M79642	M79651
M79652	M79661	M79662	M79671	M79672	M797	M961	N393
N3941	N3942	N3943	N3944	N3945	N3946	N39490	N39491
N39492	N39498	N94819	R150	R151	R152	R159	R200
R201	R202	R203	R208	R209	R260	R261	R2681
R2689	R269	R290	R295	R29701	R29702	R29703	R29704
R29705	R29706	R29707	R29708	R29709	R29710	R29711	R29712
R29713	R29714	R29715	R29716	R29717	R29718	R29719	R29720
R29721	R29722	R29723	R29724	R29725	R29726	R29727	R29728
R29729	R29730	R29731	R29732	R29733	R29734	R29735	R29736
R29737	R29738	R29739	R29740	R29741	R29742	R320	R3914
R39191	R39192	R39198	R4702	R471	R4781	R4789	R498

Diagnosis Codes							
R6884	R7681	S14101A	S14101D	S14101S	S14102A	S14102D	S14102S
S14103A	S14103D	S14103S	S14104A	S14104D	S14104S	S14105A	S14105D
S14105S	S14106A	S14106D	S14106S	S14107A	S14107D	S14107S	S14108A
S14108D	S14108S	S14109A	S14109D	S14109S	S14111A	S14111D	S14111S
S14112A	S14112D	S14112S	S14113A	S14113D	S14113S	S14114A	S14114D
S14114S	S14115A	S14115D	S14115S	S14116A	S14116D	S14116S	S14117A
S14117D	S14117S	S14118A	S14118D	S14118S	S14121A	S14121D	S14121S
S14122A	S14122D	S14122S	S14123A	S14123D	S14123S	S14124A	S14124D
S14124S	S14125A	S14125D	S14125S	S14126A	S14126D	S14126S	S14127A
S14127D	S14127S	S14128A	S14128D	S14128S	S14131A	S14131D	S14131S
S14132A	S14132D	S14132S	S14133A	S14133D	S14133S	S14134A	S14134D
S14134S	S14135A	S14135D	S14135S	S14136A	S14136D	S14136S	S14137A
S14137D	S14137S	S14138A	S14138D	S14138S	S14141A	S14141D	S14141S
S14142A	S14142D	S14142S	S14143A	S14143D	S14143S	S14144A	S14144D
S14144S	S14145A	S14145D	S14145S	S14146A	S14146D	S14146S	S14147A
S14147D	S14147S	S14148A	S14148D	S14148S	S14151A	S14151D	S14151S
S14152A	S14152D	S14152S	S14153A	S14153D	S14153S	S14154A	S14154D
S14154S	S14155A	S14155D	S14155S	S14156A	S14156D	S14156S	S14157A
S14157D	S14157S	S14158A	S14158D	S14158S	S142XXA	S142XXD	S142XXS
S143XXA	S143XXD	S143XXS	S144XXA	S144XXD	S144XXS	S145XXA	S145XXD
S145XXS	S148XXA	S148XXD	S148XXS	S149XXA	S149XXD	S149XXS	S24101A
S24101D	S24101S	S24102A	S24102D	S24102S	S24103A	S24103D	S24103S
S24104A	S24104D	S24104S	S24109A	S24109D	S24109S	S24111A	S24111D
S24111S	S24112A	S24112D	S24112S	S24113A	S24113D	S24113S	S24114A
S24114D	S24114S	S24131A	S24131D	S24131S	S24132A	S24132D	S24132S
S24133A	S24133D	S24133S	S24134A	S24134D	S24134S	S24141A	S24141D
S24141S	S24142A	S24142D	S24142S	S24143A	S24143D	S24143S	S24144A
S24144D	S24144S	S24151A	S24151D	S24151S	S24152A	S24152D	S24152S
S24153A	S24153D	S24153S	S24154A	S24154D	S24154S	S242XXA	S242XXD
S242XXS	S243XXA	S243XXD	S243XXS	S244XXA	S244XXD	S244XXS	S248XXA
S248XXD	S248XXS	S249XXA	S249XXD	S249XXS	S34109A	S34109D	S34109S
S34111A	S34111D	S34111S	S34112A	S34112D	S34112S	S34113A	S34113D
S34113S	S34114A	S34114D	S34114S	S34115A	S34115D	S34115S	S34121A
S34121D	S34121S	S34122A	S34122D	S34122S	S34123A	S34123D	S34123S
S34124A	S34124D	S34124S	S34125A	S34125D	S34125S	S34131A	S34131D
S34131S	S34132A	S34132D	S34132S	S34139A	S34139D	S34139S	S3421XA
S3421XD	S3421XS	S3422XA	S3422XD	S3422XS	S343XXA	S343XXD	S343XXS
S344XXA	S344XXD	S344XXS	S345XXA	S345XXD	S345XXS	S4400XA	S4400XD
S4400XS	S4400XX	S4401XA	S4401XD	S4401XS	S4402XA	S4402XD	S4402XS
S4410XA	S4410XD	S4410XS	S4411XA	S4411XD	S4411XS	S4412XA	S4412XD

Diagnosis Codes							
S4412XS	S4420XA	S4420XD	S4420XS	S4421XA	S4421XD	S4421XS	S4422XA
S4422XD	S4422XS	S4430XA	S4430XD	S4430XS	S4431XA	S4431XD	S4431XS
S4432XA	S4432XD	S4432XS	S4440XA	S4440XD	S4440XS	S4441XA	S4441XD
S4441XS	S4442XA	S4442XD	S4442XS	S4450XA	S4450XD	S4450XS	S4451XA
S4451XD	S4451XS	S4452XA	S4452XD	S4452XS	S448X1A	S448X1D	S448X1S
S448X2A	S448X2D	S448X2S	S448X9A	S448X9D	S448X9S	S4490XA	S4490XD
S4490XS	S4491XA	S4491XD	S4491XS	S4492XA	S4492XD	S4492XS	S5400XA
S5400XD	S5400XS	S5401XA	S5401XD	S5401XS	S5402XA	S5402XD	S5402XS
S5410XA	S5410XD	S5410XS	S5411XA	S5411XD	S5411XS	S5412XA	S5412XD
S5412XS	S5420XA	S5420XD	S5420XS	S5421XA	S5421XD	S5421XS	S5422XA
S5422XD	S5422XS	S5430XA	S5430XD	S5430XS	S5431XA	S5431XD	S5431XS
S5432XA	S5432XD	S5432XS	S5490XA	S5490XD	S5490XS	S5491XA	S5491XD
S5491XS	S5492XA	S5492XD	S5492XS	S6400XA	S6400XD	S6400XS	S6401XA
S6401XD	S6401XS	S6402XA	S6402XD	S6402XS	S6410XA	S6410XD	S6410XS
S6411XA	S6411XD	S6411XS	S6412XA	S6412XD	S6412XS	S6420XA	S6420XD
S6420XS	S6421XA	S6421XD	S6421XS	S6422XA	S6422XD	S6422XS	S6430XA
S6430XD	S6430XS	S6431XA	S6431XD	S6431XS	S6432XA	S6432XD	S6432XS
S64490A	S64490D	S64490S	S64491A	S64491D	S64491S	S64492A	S64492D
S64492S	S64493A	S64493D	S64493S	S64494A	S64494D	S64494S	S64495A
S64495D	S64495S	S64496A	S64496D	S64496S	S64497A	S64497D	S64497S
S64498A	S64498D	S64498S	S648X1A	S648X1D	S648X1S	S648X2A	S648X2D
S648X2S	S648X9A	S648X9D	S648X9S	S6490XA	S6490XD	S6490XS	S6491XA
S6491XD	S6491XS	S6492XA	S6492XD	S6492XS	S7401XA	S7401XD	S7401XS
S7402XA	S7402XD	S7402XS	S7411XA	S7411XD	S7411XS	S7412XA	S7412XD
S7412XS	S7421XA	S7421XD	S7421XS	S7422XA	S7422XD	S7422XS	S748X1A
S748X1D	S748X1S	S748X2A	S748X2D	S748X2S	S7491XA	S7491XD	S7491XS
S7492XA	S7492XD	S7492XS	S8401XA	S8401XD	S8401XS	S8402XA	S8402XD
S8402XS	S8410XS	S8411XA	S8411XD	S8411XS	S8412XA	S8412XD	S8412XS
S8421XA	S8421XD	S8421XS	S8422XA	S8422XD	S8422XS	S84801A	S84801D
S84801S	S84802A	S84802D	S84802S	S8491XA	S8491XD	S8491XS	S8492XA
S8492XD	S8492XS	S9421XA	S9421XD	S9421XS	S9422XA	S9422XD	S9422XS
S9431XA	S9431XD	S9431XS	S9432XA	S9432XD	S9432XS	S948X1A	S948X1D
S948X1S	S948X2A	S948X2D	S948X2S	S948X9A	S948X9D	S948X9S	S9490XA
S9490XD	S9490XS	S9491XA	S9491XD	S9491XS	S9492XA	S9492XD	S9492XS
T85840A	T85840D	T85840S					

The electrodiagnostic testing must be guided by accepted practice parameters and physician guidelines. The number of studies performed is expected to be tailored to the clinical findings of the individual client.

Any electrodiagnostic testing procedures may be reimbursed up to four distinct dates of service per calendar year by the same provider.

Any evaluation and management service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

31.2.19.2.1 EMG

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine.

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

Procedure Codes									
51784	51785	95860	95861	95863	95864	95865	95867	95868	95869
95872	95875								

Procedure code 95866 may be reimbursed up to one service per day, same provider.

Procedure code 95870 may be reimbursed in multiple quantities of up to four services per day, if specific muscles are documented.

Procedure codes 95872 and 95875 may be reimbursed up to two services per day, same provider.

31.2.19.2.2 NCS

NCS must be performed by a physician or a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the electrodiagnostic laboratory while testing is underway, immediately available to provide the trained individual with assistance and direction, and responsible for selecting the appropriate NCS to be performed.

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with modifier XE, XP, XS, XU, or 59. Modifier 59 should be used only when modifier XE, XP, XS, or XU is not appropriate.

Procedure codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 may be reimbursed only once when multiple sites on the same nerve are stimulated or recorded.

Procedure codes 95885 and 95886 may be reimbursed once per extremity up to 2 units, any combination of procedure codes, per day, by any provider.

Procedure codes 95885, 95886, and 95887 must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913 on the same day, by the same provider.

Prior authorization is required for NCS for any diagnosis other than those listed above or when the anticipated number of studies planned for an evaluation exceeds the maximum number of studies, per date of service, by the same provider:

NCS Procedure Code	Studies Allowed per Date of Service
95937	3

Claims for nerve conduction studies that are denied for exceeding the maximum number of studies allowed per day may be appealed with documentation of medical necessity.

Prior authorization is required for more than three studies per day. Documentation must be submitted to establish medical necessity for the additional studies, including one or more of the following:

- Additional diagnoses to be considered
- Clinical signs, symptoms, or electrodiagnostic findings that necessitate the consideration of the additional diagnosis

Requests must include documentation supporting medical necessity for the number of studies requested, and they must be received on or before the requested DOS.

Medical record documentation must establish medical necessity for any additional studies, including one or more of the following:

- Other diagnoses in the differential requires consideration. The provider must identify both of the additional diagnoses considered and the clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
- Multiple diagnoses are established by NCS, and the limitations listed above for a single diagnostic category do not apply. Providers must document all diagnoses established as a result of electrodiagnostic testing.
- Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol usage) has been conducted.
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms. Some examples include underlying metabolic disease (e.g., thyroid condition or diabetes mellitus), nutritional deficiency (alcoholism), malignant disease, or inflammatory disorder (including, but not limited to, lupus, sarcoidosis, or Sjögren's syndrome).

NCS prior authorization requests must be submitted by the ordering provider on the CSHCN Services Program Authorization and Prior Authorization Request Form. The form must be signed and dated by the ordering provider.

Note: *An APRN or a physician assistant (PA) may sign all documentation related to the provision of evoked response tests and neuromuscular procedures on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number blocks are required.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

31.2.19.3 Evoked Potential Procedures

Evoked potential (EP) procedures are a benefit of the CSHCN Services Program. The most common EP procedures are:

- Brainstem auditory evoked potentials (BAEPs)
- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Visual evoked potentials (VEPs)

Prior authorization is not required for EP procedures.

Each EP test (procedure codes 92650, 92651, 92652, 92653, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and is limited to once per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

31.2.19.3.1 Vestibular Evoked Myogenic Potentials (VEMP)

VEMP testing procedure codes 92517, 92518, and 92519 are benefits of the CSHCN Services Program.

Some conditions under which VEMP testing (procedure codes 92517, 92518, and 92519) may be appropriate include:

- Evaluation of chronic symptoms of pressure, tinnitus, disorientation, or chronic vertigo after all other recommended vestibular tests are completed and is lacking a definitive diagnosis.
- Evaluation after a positive CT scan for Superior Semicircular Canal Dehiscence Syndrome (SCDS).

Documentation must include the following:

- The other differential diagnoses under consideration
- The additional diagnoses considered
- The clinical signs, symptoms or electrodiagnostic findings that necessitated the inclusion

VEMP testing must be medically indicated, and reimbursement requires one of the diagnosis codes listed:

Diagnosis Codes							
H81311	H81312	H81313	H81319	H81391	H81392	H81393	H81399
H814	H818X1	H818X2	H818X3	H818X9	H8190	H8191	H8192
H8193	H821	H822	H823	H829	H8301	H8302	H8303
H8309	H8311	H8312	H8313	H8319	H832X1	H832X2	H832X3
H832X9	H833X1	H833X2	H833X3	H833X9	H838X1	H838X2	H838X3
H838X9	H8390	H8391	H8392	H8393	H9311	H9312	H9313
H9319	R110	R111	R112	R42			

VEMP testing is not medically necessary for any other indications and will not be covered.

All of the following criteria are documentation requirements for VEMP testing:

- For each VEMP test performed, the referral reason must include a clear diagnostic impression documented in the client's medical record.
- Medical necessity for the VEMP test must be clearly documented in the client's medical record and reflect the actual results of specific tests (which could include latency and amplitude).
- Medical necessity for client reevaluation after the initial consultation and testing must be clearly documented in the client's medical record. Supporting documentation must include the following:
  - New symptoms unrelated to previously evaluated symptoms that may result in a new diagnosis
  - Rapidly changing client condition documentation supported by the following:
    - Diagnosis
    - Current clinical signs and symptoms
    - Prior clinical condition
    - Expected clinical disease course
    - Clinical benefit of additional studies

The client's medical records are subject to retrospective review.

31.2.19.3.2 Intraoperative Neurophysiology Monitoring (IONM)

Intraoperative neurophysiology monitoring (procedure codes 95940 and 95941) are a benefit when performed in addition to each evoked potential test on the same day. Prior authorization is not required for intraoperative neurophysiology monitoring.

The documentation for the intraoperative neurophysiology testing must include the time for which each test is performed.

Procedure code 95940 and 95941 are limited to a maximum of two hours per date of service, per client, per same procedure, by any provider.

Procedure code 95940 and 95941 must be billed in conjunction with one of the following procedure codes on the same day, by the same provider, or the service will be denied:

Procedure Codes									
95822	95860	95861	95863	95864	95865	95866	95867	95868	95869
95870	95907	95908	95909	95910	95911	95912	95913	95925	95926
95927	95928	95929	95930	95933	95937	95938	95939		

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

31.2.19.4 Motion Analysis Studies (MAS)

MA studies (procedure codes 96000, 96001, and 96002) will be considered for reimbursement through the CSHCN Services Program for clients who are 3 through 20 years of age and have a diagnosis of, but not limited to, cerebral palsy, traumatic brain injury, myelomeningocele, or stroke. Motion analysis is most often used as a diagnostic tool for clients with neuromuscular conditions, primarily as part of the surgical decision-making process when all conservative measures have been exhausted and surgical intervention is being considered.

Procedure codes 96000, 96001, and 96002 are limited to one per date of service by the same provider and two per year, any provider.

Procedure code 96000 will be denied if billed with 96001 by the same provider for the same date of service.

Procedure codes 95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, and 95872 will be denied if billed with 96002 by the same provider for the same date of service.

Prior authorization requests for a diagnosis other than cerebral palsy, traumatic brain injury, myelomeningocele, or stroke, or for more than two services per year, will be considered with medical necessity on a case-by-case basis upon review by the CSHCN Services Program medical director or designee.

Prior authorization requests for MA studies must include documentation with the following information that indicates the client meets all the requirements for MA studies:

- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices
- Client is 3 through 20 years of age
- Physically able to tolerate up to three hours of testing
- Clear documentation that indicates the study is performed as part of a preoperative or postoperative assessment based on the surgical plan of the client

Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for MA studies prior authorization requests.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

31.2.19.5 Prior Authorization for Unlisted Procedure Code 95999

Prior authorization is required for unlisted neurological or neuromuscular diagnostic procedure code 95999; the following information is required to determine coverage:

- The client's diagnosis

- A clear description of the neurological procedure that will be performed
- Documentation that indicates medical necessity of the neurological procedure
- Place of service where the neurological procedure is to be performed
- The physician's intended fee for the neurological procedure being requested or a CPT or HCPCS procedure code that is comparable to the procedure.

Providers must complete the CSHCN Services Program Authorization and Prior Authorization Request Form for prior authorization requests.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

31.2.20 Extracapsular Cataract Removal

Extracapsular cataract removal (procedure codes 66989 and 66991) is a benefit of the CSHCN Services Program for clients who are 21 years of age or older.

Procedure codes 66989 and 66991 are limited to the following diagnosis codes:

Diagnosis Codes					
H401111	H401112	H401121	H401122	H401131	H401132

Procedure codes 66989 and 66991 are limited to two services per lifetime, and must be billed with modifier LT or RT to identify the eye on which the service was performed.

Procedure code 66989 is denied if billed on the same date of service by the same provider as procedure code 67015, 67025, 67027, 67030, or 67031.

31.2.21 Extracorporeal Shock Wave Lithotripsy (ESWL)

Procedure code 50590 is a benefit for the following diagnosis codes:

Diagnosis Codes							
N130	N131	N132	N1330	N1339	N200	N201	N202
N209	N219	N22					

All claims received for ESWL must include one of these diagnoses.

31.2.22 Gastrostomy Devices

Low-profile gastrostomy devices are a benefit of the CSHCN Services Program when prescribed by a physician. Authorization is required.

Physicians may be reimbursed for nonobturated and obturated gastrostomy devices.

Refer to: Section 18.2.4.1, "Gastrostomy Devices" in Chapter 18, "Expendable Medical Supplies" for more information about documentation requirements, limitations, and additional devices.

Chapter 18, "Expendable Medical Supplies" for more information about related supplies and equipment.

Section 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization requirements.

31.2.23 Genetics

Genetic services are a benefit of the CSHCN Services Program.

Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response.

Genetic services may be provided by a physician and typically include one or more of the following:

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

The following procedure codes may be reimbursed for geneticists when provided in the office, inpatient hospital, or outpatient hospital setting:

Procedure Codes									
96041	99213	99214	99215	99244	99245	99254	99255	99402	99404

Office or other outpatient consultations (procedure codes 99244, 99245, or 99404) are limited to once every 3 years. One office or other outpatient consultation (procedure codes 99244 or 99245) may be reimbursed if an office/outpatient/inpatient consultation has not been reimbursed in the previous 3 years.

Inpatient or observation consultations (procedure code 99254 or 99255) may be reimbursed once every 3 years regardless of whether an office consultation was reimbursed in the previous 3 years.

A comprehensive follow up visit (procedure code 99215) is limited to once per year.

No authorization is required for genetic services that are a benefit of the CSHCN Services Program.

31.2.23.1 Family History

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

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

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

31.2.23.2 Genetic Tests

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

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

Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to confer about the client and his or her needs.

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

31.2.23.3 Laboratory Practices

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

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

- Indications for testing
- Relevant clinical and laboratory information
- Client race and ethnicity
- Family history
- Pedigree

Testing performed on a client to provide genetic information for a family member, and testing performed on a non-CSHCN Services Program client to provide genetic information for a CSHCN Services Program client are not benefits of the CSHCN Services Program.

31.2.23.4 Genetic Counselors

Genetic counselor services may be billed by a physician when the genetic counselor is an employee of the physician. Services provided by independent genetic counselors are not a benefit of the CSHCN Services Program.

Refer to: Section 25.2.5.2, "Cytogenetics Testing" in Chapter 25, "Laboratory Services" for more information on cytogenetic testing.

31.2.24 Hyperbaric Oxygen Therapy (HBOT)

Hyperbaric oxygen therapy is a type of treatment that increases the environmental oxygen pressure to promote the movement of oxygen from the environment into the client's body tissues. HBOT is a benefit when it is performed in specially constructed hyperbaric chambers, pressurized to 1.4 atmospheric absolute (atm.abs) or higher, that may hold one or several clients.

The CSHCN Services Program recognizes the following indications for HBOT, as approved by the Undersea & Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps

- Crush injuries, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Necrotizing soft tissue infections
- Delayed radiation injury (soft tissue and bony necrosis)
- Refractory osteomyelitis
- Acute thermal burn injury
- Intracranial abscess

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

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

HBOT services must be provided in facilities that have experience in HBOT treatment of pediatric clients. The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber, and may not delegate this service.

Both the facility's medical record and the client's medical record must contain documentation to support that there was a physician in attendance who provided supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

Physicians who bill for the professional component of HBOT must use procedure code 99183.

Hospital providers who bill for the chamber time must use procedure code G0277 with revenue code 413.

31.2.24.1 Prior Authorization Requirements

HBOT procedure codes 99183 and G0277 require prior authorization. When requesting prior authorization, providers should use the CSHCN Services Program Authorization and Prior Authorization Request Form.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

The prior authorization request must include documentation that supports medical necessity and is specific to each appropriate covered indication as listed in the following table:

Covered Indication	Total Number of 30 Minute Intervals Allowed for Procedure Code G0277	Total Number of Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Air or gas embolism	6	2	Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics
Carbon monoxide poisoning - initial authorization	15	5	Persistent neurological dysfunction secondary to carbon monoxide inhalation
Carbon monoxide poisoning - one subsequent authorization	9	3	Evidence of continuing improvement in cognitive functioning
Central retinal artery occlusion	36	6	Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion
Compromised skin grafts and flaps - initial authorization	80	10	Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia
Compromised skin grafts and flaps - one subsequent authorization	40	5	Evidence of stabilization of graft or flap
Crush injury, compartment syndrome and other acute traumatic ischemias	36	12	Adjunct to standard medical and surgical interventions
Decompression sickness	28	1	Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure
Diabetic foot ulcer -initial authorization	60	30	After at least 30 days of standard medical wound therapy, with a wound pO2 less than 40 mmHg AND wound classified as Wagner grade 3 or higher. *
Diabetic foot ulcer - two subsequent authorizations	60	20	Evidence of continuing healing and wound pO2 less than 40 mmHg

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

- **Grade 1: Superficial diabetic ulcer**
- **Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)**
- **Grade 3: Deep ulcer with abscess or osteomyelitis**
- **Grade 4: Gangrene to portion of forefoot**
- **Grade 5: Extensive gangrene of foot**

Covered Indication	Total Number of 30 Minute Intervals Allowed for Procedure Code G0277	Total Number of Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Severe anemia	50	10	Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs
Clostridial myositis and myonecrosis (gas gangrene)	39	13	Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid
Necrotizing soft tissue infections – initial authorization	36	12	Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue
Necrotizing soft tissue infections - two subsequent authorizations	15	5	Evidence that advancement of dying tissue has slowed
Delayed radiation injury (soft tissue and bony necrosis) - initial authorization	40	10	Evidence of unsatisfactory response to conventional treatment
Delayed radiation injury - one subsequent authorization	40	10	Evidence of improvement demonstrated by clinical response
Refractory osteo-myelitis - initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional multidisci-plinary treatment
Refractory osteo-myelitis - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response
Acute thermal burn injury - initial authorization	45	15	Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum
Acute thermal burn injury – three subsequent authorizations	30	10	Evidence of continuing improvement demonstrated by clinical response

***Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:**
- **Grade 1: Superficial diabetic ulcer**
- **Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)**
- **Grade 3: Deep ulcer with abscess or osteomyelitis**
- **Grade 4: Gangrene to portion of forefoot**
- **Grade 5: Extensive gangrene of foot**

Covered Indication	Total Number of 30 Minute Intervals Allowed for Procedure Code G0277	Total Number of Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Intracranial abscess - initial authorization	15	5	Adjunct to standard medical and surgical interventions when one or more of the following conditions exist: • Multiple abscesses • Abscesses in a deep or dominant location • Compromised host • Surgery contraindicated or client is a poor surgical risk
Intracranial abscess - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response and radiological findings
***Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications:** **• Grade 1: Superficial diabetic ulcer** **• Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis)** **• Grade 3: Deep ulcer with abscess or osteomyelitis** **• Grade 4: Gangrene to portion of forefoot** **• Grade 5: Extensive gangrene of foot**			

Procedure code 99183 is authorized according to the number of professional sessions (total HBOT treatments), and procedure code G0277 is authorized according to the number of 30-minute intervals of chamber time. The units in the columns for procedure codes 99183 and G0277 represent the maximum number of sessions and intervals that are allowed for that procedure code per authorization

Example: *In accordance with recommended protocols, a client with an air/gas embolus may receive up to 6 units (180 minutes) of HBOT over two treatments.*

- One prior authorization number may be issued for a quantity of 6 units for procedure code G0277 for the facility and 2 professional sessions for procedure code 99183.
- The 6 units of chamber time for procedure code G0277 may be divided in any manner across the two professional sessions. For procedure code 99183, the usual protocol is two 90-minute treatments.
- The facility bills 90 consecutive minutes (3 units) per HBOT treatment for procedure code G0277. The physician bills per treatment, which in this case would be 2 professional sessions for procedure code 99183.

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

31.2.25 Immunizations (Vaccines and Toxoids)

Vaccines and vaccine administration, as recommended by the Advisory Committee on Immunization Practices (ACIP), is a benefit of the Children with Special Health Care Needs (CSHCN) Services Program.

A vaccine stimulates a person's immune system to produce immunity to a disease, thereby providing protection from that disease.

Vaccines may be administered orally, nasally, or by subcutaneous or intramuscular injection.

Providers must follow current ACIP recommendations; however, in the event of conflict, providers are required to more closely follow the Texas Vaccines for Children (TVFC) guidelines.

31.2.25.1 Texas Vaccines for Children (TVFC) Program

The CSHCN Services Program encourages providers administering vaccines to enroll in TVFC. Providers interested in enrollment information for TVFC may call the Department of State Health Services (DSHS), Immunizations Branch at 1-800-252-9152 or access the TVFC website at www.dshs.texas.gov/immunize/tvfc/.

If the provider is enrolled in TVFC, the provider must screen the client and, if indicated, immunize the client using TVFC-obtained vaccine.

Providers must provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC) to each client. VISs explain the benefits and risks of the vaccine.

31.2.25.2 Documentation Recommendations

Providers must document the following information in the client's medical record for each vaccine administered:

- The vaccine given
- The date of the vaccine administration (day, month, year)
- The name of the vaccine manufacturer
- The vaccine lot number
- The signature and title of the person who administered the vaccine
- The location of where the vaccine was administered
- The publication date of the VIS issued to the client, parent, or guardian

If a vaccine was administered outside of ACIP's recommended routine immunization schedules, the reason must be included in the client's medical record. Reasons for administering a vaccine outside the routine schedule may include but are not limited to:

- An impaired immune system.
- Suspected exposure to a disease.

The client's medical records are subject to retrospective review to determine whether the utilization and reimbursement of this service was appropriate.

Procedure codes 90460 and 90461 include counseling by a qualified healthcare professional. Documentation of the counseling must be noted in the client's medical record.

31.2.25.3 Vaccine Reporting to the DSHS

All administered vaccines and toxoids must be reported to DSHS. DSHS submits all reported vaccinations with consent to a centralized repository of immunization histories. This repository is known in Texas as ImmTrac2.

Note: *Documentation of the injection site is recommended, but not required.*

31.2.25.3.1 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after a vaccine has been administered. Even if the provider is unclear whether the adverse event was caused by the vaccine, it should still be reported. The National Childhood Vaccine Injury Act (NCVIA) requires health care providers to report:

- "Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- "Any reaction that is listed in the VAERS Reportable Events Table that occurs within the specified time period post vaccination.

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

31.2.25.4 Authorization Requirements

Authorization is not required for any vaccine or its associated administration fee. Providers enrolled in TVFC are responsible for determining the eligibility of clients to receive TVFC reimbursement.

31.2.25.5 Vaccine Reimbursement

The diagnosis code Z23 should be reported regardless of the type of encounter when a vaccine was given. It must be reported and linked to both the vaccine product and the vaccine administration code.

When the client visit is only for vaccine administration, diagnosis code Z23 should be used as the appropriate vaccine diagnosis code.

When vaccines are given during a preventive health visit (e.g., well child exam), diagnosis code Z23 will follow the age appropriate diagnosis code for the preventive health visit.

When the client visit is only for vaccine administration, the office visit will not be reimbursed.

If a vaccine is administered as part of a preventive health visit (e.g., well child exam), or a visit due to a medical condition, the office visit will be reimbursed in addition to the vaccine given.

Reimbursement may be considered for any vaccine if it is not obtained through TVFC but has been recommended by ACIP and approved by the Health and Human Services Commission (HHSC).

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

Vaccines that are purchased by a provider may be reimbursed if the state-defined modifier U4 is billed with the vaccine and one of the following conditions is met:

- The provider is not enrolled in TVFC.
- The client does not meet the TVFC criteria.
- TVFC resolutions do not match the ACIP's general usage recommendations.
- The provider purchases an ACIP-recommended vaccine that is not distributed by TVFC.

Providers purchasing the vaccine are reimbursed the lower of the billed amount for the vaccine or the amount allowed by Texas Medicaid or the maximum fee established by the CSHCN Services Program. The maximum fee will be determined from the least average wholesale price (AWP) per vaccine dose according to the current information reflected in the Texas Vendor Drug Program system.

Providers must submit claims for procedure codes 90460 (administration of first/only component of vaccine, with counseling) and 90461 (administration of each additional vaccine component, with counseling) based on the number of components per vaccine.

31.2.25.6 Vaccine Administration

Procedure code 90460 must be submitted for the administration of the first component.

Procedure code 90461 must be submitted for the administration of each additional component identified in the vaccine.

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

Procedure codes 90471, 90472, 90473, and 90474 do not require counseling and can be reimbursed at any age.

RSV monoclonal antibodies (nirsevimab, procedure codes 90380 and 90381) may be administered to clients who are birth through 19 months of age.

Administration of nirsevimab (procedure codes 96380 and 96381) are limited to two per lifetime.

The age ranges for vaccine administration are listed in the following table:

Procedure Codes	Age Range
90460	Birth through 18 years of age
90461	Birth through 18 years of age
90471	All ages
90472	All ages
90473	All ages
90474	All ages
90653	65 years of age or older
96372	All ages
96372	All ages
96374	All ages
96380	Birth through 19 months of age
96381	Birth through 19 months of age

31.2.25.6.1 Administration With Counseling

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

- Procedure code 90460 is submitted for the administration of the 1st component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

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

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

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code with 1 component	1
90460 (1st component)	1
Vaccine or toxoid procedure code with 3 components	1
90460 (1st component)	1
90461 (2nd and 3rd components)	2
Vaccine or toxoid procedure code with 2 components	1
90460 (1st component)	1
90461 (2nd component)	1
Vaccine or toxoid procedure code with 4 components	1
90460 (1st component)	1
90461 (2nd, 3rd, and 4th components)	3
Vaccine or toxoid procedure code with 5 components	1
90460 (1st component)	1
90461 (2nd, 3rd, 4th, and 5th components)	4

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

31.2.25.6.2 Administration Without Counseling

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

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

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code	1
90471 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1
Vaccine or toxoid procedure code	1
90472 (Injection administration)	1

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

Procedure Code	Quantity Billed
Vaccine or toxoid procedure code	1
90473 (Oral/nasal administration)	1
Vaccine or toxoid procedure code	1
90474 (Oral/nasal administration)	1

31.2.25.7 Vaccine and Toxoid Procedure Codes

The vaccine procedure codes listed in the following table are benefits of the CSHCN Services Program.

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple components. All procedure codes with an asterisk (*) can be distributed through TVFC.*

Procedure Code	Age Range	Number of Recognized Components
90287	All ages	1
90585	All ages	1
90611	18 years of age and older	1
90619	19 years of age and older	1
90620*	All ages	1
90621*	All ages	1
90623	10 years of age through 23 years of age	1
90632*	Birth through 20 years of age	1
90633*	Birth through 20 years of age	2
90636*	All ages	2
90647*	All ages	1
90648*	All ages	1
90651*	All ages	1
90670*	All ages	1
90678	10 years of age and older	1
90680*	Birth through 11 months of age	1
90681*	All ages	1
90684	19 years of age or older	1
90696*	4 years of age through 6 years of age	4
90698*	All ages	5
90700*	Birth through 6 years of age	3
90702*	Birth through 6 years of age	2
90707*	All ages	3
90710*	All ages	4
90713*	All ages	1
90714*	7 years of age and older	2
90715*	7 years of age and older	3
90716*	All ages	1
90723*	All ages	5
90732*	2 years of age and older	1
90733*	All ages	1
90734*	All ages	1
90736	60 years of age and older	1

90739	18 years of age and older	1
90740	All ages	1
90743*	All ages	1
90744*	All ages	1
90746*	All ages	1
90747	All ages	1
90748	All ages	2
90749	All ages	1
90750	50 years of age and older	1

Procedure code 90670 is limited to one per day for clients who are birth through five years of age, same procedure, any provider, and to one per lifetime for clients who are age six and older.

The following immunizations are not a benefit of the CSHCN Services Program:

- Cholera vaccine, injectable
- Plague vaccine, intramuscular (IM)
- Typhoid vaccines
- Yellow fever vaccine, subcutaneous (SC)

31.2.25.8 Influenza Vaccines

The Advisory Committee on Immunization Practices (ACIP) reviews the composition of influenza vaccines annually and frequently makes updates to their recommendations. Providers should refer to the Centers for Disease Control and Prevention (CDC) website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the influenza vaccines that TVFC is distributing for clients and their age group for the current flu season.

Reimbursement for influenza vaccines is limited to three occurrences per one rolling year. Claims submitted for any influenza vaccine beyond three occurrences in a rolling year will be denied.

The age ranges for influenza vaccines are listed in the following table:

Procedure Code	Age Range
90655	6 months of age through 35 months of age
90656	3 years of age and older
90657	6 months of age through 35 months of age
90658	3 years of age and older
90660	All ages
90661	All ages
90662	All ages
90672	All ages
90673	All ages
90674	All ages
90682	18 years of age and older
90685	6 months of age through 35 months of age
90686	All ages
90687	6 months of age through 35 months of age

90688	All ages
90756	4 years of age and older

31.2.25.9 Bacille Calmette-Guerin (BCG) Vaccine

BCG vaccine (procedure code 90585) is a benefit of the CSHCN Services Program for diagnosis code Z23.

31.2.25.10 Botulinum Antitoxin

Procedure code 90287 is a benefit of the CSHCN Services Program for diagnosis code A051, A4851, A4852, or one of the following diagnosis codes for botulinum overdose or misinjection:

Diagnosis Codes							
T50901A	T50901D	T50901S	T50902A	T50902D	T50902S	T50903A	T50903D
T50903S	T50904A	T50904D	T50904S	T50991A	T50991D	T50991S	T50992A
T50992D	T50992S	T50993A	T50993D	T50993S	T50994A	T50994D	T50994S
T50Z91A	T50Z91D	T50Z91S	T50Z92A	T50Z92D	T50Z92S	T50Z93A	T50Z93D
T50Z93S	T50Z94A	T50Z94D	T50Z94S				

31.2.25.11 Hepatitis B Vaccine

Procedure codes 90740 and 90747 are not considered routine vaccines and must be billed using administration procedure code 96372 or 96374.

31.2.25.12 Rabies Postexposure Prophylaxis

Postexposure prophylaxis for rabies (procedure codes 90375, 90376, 90377, and 90675) is a benefit of the CSHCN Services Program.

An exposed person who has never received a complete pre- or postexposure rabies vaccine series will first receive a dose of rabies immune globulin (HRIG). This is a blood product that contains antibodies against rabies and gives immediate, short-term protection. The recommended dose of HRIG is 20 IU/kg body weight. This formula is applicable to all age groups, including children. The injection should be given in or near the wound area.

The postexposure treatment will also include 5 doses of rabies vaccine (1.0 ml. intramuscular). The first dose should be given as soon as possible after the exposure (day 0). Additional doses should be given on days 3, 7, 14, and 28 after the first shot. For an exposed person wh

21o has previously been vaccinated with a complete pre- or postexposure vaccine series, 2 doses of rabies vaccine should be given, one on day 0 and one on day 3.

HRIG that is not administered when vaccination begins can be administered up to 7 days after the administration of the first dose of vaccine. Beyond the seventh day, HRIG is not recommended since an antibody response to the vaccine is presumed to have occurred, and HRIG may inhibit the immune response to the vaccine.

Reimbursement for postexposure rabies vaccine is limited to 1 per client, per day, by any provider, not to exceed a total of 5 per 90 rolling days.

Animal bites to people must be reported as soon as possible to the local rabies control authority. Postexposure prophylaxis for rabies is not necessary following exposure to an animal that tests negative for the rabies virus. Health-care providers who determine that their client requires the preventive rabies vaccination series after valid rabies exposure may obtain the biologicals directly from the manufacturer or through one of the DSHS depots around the state. The physician must maintain documentation of the exposure in the client's medical record.

Postexposure rabies treatment is limited to clients with diagnosis code Z203.

Injection administration is a benefit for administration of postexposure rabies vaccine.

31.2.25.13 Respiratory Syncytial Virus (RSV) Prophylaxis

The RSV prophylaxis drug palivizumab (Synagis) must be obtained through the Texas Vendor Drug Program (VDP). Providers must obtain prior authorization through the CSHCN Services Program using the CSHCN Services Program Synagis Prior Authorization form.

Providers may refer to the Texas Vendor Drug Program website at www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment for more information about obtaining palivizumab for CSHCN Services Program clients.

Prior authorization request forms are reviewed annually. Providers must use the most current version of the CSHCN Synagis Prior Authorization Request (HHS Form 1055) to submit prior authorization requests. Forms received outside the RSV season schedule will not be processed.

31.2.26 Injections and Oral Medications

Oral medication must be used in preference to injectable medication in the office and outpatient hospital unless one of the following circumstances applies:

- No acceptable oral equivalent is available.
- Injectable medication is the standard treatment of choice.
- The oral route is contraindicated.
- The client has a temperature over 102°F (documented on the claim and in the medical record) and a high blood level of antibiotic is needed quickly.
- The client has demonstrated noncompliance with orally prescribed medication (documented on the claim and in the medical record).
- Previously attempted oral medication regimens have proven ineffective and are supported by the medical record.
- An emergency situation occurs.

Claims submitted for antibiotic or steroid injections billed in a physician's office or in the outpatient hospital setting must include modifiers AT, ET, or KX.

Providers dispensing physician-administered drugs in an outpatient setting may utilize an optional delivery method referred to as "white bagging," in which the treating provider submits prescriptions to pharmacies and the prescription is shipped or mailed to the provider's office. Providers must use the following steps for this delivery method:

1) The treating provider identifies a CSHCN Services Program-enrolled client.

2) The treating provider or treating provider's agent sends a single prescription with no additional refills to a CSHCN Services Program-enrolled pharmacy and obtains any necessary prior authorizations. (The provider must write a new prescription for any additional refills.)

3) Once approved, the dispensing pharmacy fills the prescription and overnight ships an individual dose of the medication, in the name of the CSHCN Services Program client, directly to the treating provider. These medications must not be used on any other patient and cannot be returned to the pharmacy for credit.

4) The treating provider administers the medication to the CSHCN Services Program client in the office setting. The treating provider bills for an administration fee and any medically necessary service provided at time of administration. The treating provider must not bill the CSHCN Services Program for the drug.

Note: *Providers may perform other services in addition to any evaluation and management during the client's white bagging medication administration visit, such as: administering other medications or immunizations maintained in the office, administering treatments, X-rays, or labs.*

31.2.26.1 Reimbursement for the Unused Portion of the Single-Dose Vial

Providers may bill and receive reimbursement for the unused portion of weight-based or variable dosing clinician-administered drugs (CADs) manufactured only in single-dose vials.

Providers must also include modifier JW on their claims for consideration of reimbursement. The JW modifier on the claim will identify the unused portion and discarded portion of the vial contents.

This only applies to medical claims for weight-based or variable dosing CADs billed with HCPCS procedure codes, manufactured only in single-dose vials, and provided in a professional or outpatient setting.

31.2.26.2 Injection Administration Billed by a Physician

Injection administration billed by a physician may be reimbursed separately from the medication. Injection administration must be billed using procedure code 96372. Procedure code 96372 may be reimbursed in addition to an E/M or consultation visit. This ensures that each injection receives one administration fee regardless of the dosage.

Most injectable medications may be reimbursed the average wholesale price (AWP) minus 10.5 percent. However, the CSHCN Services Program reserves the option to use other data services when the AWP results have been determined as unreasonable or inefficient.

31.2.26.3 Unit Calculations for Billing Drugs

Providers must calculate the number of units to be billed on the claim based on the number of units indicated in the procedure code description and the amount of the drug actually administered. Providers should refer to the procedure code description for the unit amount to calculate the number of units to be billed.

The formula to calculate the appropriate quantity of units to bill is the amount administered divided by the units indicated in the procedure code description. For example:

Units Indicated in the Description	Amount Administered by the Provider	Calculation	Quantity to Bill on the Claim
50 mg	100 mg	100/50 = 2	2 units
per unit	20 units	20/1 = 20	20 units
per 100 units	2500 units	2500/100 = 25	25 units
per 50 mg	250 mg	250/50 = 5	5 units

Claims submitted with incorrect unit calculations may cause delayed or incorrect payment.

The specific National Drug Code (NDC) of the drug actually dispensed should be entered on the claim form.

Refer to: Section 5.6.2.4, "National Drug Codes (NDC)" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for more information.

Section 5.6.2.5, "Drug Rebate Program" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for information about the reimbursement of clinician-administered drugs and biologicals

Additional information about NDC code requirements is also available on the NDC page of the TMHP website at www.tmhp.com.

31.2.26.4 JW Modifier Claims Filing Instructions

Providers must not use the JW modifier for medications manufactured in a multi-dose vial format.

Providers must choose the most appropriate vial size(s) required to prepare a dose to minimize the discarded portion of the vial payable.

Claims considered for reimbursement must not exceed the package size of the vial used for preparation of the dose. Providers must not bill for vial contents overfill.

Providers must not use the JW modifier when the actual dose of the drug or biological administered is less than the billing unit.

Example: One billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a client while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would process for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.

Reimbursement for JW modifier claims is only available for drugs covered in an outpatient setting.

Inpatient and diagnostic radiopharmaceuticals claims are not eligible for reimbursement, and may not include the JW modifier.

Coverage is for "buy and bill" providers only. Specialty pharmacies billing through the medical benefit must not submit claims with a JW modifier because they are unaware of how much the provider administered or discarded.

Federally Qualified Health Center (FQHC) and Rural Healthcare Clinic RHC) are not eligible to bill with the JW modifier because these providers do not bill for the coverage of drugs or biologicals separately.

Critical Access Hospitals (CAH) are eligible to bill with the JW modifier because these providers bill for the coverage of drugs or biologicals separately.

The JW modifier is not allowed for medications prepared in an institutional setting via "batch processing or bulk productions" methods. An example of a batch processing method is when a hospital or repackaging facility produces multiple non-patient specific doses of medications in advance of anticipated use. These preparations are labeled and distributed with client specific information only when orders are received. Because these doses may be recycled for other client use, they are not eligible.

Providers may utilize automatic systems to calculate dose and discard amounts. However, providers must continue to document the exact usage/discard accurately.

Providers must enter the dose administered (used portion) line item detail of the CAD and also enter the dose discarded (unused portion) line item detail of the CAD on the same claim. The dose discarded (unused portion) line item detail must include the JW modifier to be considered for reimbursement. When billing for reimbursement of wastage on an outpatient claim, the HCPCS and Current Procedural Terminology (CPT) code should always be provided along with the revenue code.

31.2.26.5 Injection Procedure Codes

The following injections are benefits of the CSHCN Services Program and are subject to the indicated limitations:

Name of Injection	Procedure Code(s)	Limitation(s)
Alglucosidase alfa	J0220	Diagnosis limitations: E7400, E7401, E7402, E7403, E7404, E7409
Andexxa	J7169	Restricted to clients who are 18 years of age or older
Anifrolumab-fnia	J0491	Restricted to clients who are 18 years of age or older
Antithrombin	J7197	Diagnosis limitations: D6800, D6801, D68020, D68021, D68022, D68023, D68029, D6803, D6804, D6809, D6851, D6852, D6859, D6861, D6862, D6869, D75821, D75822, D75828, D75829, D75838, D7584
Avalglucosidase Alfa-ngpt	J0219	Restricted to clients who are 1 year of age or older
Azacitidine (Vidaza)	J9025	Benefit for clients 13 years of age or older Diagnosis limitations: C9200, C9202, C9210, C9212, C9220, C9222, C9232, C9242, C9252, C9262, C9290, C9292, C92A2, C92Z0, C92Z2, C9310, C9312, C9330, C9332, C9502, C9510, C9512, C9592, D460, D461, D4621, D4622, D469, D46A, D46B, D46C, D640, D641, D642, D643 Must be submitted with an 11-digit NDC
Bevacizumab-maly (Alymsys)	Q5126	Restricted to clients who are 18 years of age or older
Blood Factor Product VIII (Jivi)	J7208	N/A
Bupivacaine	J0665	Restricted to clients who are 18 years of age or older
Cabotegravir (Apretude)	J0739	Restricted to clients who are 10 years of age or older
Cantharidin	J7354	Restricted to clients who are 2 years of age or older Diagnosis limitation: B081
Cidofovir	J0740	N/A
Ciltacabtagene autoleucel	Q2056	Restricted to clients who are 18 years of age or older
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Clofarabine (Clorar)	J9027	Prior authorization is required. Requests for prior authorization must be submitted by the ordering provider using the CSHCN Services Program Authorization and Prior Authorization Request Form. Documentation of the following must be submitted with the prior authorization request form: • Diagnosis code C9100 or C9102 • At least 2 prior failed regimens
Coagulation Factor IX (Ixinity)	J7213	Restricted to clients who are 12 years of age or older
C1 Esterase Inhibitor (Human) (Cinryze)	J0598	Restricted to clients who are 6 years of age or older
C1 Esterase Inhibitor (Human) (Haegarda)	J0599	Restricted to clients who are 6 years of age or older Diagnosis limitation: D841
C1 Esterase Inhibitor (Recombinant) (Ruconest)	J0596	Restricted to clients who are 13 years of age or older Diagnosis limitation: D841
Dalteparin sodium	J1645	N/A
Eculizumab	J1299	Diagnosis limitations: D5932, D5939, D595, G360, G7000, G7001
Efgartigimod Alfa-fcab (Vyvgart)	J9332	Restricted to clients who are 18 years of age or older Diagnosis limitations: G700, G7001
Eflapegrastim-xnst	J1449	Restricted to clients who are 18 years of age or older
Emapalumab-lzsg (Gamifant)	J9210	N/A
Enoxaparin sodium	J1650	N/A
Epcoritamab-bysp (Epkinly)	C9155	Restricted to clients who are 18 years of age or older
Epoprostenol	J1325	Diagnosis limitations: I270, I2720, I2721, I2722, I2723, I2724, I2729, I2783, P2930
Esmolol hydrochloride	J1805	Restricted to clients who are 18 years of age or older
Faricimab-svoa	J2777	Restricted to clients who are 18 years of age or older
Fecal microbiota	J1440	Restricted to clients who are 18 years of age or older Diagnosis limitations: A0471, A0472
Fondaparinux sodium	J1652	N/A
Furosemide (Furoscix)	J1941	Restricted to clients who are 18 years of age or older
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Galsulfase	J1458	Diagnosis limitations: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, E769
Granisetron hydrochloride	J1626	Diagnosis limitations: Z510, Z5111, Z5112 The quantity used must appear on the claim.
Idursulfase	J1743	Diagnosis limitations: E7601, E7602, E7603, E761, E76210, E76211, E76219, E7622, E7629, E763, E768, E769
Inclisiran	J1306	Restricted to clients who are 18 years of age or older
Invega hafyera	J2427	Restricted to clients who are 18 years of age or older
Ixabepilone	J9207	Diagnosis limitations: C50011, C50012, C50019, C50111, C50112, C50119, C50211, C50212, C50219, C50311, C50312, C50319, C50411, C50412, C50419, C50511, C50512, C50519, C50611, C50612, C50619, C50811, C50812, C50819, C50911, C50912, C50919, C563, C7963, C847A, D0500, D0501, D0502, D0510, D0511, D0512, D0580, D0581, D0582, D0590, D0591, D0592
Lanoxin (Digoxin)	J1920	Restricted to clients who are 1 year of age or older
Lanreotide (Cipla)	J1932	Restricted to clients who are 18 years of age or older
Linezolid	J2020	N/A
Lioresal	J0475 J0476	Separate payment for the device is not a benefit for the physician or the hospital.
Loncastuximab Tesirine-lpyl	J9359	Restricted to clients who are 18 years of age or older Diagnosis limitations: C8330, C8331, C8332, C8333, C8334, C8335, C8336, C8337, C8338, C8339
Melphalan	J9245	Diagnosis limitations: C9000, C9001, C9002
Melphalan (Evomela)	J9246	Diagnosis limitations: C9000, C9001, C9002
Methotrexate (Jylamvo)	J8611	Restricted to clients who are 18 years of age or older
Midazolam hydrochloride	J2250	N/A
Natalizumab injection	J2323	Diagnosis limitations: G35A, G35B0, G35B1, G35B2, G35C0, G35C1, G35C2, G35D, K5000, K50011, K50012, K50013, K50014, K50018, K5010, K50111, K50112, K50113, K50114, K50118, K5080, K50811, K50812, K50813, K50814, K50818, K5090, K50911, K50912, K50913, K50914, K50918, K50919, K5650, K5651, K5652, K56600, K56601, K56609, K56690, K56691, K56699, K9130, K9131, K9132
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Naxitamab-gqgk (Danyelza)	J9348	Restricted to clients who are 1 year of age or older.
Nivolumab and Relatlimab-rmbw	J9298	Restricted to clients who are 12 years of age or older
Nitroglycerin	J2305	Restricted to clients who are 18 years of age or older
Nogapendekin Alfa Inbakicept-pmln (Anktiva)	J9028	Restricted to clients who are 18 years of age or older
Oliceridine	C9101	Restricted to clients who are 18 years of age or older
Omadacycline	J0121	Restricted to clients who are 8 years of age and older
Pegcetacoplan	J2781	Restricted to clients who are 18 years of age or older
Phenylephrine hydrochloride (Immphentiv)	J2373	Restricted to clients who are 18 years of age or older
Plazomicin	J0291	Restricted to clients who are 18 years of age and older
Porfimer sodium	J9600	Diagnosis limitations: C153, C154, C155, C158, C159, C787, C7880, C7889
Ranibizumab-eqrn (Cimerli)	Q5128	Restricted to clients who are 18 years of age or older
Ravulizumab-cwvz (Ultomiris)	J1303	Diagnosis limitations: D5930, D5931, D5932, D5939, G360
Releuko	Q5125	N/A
Remimazolam	J2249	Restricted to clients who are 18 years of age or older
Retifanlimab-dlwr (Zynyz)	J9345	Restricted to clients who are 18 years of age or older
Rituximab	J9310	N/A
Sirolimus Protein-bound Particles (Fyarro)	J9331	Restricted to clients who are 18 years of age or older
Sumatriptan succinate	J3030	Limited to treatment of classical migraines Diagnosis limitations: G43001, G43011, G43101, G43109, G43111, G43119, G43401, G43409, G43411, G43419, G43501, G43509, G43511, G43519, G43601, G43609, G43611, G43619, G43701, G43709, G43711, G43719, G43801, G43809, G43811, G43819, G43821, G43829, G43831, G43839, G43901, G43909, G43911, G43919, G43A0, G43A1, G43B0, G43B1, G43C0, G43C1, G43D0, G43D1
Sutimlimab-jome (Enjaymo)	J1302	Restricted to clients who are 18 years of age or older
Tebentafusp-tebn	J9274	Restricted to clients who are 18 years of age or older
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

Name of Injection	Procedure Code(s)	Limitation(s)
Tezepelumab-ekko (Tezspire)	J2356	Restricted to clients who are 12 years of age or older
Tildrakizumab (Ilumya)	J3245	Restricted to clients who are 18 years of age and older
Tisotumab Vedotin-tftv	J9273	Restricted to female clients who are 18 years of age or older
Triamcinolone Acetonide (Xipere)	J3299	Restricted to clients who are 18 years of age or older
Ublituximab-xiiy (Briumvi)	J2329	Restricted to clients who are 18 years of age or older
Valrubicin	J9357	Diagnosis limitation: D090
Vasopressin	J2598 J2599 J2601	Restricted to clients who are 18 years of age or older
Verteporfin	J3396	Diagnosis limitations: H35021, H35022, H35023, H353110, H353111, H353112, H353113, H353114, H353120, H353121, H353122, H353123, H353124, H353130, H353131, H353132, H353133, H353134, H353190, H353191, H353192, H353193, H353194, H353210, H353211, H353212, H353213, H353220, H353221, H353222, H353223, H353230, H353231, H353232, H353233, H353290, H353291, H353292, H353293
(Diagnosis limitations) The procedure code must be billed with one of the codes listed.		

In addition to the injections listed in the above table, the following sections indicate additional injections that may be reimbursed by the CSHCN Services Program and the applicable limitations.

31.2.26.6 Adalimumab

Adalimumab (procedure codes J0139 and Q5140) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5100	K51011	K51012	K51013	K51014	K51018	K51019
K5120	K51211	K51212	K51213	K51214	K51218	K5130	K51311
K51312	K51313	K51314	K51318	K5140	K51411	K51412	K51413
K51414	K51418	K51419	K5150	K51511	K51512	K51513	K51514
K51518	K51519	K5180	K51811	K51812	K51813	K51814	K51818
K51819	K5190	K51911	K51912	K51913	K51914	K51918	K5650
K5651	K5652	K56600	K56601	K56609	K56690	K56691	K56699
K9130	K9131	K9132	L400	L401	L402	L403	L404
L4050	L4051	L4052	L4053	L4054	L4059	L408	M00039
M00071	M00072	M00079	M00171	M00172	M00179	M00271	M00272
M00279	M00871	M00872	M00879	M0500	M05011	M05012	M05019
M05021	M05022	M05029	M05031	M05032	M05039	M05041	M05042
M05049	M05051	M05052	M05059	M05061	M05062	M05069	M05071
M05072	M05079	M0509	M05271	M0530	M0540	M05411	M05412
M05419	M05421	M05422	M05429	M05431	M05432	M05439	M05441
M05442	M05449	M05451	M05452	M05459	M05461	M05462	M05469
M05471	M05472	M05479	M0549	M0550	M05511	M05512	M05519
M05521	M05522	M05529	M05531	M05532	M05539	M05541	M05542
M05549	M05551	M05552	M05559	M05561	M05562	M05569	M05571
M05572	M05579	M0559	M0560	M05611	M05612	M05619	M05621
M05622	M05629	M05631	M05632	M05639	M05641	M05642	M05649
M05651	M05652	M05659	M05661	M05662	M05669	M05671	M05672
M05679	M0569	M0570	M05711	M05712	M05719	M05721	M05722
M05729	M05731	M05732	M05739	M05741	M05742	M05749	M05751
M05752	M05759	M05761	M05762	M05769	M05771	M05772	M05779
M0579	M057A	M0580	M05811	M05812	M05819	M05821	M05822
M05829	M05831	M05832	M05839	M05841	M05842	M05849	M05851
M05852	M05859	M05861	M05862	M05869	M05871	M05872	M05879
M0589	M058A	M059	M0600	M06011	M06012	M06019	M06021
M06022	M06029	M06031	M06032	M06039	M06041	M06042	M06049
M06051	M06052	M06059	M06061	M06062	M06069	M06071	M06072
M06079	M0608	M0609	M060A	M061	M0620	M06211	M06212
M06219	M06221	M06222	M06229	M06231	M06232	M06239	M06241
M06242	M06249	M06251	M06252	M06259	M06261	M06262	M06269

Diagnosis Codes							
M06271	M06272	M06279	M0628	M0629	M0630	M06311	M06312
M06319	M06321	M06322	M06329	M06331	M06332	M06339	M06341
M06342	M06349	M06351	M06352	M06359	M06361	M06362	M06369
M06371	M06372	M06379	M0638	M0639	M0680	M06811	M06812
M06819	M06821	M06822	M06829	M06831	M06832	M06839	M06841
M06842	M06849	M06851	M06852	M06859	M06861	M06862	M06869
M06871	M06872	M06879	M0688	M0689	M068A	M069	M0800
M08011	M08012	M08019	M08021	M08022	M08029	M08031	M08032
M08039	M08041	M08042	M08049	M08051	M08052	M08059	M08061
M08062	M08069	M08071	M08072	M08079	M0808	M0809	M081
M08811	M08812	M08821	M08822	M08831	M08832	M08839	M08841
M08842	M08849	M08851	M08852	M08859	M08861	M08862	M08871
M08872	M0888	M0889	M08911	M08912	M08919	M08921	M08922
M08929	M08931	M08932	M08939	M08941	M08942	M08949	M08951
M08952	M08959	M08961	M08962	M08969	M08971	M08972	M0898
M13871	M13872	M13879	M450	M451	M452	M453	M454
M455	M456	M457	M458	M459	M45A0	M45A1	M45A2
M45A3	M45A4	M45A5	M45A6	M45A7	M45A8	M45AB	M48061
M48062	M488X1	M488X2	M488X3	M488X4	M488X5	M488X6	M488X7
M488X8	M488X9						

31.2.26.7 Ado-Trastuzumab Emtansine

Ado-trastuzumab emtansine (procedure code J9354) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929		

Documentation must support the administration of Ado-trastuzumab emtansine and include all of the following:

- Evidence of HER2 positive breast cancer as evidenced by an immunochemistry (IHC) test or fluorescent in situ hybridization (FISH) test
- Evidence of metastatic breast cancer
- Evidence of prior treatment for HER2 positive metastatic breast cancer with trastuzumab and a taxane oncology agent given separately or in combination

- Evidence demonstrating receipt of prior therapy for HER2 positive metastatic breast cancer or recurrent disease, including previous treatment protocol, within six months of completing adjuvant therapy.

All documentation must be maintained in the client's medical record and is subject to retrospective review.

31.2.26.8 Bevacizumab

Bevacizumab (procedure code J9035) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
C180	C181	C182	C183	C184	C185	C186	C187
C188	C189	C19	C20	C210	C211	C218	C3400
C3401	C3402	C3410	C3411	C3412	C342	C3430	C3431
C3432	C3480	C3481	C3482	C3490	C3491	C3492	C538
C539	C563	C641	C642	C649	C711	C712	C713
C714	C715	C716	C717	C718	C719	C7800	C7801
C7802	C7931	C7963	Z85038	Z85048	Z85118	Z853	

31.2.26.9 Botulinum Toxin (Type A and Type B)

The CSHCN Services Program may reimburse botulinum toxin, types A and B, for clients with specific diagnoses. Botulinum toxin, type A procedure code J0585 is payable when billed with the following diagnosis codes:

Diagnosis Codes							
G114	G2401	G2402	G241	G243	G244	G245	G248
G250	G251	G252	G253	G35A	G35B0	G35B1	G35B2
G35C0	G35C1	G35C2	G35D	G360	G370	G371	G372
G373	G374	G375	G3781	G3789	G379	G43701	G43709
G43711	G43719	G5131	G5132	G5133	G5139	G800	G801
G802	G803	G804	G808	G809	G8110	G8111	G8112
G8113	G8114	G8191	G8192	G8193	G8194	G8220	G8221
G8222	G8250	G8251	G8252	G8253	G8254	G830	G8310
G8311	G8312	G8313	G8314	G8320	G8321	G8322	G8323
G8324	G8330	G8331	G8332	G8333	G8334	G834	G8921
H4901	H4902	H4903	H4911	H4912	H4913	H4921	H4922
H4923	H4931	H4932	H4933	H4941	H4942	H4943	H499
H5000	H50011	H50012	H50021	H50022	H50031	H50032	H50041
H50042	H5005	H5006	H5007	H5008	H5010	H50111	H50112
H50121	H50122	H50131	H50132	H50141	H50142	H5015	H5016
H5017	H5018	H5021	H5022	H5030	H50311	H50312	H5032
H50331	H50332	H5034	H5040	H50411	H50412	H5042	H5043
H5050	H5051	H5052	H5053	H5054	H5055	H5060	H50611
H50612	H50621	H50622	H50629	H50631	H50632	H50639	H50641
H50642	H50649	H50651	H50652	H50659	H50661	H50662	H50669

Diagnosis Codes							
H50671	H50672	H50679	H50681	H50682	H50689	H5069	H50811
H50812	H5089	H510	H5111	H5112	H5121	H5122	H5123
H518	H519	I69031	I69032	I69033	I69034	I69041	I69042
I69043	I69044	I69051	I69052	I69053	I69054	I69061	I69062
I69063	I69064	I69065	I69098	I69131	I69132	I69133	I69134
I69141	I69142	I69143	I69144	I69151	I69152	I69153	I69154
I69161	I69162	I69163	I69164	I69165	I69198	I69231	I69232
I69233	I69234	I69241	I69242	I69243	I69244	I69251	I69252
I69253	I69254	I69261	I69262	I69263	I69264	I69265	I69298
I69331	I69332	I69333	I69334	I69341	I69342	I69343	I69344
I69351	I69352	I69353	I69354	I69361	I69362	I69363	I69364
I69365	I69398	I69831	I69832	I69833	I69834	I69841	I69842
I69843	I69844	I69851	I69852	I69853	I69854	I69861	I69862
I69863	I69864	I69865	I69898	J385	K117	K220	K594
K600	K601	K602	M436	M62838	M722	N310	N311
N312	N318	N319	N3281	N3644	R490	R498	R532

Procedure code J0586 is payable when billed with the following diagnosis codes:

Diagnosis Codes							
G114	G2401	G2402	G241	G243	G244	G245	G248
G35A	G35B0	G35B1	G35B2	G35C0	G35C1	G35C2	G35D
G360	G370	G371	G372	G373	G374	G375	G3781
G3789	G379	G800	G801	G802	G803	G804	G808
G809	G8110	G8111	G8112	G8113	G8114	G8191	G8192
G8193	G8194	G8253	G8254	G830	G8320	G8321	G8322
G8323	G8324	I69031	I69032	I69033	I69034	I69039	I69051
I69052	I69053	I69054	I69059	I69131	I69132	I69133	I69134
I69139	I69151	I69152	I69153	I69154	I69231	I69232	I69233
I69234	I69239	I69251	I69252	I69253	I69254	I69259	I69331
I69332	I69333	I69334	I69339	I69351	I69352	I69353	I69354
I69359	I69831	I69832	I69833	I69834	I69839	I69851	I69852
I69853	I69854	I69859	I69931	I69932	I69933	I69934	I69939
I69951	I69952	I69953	I69954	I69959	J385	M436	M62838
M722	R532						

The chemodenervation procedure codes in the following table are a benefit in addition to botulinum toxin type A:

Procedure Codes							
64600	64605	64610	64611	64612	64615	64616	64617
64620	64624	64625	64630	64632	64633	64634	64635

Procedure Codes							
64636	64640	64642	64643	64644	64645	64646	64647
64680	64681	67345					

Procedure code 64612 requires prior authorization. All other chemodenervation and nerve destruction by neurolytic agent procedure codes do not require prior authorization. Add-on procedure codes 95873 and 95874 will be reimbursed only when billed with the appropriate primary procedure code on the same day, by the same provider.

Procedure code J0588 is a benefit and is limited to the following diagnosis codes:

Diagnosis Codes							
G243	G245	G800	G801	G802	G8110	G8111	G8112
G8113	G8114	G8253	G8254	G830	G8320	G8321	G8322
G8323	G8324	I69031	I69032	I69033	I69034	I69039	I69051
I69052	I69053	I69054	I69059	I69131	I69132	I69133	I69134
I69139	I69151	I69152	I69153	I69154	I69231	I69232	I69233
I69234	I69239	I69251	I69252	I69253	I69254	I69259	I69331
I69332	I69333	I69334	I69339	I69351	I69352	I69353	I69354
I69359	I69831	I69832	I69833	I69834	I69839	I69851	I69852
I69853	I69854	I69859	I69931	I69932	I69933	I69934	I69939
I69951	I69952	I69953	I69954	I69959			

Procedure code J0587 must be submitted for reimbursement of the type B botulinum toxin (per 100 units) and is limited to the following diagnosis codes:

Diagnosis Codes		
G243	G8921	K117

Procedure code J0587 is limited to a billed quantity of 100 units. Any claim billed in excess of 100 billing units will be denied.

The CSHCN Services Program requires a trial of type A botulinum toxin prior to the use of type B botulinum toxin.

Injections of either toxin are limited to no more than once every three months. Supplies used to administer the toxins will not be reimbursed separately.

Medications other than botulinum toxins may be used for chemodenervation procedures.

Claims for Botulinum Toxin Type A and B must indicate the number of units used. Providers should bill the amount of injections per units used for Botulinum Toxin. If the units are not specified, the claim may be reimbursed as a quantity of one.

Procedure Codes	Quantity Limitations of Medication	Billing Units
J0585	400 units	One billing unit is equal to 1 unit of medication. ***Example:*** *A provider that administers 400 units of medication would submit a claim for a quantity of 400.*

Procedure Codes	Quantity Limitations of Medication	Billing Units
J0586	1,500 units	One billing unit is equal to 5 units of medication. ***Example:*** *A provider that administers 1,500 units of medication would submit a claim for a quantity of 300.*
J0587	10,000 units	One billing unit is equal to 100 units of medication. ***Example:*** *A provider that administers 10,000 units of medication would submit a claim for a quantity of 100.*
J0588	400 units	One billing unit is equal to 1 unit of medication. ***Example:*** *A provider that administers 400 units of medication would submit a claim for a quantity of 400.*

Procedure codes J0586, J0587, and J0588 will be denied when billed on the same date of service, by any provider with procedure code J0585.

Procedure codes J0587 and J0588 will be denied when billed on the same date of service, by any provider with procedure code J0586.

Procedure code J0587 will be denied when billed on the same date of service, by any provider with procedure code J0588.

Providers may not bill for an office visit if botulinum injections are the only reason for the visit.

31.2.26.9.1 Prior Authorization Requirements

Prior authorization is required for quantities of medication greater than the defined limitations for botulinum toxins. Documentation of medical need for exceeding the limit must be submitted with the request for prior authorization.

Prior authorization and medical review is required for diagnoses other than those listed above. Documentation for consideration of other diagnoses must include the diagnosis, clinical course, clinical history, and other treatments with an explanation of ineffective results. This documentation to support medical necessity must be submitted to the TMHP-CSHCN Services Program Authorization Department with the CSHCN Services Program Authorization and Prior Authorization Request Form. Prior authorization requests may be approved for a 12-month period. All extension requests must include diagnosis, clinical course, and result of previous botulinum toxin therapy and expected length of treatment.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for more information about authorization and prior authorization requirements.

Procedures incidental to the administration of botulinum toxin, such as EMGs, do not require authorization and may be reimbursed in the quantity billed.

APRNs and physician assistants administering botulinum toxin therapy must be supervised by a physician who is board eligible or board certified in the physician's specialty. Documentation of the APRN's and physician assistant's training must be kept in the supervising physician's records and be available for review on request by the CSHCN Services Program or its designee.

31.2.26.9.2 Reimbursement

Botulinum toxin may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.26.10 Epirubicin Hydrochloride

Epirubicin hydrochloride (procedure code J9178) is a benefit of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929	C847A	

31.2.26.11 Erythropoietin Alfa (EPO) and Darbepoetin

EPO and darbepoietin (procedure codes J0881 and J0885) are benefits of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Codes							
B20	C880	C9000	C9001	C9002	D500	D501	D508
D509	D510	D511	D512	D513	D518	D519	D520
D521	D528	D529	D530	D531	D532	D538	D539
D550	D551	D553	D558	D560	D561	D562	D563
D564	D565	D568	D569	D5701	D5702	D571	D5720
D57211	D57212	D573	D5740	D57411	D57412	D5780	D57811
D57812	D580	D581	D582	D588	D590	D592	D594
D595	D596	D598	D600	D601	D608	D6101	D6109
D611	D612	D613	D61810	D61811	D61818	D6182	D6189
D619	D62	D630	D631	D638	D640	D641	D642
D643	D644	D6481	D6489	D649	D7801	D7802	D7821
D7822	E3601	E3602	G9731	G9732	G9751	G9752	H59111
H59112	H59113	H59119	H59121	H59122	H59123	H59129	H59311
H59312	H59313	H59319	H59321	H59322	H59323	H59329	H9521
H9522	H9541	H9542	I120	I129	I130	I1310	I1311
I132	I97410	I97411	I97418	I9742	I97610	I97611	I97618
I9762	J9561	J9562	J95830	J95831	K9161	K9162	K91840
K91841	L7601	L7602	L7621	L7622	M0540	M05411	M05412
M05419	M05421	M05422	M05429	M05431	M05432	M05439	M05441
M05442	M05449	M05451	M05452	M05459	M05461	M05462	M05469
M05471	M05472	M05479	M0549	M0550	M05511	M05512	M05519
M05521	M05522	M05529	M05531	M05532	M05539	M05541	M05542
M05549	M05551	M05552	M05559	M05561	M05562	M05569	M05571
M05572	M05579	M0559	M0570	M05711	M05712	M05719	M05721
M05722	M05729	M05731	M05732	M05739	M05741	M05742	M05749

Diagnosis Codes							
M05751	M05752	M05759	M05761	M05762	M05769	M05771	M05772
M05779	M0579	M0580	M05811	M05812	M05819	M05821	M05822
M05829	M05831	M05832	M05839	M05841	M05842	M05849	M05851
M05852	M05859	M05861	M05862	M05869	M05871	M05872	M05879
M0589	M059	M0600	M06011	M06012	M06019	M06021	M06022
M06029	M06031	M06032	M06039	M06041	M06042	M06049	M06051
M06052	M06059	M06061	M06062	M06069	M06071	M06072	M06079
M0608	M0609	M0620	M06211	M06212	M06219	M06221	M06222
M06229	M06231	M06232	M06239	M06241	M06242	M06249	M06251
M06252	M06259	M06261	M06262	M06269	M06271	M06272	M06279
M0628	M0629	M0630	M06311	M06312	M06319	M06321	M06322
M06329	M06331	M06332	M06339	M06341	M06342	M06349	M06351
M06352	M06359	M06361	M06362	M06369	M06371	M06372	M06379
M0638	M0639	M0680	M06811	M06812	M06819	M06821	M06822
M06829	M06831	M06832	M06839	M06841	M06842	M06849	M06851
M06852	M06859	M06861	M06862	M06869	M06871	M06872	M06879
M0688	M0689	M069	M96810	M96811	M96830	M96831	N19
N2589	N9961	N9962	N99820	N99821	Z48298	Z5111	Z5112
Z7682							

In addition to the diagnosis codes listed above, procedure code J0885 may also be considered for reimbursement with the following diagnosis codes:

Diagnosis Codes					
N181	N182	N184	N185	N186	N189

Procedure code J0882 is a benefit of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Codes							
B20	C880	C9000	C9001	C9002	D500	D501	D508
D509	D510	D511	D512	D513	D518	D519	D520
D521	D528	D529	D530	D531	D532	D538	D539
D550	D551	D553	D558	D560	D561	D562	D563
D564	D565	D568	D569	D5701	D5702	D571	D5720
D57211	D57212	D573	D5740	D57411	D57412	D5780	D57811
D57812	D580	D581	D582	D588	D590	D592	D594
D595	D596	D598	D600	D601	D608	D6101	D6109
D611	D612	D613	D61810	D61811	D61818	D6182	D6189
D619	D62	D630	D631	D638	D640	D641	D642
D643	D644	D6481	D6489	D649	D7801	D7802	D7821
D7822	E3601	E3602	G9731	G9732	G9751	G9752	H59111
H59112	H59113	H59119	H59121	H59122	H59123	H59129	H59311

Diagnosis Codes							
H59312	H59313	H59319	H59321	H59322	H59323	H59329	H9521
H9522	H9541	H9542	I120	I129	I130	I1310	I1311
I132	I97410	I97411	I97418	I9742	I97610	I97611	I97618
I9762	J9561	J9562	J95830	J95831	K9161	K9162	K91840
K91841	L7601	L7602	L7621	L7622	M0540	M05411	M05412
M05419	M05421	M05422	M05429	M05431	M05432	M05439	M05441
M05442	M05449	M05451	M05452	M05459	M05461	M05462	M05469
M05471	M05472	M05479	M0549	M0550	M05511	M05512	M05519
M05521	M05522	M05529	M05531	M05532	M05539	M05541	M05542
M05549	M05551	M05552	M05559	M05561	M05562	M05569	M05571
M05572	M05579	M0559	M0570	M05711	M05712	M05719	M05721
M05722	M05729	M05731	M05732	M05739	M05741	M05742	M05749
M05751	M05752	M05759	M05761	M05762	M05769	M05771	M05772
M05779	M0579	M0580	M05811	M05812	M05819	M05821	M05822
M05829	M05831	M05832	M05839	M05841	M05842	M05849	M05851
M05852	M05859	M05861	M05862	M05869	M05871	M05872	M05879
M0589	M059	M0600	M06011	M06012	M06019	M06021	M06022
M06029	M06031	M06032	M06039	M06041	M06042	M06049	M06051
M06052	M06059	M06061	M06062	M06069	M06071	M06072	M06079
M0608	M0609	M0620	M06211	M06212	M06219	M06221	M06222
M06229	M06231	M06232	M06239	M06241	M06242	M06249	M06251
M06252	M06259	M06261	M06262	M06269	M06271	M06272	M06279
M0628	M0629	M0630	M06311	M06312	M06319	M06321	M06322
M06329	M06331	M06332	M06339	M06341	M06342	M06349	M06351
M06352	M06359	M06361	M06362	M06369	M06371	M06372	M06379
M0638	M0639	M0680	M06811	M06812	M06819	M06821	M06822
M06829	M06831	M06832	M06839	M06841	M06842	M06849	M06851
M06852	M06859	M06861	M06862	M06869	M06871	M06872	M06879
M0688	M0689	M069	M96810	M96811	M96830	M96831	N19
N2589	N9961	N9962	N99820	N99821	Z48298	Z5111	Z5112
Z7682							

EPO is limited to three injections per calendar week (Sunday through Saturday). Procedure code J0885 must be submitted with an 11-digit NDC.

31.2.26.12 Growth Hormone

The Vendor Drug Program (VDP) reimburses growth hormone (hGH) injections for CSHCN Services Program clients for any of the following conditions:

- Chronic kidney disease
- Pituitary gland insufficiency
- Prader-Willi syndrome

- Turner syndrome
- Noonan syndrome
- SHOX deficiency
- Other specified disorders resulting from impaired renal function

Pharmacies must submit claims to the VDP. Pharmacies are reimbursed the same drug costs and dispensing fees allowed by the Texas Medicaid VDP.

Providers may refer to Form 1327 - Children with Special Health Care Needs (CSHCN) Services Program Biosynthetic Growth Hormone Agents Prior Authorization Request.

31.2.26.12.1 Prior Authorization Requirements

Requests for prior approval of the medical criteria for growth hormone therapy must be submitted on the CSHCN Biosynthetic Growth Hormone Agents Prior Authorization Request (Form 1327) by a program-approved endocrinologist. In addition to the conditions listed in the section above, the following criteria must also be met for an initial request:

- Normal thyroid function or may be corrected with medication
- Normal pituitary function studies or may be corrected with medication
- Documentation of open epiphyses (done in last 12 months)
- Evidence of deficient growth hormone (GH) production on two pharmacological provocative tests (GH peak less than 10 ng/ml)
- Physical stature less than the 3rd percentile
- Growth velocity 4cm or less per year
- Below normal somatomedin C level or insulin-like growth factor binding protein 3 (IGF/BP3)

Nutropin® is the only product approved for the treatment of chronic renal failure, and Genotropin® is the only product approved for the treatment of Prader-Willi syndrome.

Clients with Turner's syndrome or Prader-Willi syndrome, Noonan Syndrome, or SHOX deficiency may be approved without evidence of deficient growth hormone production on provocative testing if other criteria are met.

Clients with a diagnosis of panhypopituitarism whose epiphyses have closed will be considered for approval with documentation of deficient growth hormone levels.

Initial approval is for a 6-month period. Requests for extensions may be granted for an additional 12 months at a time. Approval for continued growth hormone therapy may be granted if the following criteria are met:

- Growth chart documents growth equal to a minimum of 4cm per year and documents a significant increase from pretreatment levels
- Epiphyses must be open
- Bone age must be documented annually after a boy has reached a chronological age of 16 years and a girl has reached a chronological age of 14 years.

If an initial or extension request cannot be approved based on the above criteria, the approval request may be sent for medical review and reconsideration to the CSHCN Services Program.

Refer to: Section 3.1.1, "Prescription Drug Benefits" in Chapter 3, "Client Benefits and Eligibility" for more information about the VDP.

31.2.26.13 Immune Globulins

Immune globulins may be indicated for treatment of certain immune disorders and states of immunodeficiency.

Immune and gamma globulins and the administration of immune and gamma globulins are benefits of the CSHCN Services Program.

Providers are responsible for administering immune globulins based on the Food and Drug Administration (FDA)-approved guidelines. In the absence of FDA indications, a drug must meet the following criteria for consideration of coverage:

- The drug is recognized by the American Hospital Formulary Service Drug Information, the U.S. Pharmacopoeia Dispensing Information, Vol. I., or two articles from major peer-reviewed journals that have validated data supporting the proposed use for the specific medical condition is safe and effective.
- It is medically necessary to treat the specific medical condition, including life-threatening conditions or chronic debilitating conditions.
- The drug is not experimental or investigational.

The following procedure codes may be used to submit claims for immune and gamma globulin injections:

Procedure Codes									
90281	90283	90284	90291	90371	90389	90396	90399	J0850	J1459
J1460	J1551	J1555	J1556	J1557	J1559	J1561	J1566	J1568	J1569
J1571	J1572	J1573	J1575	J1576	J1670	J2788	J2791	J2792	

The following conditions apply when billing immune globulin procedure codes:

- If procedure codes 90389 and J1670 are billed with the same date of service by any provider, only one is considered for reimbursement.
- If procedure codes J1571, J1573, and 90371 are billed with the same date of service by any provider, only one may be reimbursed.

Administration procedure codes 96369, 96370, 96372, and 96374 may be billed with the immune globulins listed in this section.

Procedure code 96370 is an add-on code and must be billed with the appropriate primary procedure code on the same date of service, by the same provider, or the service will be denied.

Reimbursement for the following procedure codes will be based on the lowest AWP, minus 10.5 percent, according to the prices in the current edition of the *Red Book*, published by Thomson Healthcare, on file with the CSHCN Services Program.

Procedure Codes					
90281	90283	90291	90371	90389	90396

All other procedure codes for immune and gamma globulins may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service submitted on the claim.

31.2.26.13.1 Authorization Requirements

Unlisted procedure code 90399 may be considered for reimbursement with prior authorization. Requests for prior authorization must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request Form. The requesting provider must submit the following documentation with the authorization request:

- The client's diagnosis
- Medical records that indicate any prior treatments for this diagnosis
- A clear, concise description of the medical necessity of the immune globulin and the rationale for the recommendation of this particular immune globulin
- A procedure code that is comparable to the immune globulin being requested
- Documentation that this immune globulin is not investigational or experimental
- The place of service at which the immune globulin is to be administered
- The provider's intended fee for this immune globulin

31.2.26.14 Infliximab, Inflectra, Renflexis, and Zymfentra

Infliximab (procedure code J1745), inflectra (procedure code Q5103), and renflexis (procedure code Q5104) are benefits of the CSHCN Services Program with the following diagnosis limitations:

Diagnosis Codes							
H2013	K5000	K50011	K50012	K50013	K50014	K50018	K50019
K5010	K50111	K50112	K50113	K50114	K50118	K50119	K5080
K50811	K50812	K50813	K50814	K50818	K50819	K5090	K50911
K50912	K50913	K50914	K50918	K50919	K5100	K51011	K51012
K51013	K51014	K51018	K51019	K5120	K51211	K51212	K51213
K51214	K51218	K51219	K5130	K51311	K51312	K51313	K51314
K51318	K51319	K5140	K51411	K51412	K51413	K51414	K51418
K51419	K5150	K51511	K51512	K51513	K51514	K51518	K51519
K5180	K51811	K51812	K51813	K51814	K51818	K51819	K5190
K51911	K51912	K51913	K51914	K51918	K51919	K603	K632
L400	L401	L402	L403	L4050	L4051	L4052	L4053
L4054	L4059	L408	L409	M0500	M05011	M05012	M05019
M05021	M05022	M05029	M05031	M05032	M05039	M05041	M05042
M05049	M05051	M05052	M05059	M05061	M05062	M05069	M05071
M05072	M05079	M0509	M0510	M05111	M05112	M05119	M05121
M05122	M05129	M05131	M05132	M05139	M05141	M05142	M05149
M05151	M05152	M05159	M05161	M05162	M05169	M05171	M05172
M05179	M0519	M0520	M05211	M05212	M05219	M05221	M05222
M05229	M05231	M05232	M05239	M05241	M05242	M05249	M05251
M05252	M05259	M05261	M05262	M05269	M05271	M05272	M05279
M0529	M0530	M05311	M05312	M05319	M05321	M05322	M05329
M05331	M05332	M05339	M05341	M05342	M05349	M05351	M05352
M05359	M05361	M05362	M05369	M05371	M05372	M05379	M0539
M0540	M05411	M05412	M05419	M05421	M05422	M05429	M05431

Diagnosis Codes							
M05432	M05439	M05441	M05442	M05449	M05451	M05452	M05459
M05461	M05462	M05469	M05471	M05472	M05479	M0549	M0550
M05511	M05512	M05519	M05521	M05522	M05529	M05531	M05532
M05539	M05541	M05542	M05549	M05551	M05552	M05559	M05561
M05562	M05569	M05571	M05572	M05579	M0559	M0560	M05611
M05612	M05619	M05621	M05622	M05629	M05631	M05632	M05639
M05641	M05642	M05649	M05651	M05652	M05659	M05661	M05662
M05669	M05671	M05672	M05679	M0569	M0570	M05711	M05712
M05719	M05721	M05722	M05729	M05731	M05732	M05739	M05741
M05742	M05749	M05751	M05752	M05759	M05761	M05762	M05769
M05771	M05772	M05779	M0579	M0580	M05811	M05812	M05819
M05821	M05822	M05829	M05831	M05832	M05839	M05841	M05842
M05849	M05851	M05852	M05859	M05861	M05862	M05869	M05871
M05872	M05879	M0589	M059	M060A	M068A	M069	M08011
M08012	M08021	M08022	M08031	M08032	M08041	M08042	M08051
M08052	M08061	M08062	M08071	M08072	M0809	M08832	M08841
M08842	M08851	M08852	M08861	M08931	M08932	M08941	M08942
M08951	M08952	M08961	M08962	M1389	M450	M451	M452
M453	M454	M455	M456	M457	M458	M459	M45A0
M45A1	M45A2	M45A3	M45A4	M45A5	M45A6	M45A7	M45A8
M45AB							

Procedure codes J1745, Q5103, and Q5104 will not be reimbursed for the same date of service by any provider.

Procedure code J1748 is a benefit for clients who are 18 years of age or older with the following diagnosis limitations:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K50019	K5010
K50111	K50112	K50113	K50114	K50118	K5080	K50811	K50812
K50813	K50814	K50818	K50819	K5090	K50911	K50912	K50913
K50914	K50918	K5100	K51011	K51012	K51013	K51014	K51018
K51019	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919						

31.2.26.15 Inotuzumab ozogamicin (Besponsa)

Inotuzumab ozogamicin (Besponsa) (procedure code J9229) is a benefit of the CSHCN Services Program for pediatric and adult clients who are 1 year of age or older.

Inotuzumab ozogamicin is indicated for the treatment of relapsed or refractory precursor B-cell acute lymphoblastic leukemia (ALL) and must be prescribed by an oncologist or in consultation with an oncologist.

Procedure code J9229 requires prior authorization and may be approved when all of the following criteria is met:

- The client has a confirmed diagnosis of precursor B-cell ALL.
- The client must have relapsed or refractory disease.
- The client is 1 year of age or older.

The provider must agree to monitor the client for signs and symptoms of hepatic veno-occlusive disease (VOD) during the duration of Besponsa therapy.

Requests for prior authorization of procedure code J9229 must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request form.

31.2.26.16 Leuprolide Acetate Injection

Procedure code J1950 is limited to reimbursement once every 28 days. Procedure code J9217 is allowed for use in monthly, 3-month, 4-month, and 6-month doses. Providers must bill the following dosage increments:

Dose Period	Dose Quantity	Quantity Billed	Limitation
Monthly	7.5 mg	1	Once per 28 days
3-month	22.5 mg	3	Once every 84 days
4-month	30 mg	4	Once every 112 days
6-month	45 mg	6	Once every 168 days

31.2.26.17 Monoclonal Antibodies - Asthma and Chronic Idiopathic Urticaria

31.2.26.17.1 Omalizumab

Omalizumab (procedure code J2357) is a benefit of the CSHCN Services Program when medically necessary and must be prior authorized.

Omalizumab is FDA approved for the treatment of clients who are 6 years of age and older with moderate to severe asthma. Omalizumab is also approved for the treatment of clients who are 12 years of age and older with chronic idiopathic urticaria, who remain symptomatic despite H1 antihistamine treatment. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program Medical Director or designee.

31.2.26.17.2 Benralizumab

Benralizumab (procedure code J0517) is a benefit of the CSHCN Services Program with prior authorization.

Benralizumab is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 12 years of age and older that have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

31.2.26.17.3 Mepolizumab

Mepolizumab (procedure code J2182) is a benefit of the CSHCN Services Program when prior authorized.

Mepolizumab is an injectable drug that is approved by the U.S. Food and Drug Administration (FDA) for the treatment of clients who are 12 years of age and older and have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

Providers may not bill for an office visit if the only reason for the visit is an omalizumab, benralizumab, mepolizumab, or reslizumab injection.

31.2.26.17.4 Reslizumab

Reslizumab (procedure code J2786) is a benefit of the CSHCN Services Program when prior authorized.

Reslizumab is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 18 years of age and older and have severe asthma with an eosinophilic phenotype. Clients who are younger than the FDA-approved age will be considered on a case-by-case basis by the CSHCN Services Program medical director or designee.

Procedure codes J0517, J2182, J2786, and J2357 may not be billed in any combination for the same date of services by any provider.

31.2.26.17.5 Prior Authorization Requirements

Omalizumab (procedure code J2357), benralizumab (procedure code J0517), mepolizumab (procedure code J2182), or reslizumab (procedure code J2786) must be used to request prior authorization and the exact dosage must be indicated on the CSHCN Services Program Authorization and Prior Authorization Request Form.

Prior authorization of omalizumab may be approved for clients who are 6 years of age or older with moderate to severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorization of benralizumab and mepolizumab may be approved for clients who are 12 years of age or older that have severe asthma with an eosinophilic phenotype (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorization of reslizumab may be approved for clients who are 18 years of age or older with severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and Management of Asthma).

Prior authorizations for omalizumab, benralizumab, mepolizumab, or reslizumab are for intervals of six months at a time. Clients must be compliant with their omalizumab, benralizumab, mepolizumab, or reslizumab regimen in order to qualify for additional authorizations. The provider must submit a statement documenting compliance with the requests for each renewal.

Benralizumab, mepolizumab or reslizumab may only be initiated after a six-month trial of omalizumab therapy that has resulted in inadequate response. Criteria is detailed below in the benralizumab, mepolizumab, and reslizumab sections.

Treatment of benralizumab, mepolizumab or reslizumab may not be used concurrently with omalizumab or any other interleukin-5 antagonist.

31.2.26.17.6 Chronic Idiopathic Urticaria

Prior authorization for omalizumab will be considered for clients who are 12 years of age or older with chronic idiopathic urticaria (CIU).

Documentation supporting medical necessity for treatment of CIU with omalizumab must be submitted with the request and include all of the following:

- Documented failure of, or contraindication to, antihistamine and leukotriene inhibitor therapies.
- Evidence of an evaluation that excludes other medical diagnoses associated with chronic urticaria.

31.2.26.17.7 Asthma Moderate to Severe (Omalizumab) and Severe (Benralizumab, Mepolizumab, and Reslizumab)

Documentation supporting medical necessity for treatment of asthma with omalizumab, benralizumab, mepolizumab, or reslizumab must be submitted with the request and must indicate the following:

- Symptoms are inadequately controlled with use of one of the following combination therapies:
  - 12 months of high-dose inhaled corticosteroid (ICS) given in combination with a minimum of 3 months of controller medication (either a long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], or theophylline), unless the individual is intolerant of, or has a medical contraindication to these agents
  - 6 months of ICS with daily oral glucocorticoids given in combination with a minimum of 3 months of controller medication (a LABA, LTRA, or theophylline), unless the individual is intolerant of, or has a medical contraindication to these agents

  Note: *Exceptions to the criteria above will be considered on a case-by-case basis, which will require a letter from the prescribing provider stating the medical necessity for omalizumab, benralizumab, mepolizumab, or reslizumab, the client's asthma severity level, and the duration of current and past therapies and lack of asthma control. Consideration for these exceptions will be reviewed by the CSHCN Services Program Medical Director or designee.*
- Pulmonary function tests must have been performed within a three-month period and be documented for all clients.

  Note: *Exceptions may be considered with documentation of medical reasons explaining why pulmonary function tests cannot be performed.*
- Client is not currently smoking.
- When requesting prior authorization, the exact dosage must be included with the request.

31.2.26.17.8 Omalizumab

Additional documentation of the following must also be submitted for treatment with omalizumab:

- A positive skin test or RAST to a perennial (not seasonal) aeroallergen within the past 36 months
- Total IgE level greater than 30 IU/ml but less than 1300 IU/ml within the past 12 months

31.2.26.17.9 Benralizumab

The following additional documentation for treatment with benralizumab must be submitted with the initial prior authorization request:

- Documented diagnosis of severe eosinophilic asthma
- Blood eosinophil count greater than or equal to 150 cells/microliter before the initiation of therapy, in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection

  Note: *1microliter (ul) is equal to 1 cubic millimeter (mm3).*

- Prior authorization for an initial request for benralizumab will be considered when the client meets the criteria for benralizumab and has had an inadequate response after being compliant with 6 months of omalizumab treatment. Failure to respond to omalizumab must be documented in a letter that is signed and dated by the prescribing provider and submitted with the prior authorization request.

  Note: *Exceptions may be considered for clients who meet the requirements for treatment with benralizumab but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range, negative skin test, or RAST to a perennial aeroallergen) must be submitted along with the other required documentation for treatment with benralizumab.*

31.2.26.17.10 Mepolizumab

Additional documentation of the following must also be submitted for treatment with mepolizumab:

- One of the following blood eosinophil counts in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection:
  - Greater than or equal to 150 cells/microliter at initiation of therapy
  - Greater than or equal to 300 cells/microliter within 12 months prior to initiation of therapy

  Note: *1 microliter (ul) is equal to 1 cubic millimeter (mm3)*

Prior authorization for an initial request for mepolizumab will be considered when the client has had an inadequate response after being compliant for 6 months of treatment with omalizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

Note: *Exceptions may be considered for clients who meet the criteria for treatment with mepolizumab but do not meet the criteria for omalizumab. Supporting documentation, such as an IgE level fall outside of the required range or a negative skin test/RAST to a perennial aeroallergen, must be submitted along with the documentation for treatment with mepolizumab, as described above.*

31.2.26.17.11 Reslizumab

Additional documentation of the following must also be submitted for treatment with reslizumab:

- Has an eosinophilic phenotype as determined by blood eosinophils of 400 cells/microliter or higher to initiation of therapy (within 3-4 weeks of dosing).

  Note: *1 microliter (9ul) is equal to 1 cubic millimeter (mm3).*

- Prior authorization for an initial request for reslizumab will be considered when the client has had an inadequate response after being compliant for 6 months of treatment with omalizumab and meets the criteria for reslizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

  Note: *Exceptions may be considered for clients who meet the requirements for treatment with reslizumab, but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range and/or negative skin test/RAST to a perennial aeroallergen) must be submitted along with the documentation for treatment with reslizumab as described above.*

When requesting prior authorization, the exact dosage must be included with the request.

31.2.26.17.12 Requirements for Continuation of Therapy

For continuation of therapy with omalizumab, benralizumab, mepolizumab, or reslizumab after 6 continuous months, the requesting provider must submit the following documentation of the client's compliance and satisfactory clinical response to omalizumab, benralizumab, mepolizumab, or reslizumab:

- Documentation of clinical improvement must include one or more of the following:
  - Decreased utilization of rescue medications
  - Increase in predicted FEV1 (forced expiratory volume) from pretreatment baseline
  - Reduction in reported asthma-related symptoms, as evidenced by decreases in frequency or magnitude of one or more of the following symptoms:
    - Asthma attacks
    - Chest tightness or heaviness
    - Coughing or clearing throat
    - Difficulty taking deep breath or difficulty breathing out
    - Shortness of breath
    - Sleep disturbance, night wakening, or symptoms upon awakening
    - Tiredness
    - Wheezing/heavy breathing/fighting for air
- Client has not exhibited symptoms of hypersensitivity or anaphylaxis (bronchospasm, hypotension, syncope, urticaria, and/or angioedema) after administration of omalizumab, benralizumab, mepolizumab, or reslizumab.

After lapses in treatment of 3 months or greater, prior authorization requests submitted with documentation will be reviewed by the CSHCN Services Program Medical Director or designee.

Requests for clients who do not meet the above criteria will be reviewed for medical necessity by the CSHCN Services Program Medical Director or designee.

31.2.26.18 Secukinumab

Procedure code J3247 is a benefit for clients who are 18 years of age or older and limited to the following diagnosis codes:

Diagnosis Codes							
L400	L401	L402	L403	L404	L4050	L4051	L4052
L4053	L4054	L4059	L408	L409	M0880	M450	M451
M452	M453	M454	M455	M456	M457	M458	M459
M4680	M4681	M4682	M4683	M4684	M4685	M4686	M4687
M4688	M4689						

31.2.26.19 Tocilizumab-aazg (Tyenne)

Tocilizumab-aazg (Tyenne) (procedure code Q5135) is a benefit of the CSHCN Services Program for clients who are 2 years of age or older and is limited to the following diagnosis codes:

Diagnosis Codes							
M0500	M05011	M05012	M05019	M05021	M05022	M05029	M05031

Diagnosis Codes							
M05032	M05039	M05041	M05042	M05049	M05050	M05052	M05059
M05061	M05062	M05069	M05071	M05072	M05079	M0509	M0510
M05111	M05112	M05119	M05121	M05122	M05129	M05131	M05132
M05139	M05141	M05142	M05149	M05151	M05152	M05159	M05161
M05162	M05169	M05171	M05172	M05179	M0519	M0520	M05211
M05212	M05219	M05221	M05222	M05229	M05231	M05232	M05239
M05241	M05242	M05249	M05251	M05252	M05259	M05261	M05262
M05269	M05271	M05272	M05279	M0529	M0530	M05311	M05312
M05319	M05321	M05322	M05329	M05331	M05332	M05339	M05341
M05342	M05349	M05351	M05352	M05359	M05361	M05362	M05369
M05371	M05372	M05379	M0539	M0540	M05411	M05412	M05419
M05421	M05422	M05429	M05431	M05432	M05439	M05441	M05442
M05449	M05451	M05452	M05459	M05461	M05462	M05469	M05471
M05472	M05479	M0549	M0550	M05511	M05512	M05519	M05521
M05522	M05529	M05531	M05532	M05539	M05541	M05542	M05549
M05551	M05552	M05559	M05561	M05562	M05569	M05571	M05572
M05579	M0559	M0560	M05611	M05612	M05619	M05621	M05622
M05629	M05631	M05632	M05639	M05641	M05642	M05649	M05651
M05652	M05659	M05661	M05662	M05669	M05671	M05672	M05679
M0569	M0570	M05711	M05712	M05719	M05721	M05722	M05729
M05731	M05732	M05739	M05741	M05742	M05749	M05751	M05752
M05759	M05761	M05762	M05769	M05771	M05772	M05779	M0579
M057A	M0580	M05811	M05812	M05819	M05821	M05822	M05829
M05831	M05832	M05839	M05841	M05842	M05849	M05851	M05852
M05859	M05861	M05862	M05869	M05871	M05872	M05879	M0589
M058A	M059	M0600	M06011	M06012	M06019	M06021	M06022
M06029	M06031	M06032	M06039	M06041	M06042	M06049	M06051
M06052	M06059	M06061	M06062	M06069	M06071	M06072	M06079
M0609	M060A	M0680	M06811	M06812	M06819	M06821	M06822
M06829	M06831	M06832	M06839	M06841	M06842	M06849	M06851
M06852	M06859	M06861	M06862	M06869	M06871	M06872	M06879
M0689	M068A	M069	M0820	M08211	M08212	M08219	M08221
M08222	M08229	M08231	M08232	M08239	M08241	M08242	M08249
M08251	M08252	M08259	M08261	M08262	M08269	M08271	M08272
M08279	M0829	M082A	M083	M315	M316		

31.2.26.20 Trastuzumab

Trastuzumab (procedure code J9355) is a benefit of the CSHCN Services Program as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of clients with HER2 overexpressing, node positive breast cancer. Procedure code J9355 is payable when billed with the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50019	C50021	C50022	C50029	C50111	C50112
C50119	C50121	C50122	C50129	C50211	C50212	C50219	C50221
C50222	C50229	C50311	C50312	C50319	C50321	C50322	C50329
C50411	C50412	C50419	C50421	C50422	C50429	C50511	C50512
C50519	C50521	C50522	C50529	C50611	C50612	C50619	C50621
C50622	C50629	C50811	C50812	C50819	C50821	C50822	C50829
C50911	C50912	C50919	C50921	C50922	C50929	C563	C7963
C847A							

31.2.26.21 Triamcinolone Acetonide

Triamcinolone acetonide (procedure code J3304) is a benefit of the CSHCN Services Program and is restricted to the following diagnosis codes:

Diagnosis Codes							
M170	M1711	M1712	M172	M1731	M1732	M174	M175
M1909	M1919	M1929					

Procedure code J3304 is limited to one per 12 weeks, any provider.

31.2.27 Intracranial Pressure Monitoring

Intracranial pressure monitoring is a benefit of the CSHCN Services Program.

Authorization is not required for intracranial pressure monitoring and is not limited to specific diagnoses. Physicians should use procedure code 61210 to submit a claim for intracranial pressure monitoring. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.28 Laboratory Services

31.2.28.1 Clinical Pathology Services and Pathology Consultations

Clinical pathology consultations (procedure codes 80503, 80504, 80505, or 80506) are a benefit when they are performed by a clinical pathologist or geneticist. A geneticist may submit claims for procedure codes 80503, 80504, 80505, or 80506 using their physician provider identifier.

Routine conversations between a consultant and an attending physician about test orders or results are not considered consultations.

The service does not qualify as a consultation if the information could ordinarily be furnished by a non-physician laboratory specialist.

Claims for clinical pathology consultations must be submitted with the following documentation:

- The name and address, or the CSHCN Services Program provider identifier for the physician requesting the consultation, must be included on the claim. The national provider identifier (NPI) of the physician requesting the consultation should also be included, if known.

- A copy of the written narrative report describing the consultation findings.
- Documented interaction that clearly outlines that the consultant interpreted the test results and made specific recommendations to the ordering physician.

If the claim does not include all of this information, the clinical pathology consultation will be denied.

31.2.28.2 Claims Filing for Laboratory Tests

Physicians may only be reimbursed for the total component of laboratory tests that are actually performed in their office laboratories.

Interpretation of laboratory tests is considered part of a physician's professional services (hospital, office, or emergency room visits) and must not be billed separately.

The claim must indicate the specific type of laboratory procedure performed. Providers who perform only the technical service must bill for the technical component.

31.2.28.3 Reimbursement

Clinical laboratory services performed in a physician's office may be reimbursed 60 percent of the prevailing charge levels.

Refer to: Chapter 25, "Enrollment" for additional information concerning coding and reimbursement for laboratory procedures.

31.2.28.4 Cytopathology Studies (Gynecological, Pap Smears)

Pap smears for early detection of cancer are a benefit of the CSHCN Services Program.

Procurement and handling of the Pap smears are considered part of the E/M of the client and will not be reimbursed separately. Physicians interpreting a cytopathology specimen (Pap smears) must report the place of service according to where the cytopathology specimen is interpreted (office, inpatient hospital, outpatient hospital, or independent lab).

Because of the technical nature of processing and interpreting Pap smears or specimens for cytopathology, pathologists are the only physician specialty that may be reimbursed for these services.

Refer to: Section 25.2.5.3, "Genetic Testing for Colorectal Cancer" in Chapter 25, "Laboratory Services" for additional information concerning coding and reimbursement for gynecological cytopathology studies.

31.2.28.5 Cytogenetics Testing

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias, lymphomas, and other tumors, especially in children. The detection of the well-defined, recurring, genetic abnormalities often enables a correct diagnosis along with important prognostic information affecting the treatment protocol. Cytogenetics testing may be a part of an evaluation for unusual physical features or learning difficulties.

Refer to: Section 25.2.5.2, "Cytogenetics Testing" in Chapter 25, "Laboratory Services" for additional information about reimbursement for cytogenetics testing.

31.2.28.6 Helicobacter pylori (H. pylori)

The following procedure codes are benefits for physicians in the office setting:

Procedure Codes									
78267	78268	83009	83013	83014	86677	87338^	87513		
^ QW modifier required									

Refer to: Section 25.2.9, "Helicobacter pylori (H. pylori)" in Chapter 25, "Laboratory Services" for additional information about reimbursement for H. pylori testing.

31.2.28.7 CLIA Requirement

Refer to: Section 2.1.5.6, "Clinical Laboratory Improvement Amendments (CLIA) of 1988" in Chapter 2, "Provider Enrollment and Responsibilities."

Section 25.1.1, "Clinical Laboratory Improvement Amendments (CLIA) of 1988" in Chapter 25, "Laboratory Services" for additional information regarding CLIA regulations.

31.2.29 Magnetoencephalography (MEG)

MEG is a benefit of the CSHCN Services Program when used in pre-surgical planning for clients with intractable focal epilepsy, brain tumors, or vascular malformations.

Procedure codes 95965, 95966, and 95967 may be reimbursed for MEG services that are provided in the office, inpatient hospital, and outpatient hospital settings. Procedure code 95967 must be submitted along with primary procedure code 95966 on the same day, by the same provider.

Physicians may be reimbursed for the professional component of MEG services and the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.29.1 Authorization Requirements

Prior authorization is required for MEG procedures and must be obtained prior to the date of service. Requests for MEG must be submitted on the CSHCN Services Program Authorization and Prior Authorization Request Form to the TMHP CSHCN Services Program Authorization Department.

The provider must complete and submit a prior authorization request, which should include all required documentation through any CSHCN approved method. A copy of the prior authorization request and all submitted documentation must be maintained in the client's medical record.

Note: *All prior authorization requests must be submitted with the ordering practitioner's signature.*

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the service(s) requested.

Documentation must support the medical need of pre-surgical planning for clients with intractable focal epilepsy, brain tumors, or vascular malformations, and must include the following, as applicable:

- Evidence of intractable focal epilepsy, neoplasm, or arterial venous malformations (AVMs), and
- Evidence of prior treatment failures with antiepileptic drugs, if applicable, and
- Evidence demonstrating failure of previous brain surgery or failure of more traditional testing to locate the epileptic foci, and
- Evidence of current and past diagnostic studies indicating the need for MEG.

Note: *Requests for repeat MEG scans must include the date of the previous MEG and documentation supporting the medical necessity for the repeat scan.*

If the service is medically necessary, provided after hours or on a recognized holiday or weekend, the service may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Authorization and Prior Authorization Request Form and supporting documentation must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete PA requests.

Prior authorization and medical review is required for all other indications. Documentation for consideration must include diagnosis, clinical course, clinical history, and other treatments with an explanation of ineffective results. This documentation to support medical necessity must be submitted to the CSHCN Services Program Medical Director or designee.

31.2.29.2 Documentation Requirements

All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided. Services not supported by documentation are subject to recoupment.

Providers may be asked to provide additional documentation to clarify a prior authorization request or to clarify medical necessity of the client.

31.2.29.3 Exclusions

MEG is not a stand-alone test, and is not the first order test after clinical and routine EEG diagnosis of epilepsy, and cannot replace, but may guide, the placement of intracranial EEG.

Services and procedures that are investigational or experimental are not benefits of the CSHCN Services Program.

31.2.30 Neurostimulator Devices and Supplies

Neurostimulator devices and supplies are benefits of the CSHCN Services Program.

Refer to: Chapter 27, "Neurostimulators and Neuromuscular Stimulators" for information about benefits for neurostimulator devices and supplies.

31.2.31 Ophthalmological Services

Ophthalmological services are benefits of the CSHCN Services Program.

Refer to: Chapter 40, "Vision Services" for additional information about reimbursement for ophthalmology.

31.2.31.1 Intraocular Lenses (IOL)

An ophthalmologist who performs cataract extractions and IOL implants in the office may be reimbursed for the lens. The provider must submit a copy of the manufacturer's invoice for the IOL with the claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (minus any discount) plus a handling fee not to exceed 5 percent of the actual acquisition cost.

Note: *The CSHCN Services Program does not reimburse physicians who supply IOLs to ASCs or HASCs. Payment for the IOL is included in the facility fee.*

31.2.31.2 Vitrasert Ganciclovir Implant

Procedure code 67027 is a benefit with diagnosis code B251, B258, B259, H3090, H3091, H3092, or H3093. If a provider bills vitrectomy and implantation of intravitreal drug delivery system with the same date of service, the insertion code may be reimbursed and the vitrectomy code payment is denied as part of the other service.

31.2.32 Osteopathic Manipulative Treatment (OMT)

OMT, performed by a physician, is a benefit for acute musculoskeletal conditions, acute exacerbations of a chronic condition, and acute pre or postsurgery treatments when they are directly related to surgery.

Refer to: Chapter 30, "Physical Medicine and Rehabilitation" for more information about OMT services.

31.2.33 Physical Medicine and Physical Therapy (PT) Services

PT performed by a physician or physical therapist is a benefit of the CSHCN Services Program.

Refer to: Chapter 30, "Physical Medicine and Rehabilitation" for more information about PT services.

The CSHCN Services Program may reimburse physicians for therapy services performed in their offices.

The following procedure codes may be used for physical medicine and rehabilitation services:

Procedure Codes									
97012	97016	97018	97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124	97140	97150	97161
97162	97163	97164	97165	97166	97167	97168	97530	97535	97537
97542	97750	97755	97760	97761	97762	97799			

Physical therapy services must be billed with the GP modifier.

31.2.34 Podiatry

Services provided by a licensed podiatrist (DPM) are a benefit of the CSHCN Services Program. Podiatry services may be reimbursed when provided by a physician (MD or DO).

Surgery procedure codes 11055, 11056, 11057, 11719, and G0127 are limited to one service every 6 months per client.

Supportive devices such as molds, inlays, shoes, or supports and all services connected with the fitting or application of these devices must meet the CSHCN Services Program requirements for foot orthotics.

Refer to: Section 28.2.2, "Orthoses and Prostheses (Not All-Inclusive)" in Chapter 28, "Orthotic and Prosthetic Devices" and Section 28.3.7.2, "Prescription Shoes" in Chapter 28, "Orthotic and Prosthetic Devices" for additional information about foot orthotics.

Podiatrists may be reimbursed for medically necessary laboratory services and radiological procedures that include the foot, ankle, toes, or heel.

Podiatrists may prescribe medications, supplies, braces, and prosthetic devices for conditions of the foot and ankle.

Authorization and prior authorization requirements applied to services provided by physicians also apply to services provided by a podiatrist. All CSHCN Services Program requirements concerning reimbursement for surgical procedures, such as the global fee concept, apply to podiatrists.

Podiatrists may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization and prior authorization requirements.

31.2.35 Psychological Testing

Psychological testing (procedure codes 96130, 96131, 96136 and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are benefits of the CSHCN Services Program and may be reimbursed up to 4 hours per day and 8 hours per calendar year, per client, for any provider. Providers must bill the units of each half hour of testing and indicate that number of units on the claim form. Claim submissions for over 4 hours per day and 8 hours per calendar year must include documentation of medical necessity. Add-on procedure codes 96121, 96131, 96133, and 96137 must be billed with their corresponding primary procedure code 96116, 96130, 96132, or 96136 on the same day, by the same provider.

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Reimbursement of psychological testing, neuropsychological testing, and neurobehavioral status exams include testing scoring and interpretation of results. The number of units on the claim must reflect the time spent face-to-face testing with the client, as well as the time spent scoring and interpreting the results in one hour increments.

If the performance, interpretation, and reporting of the testing are performed on different dates of service, then the date of service on the claim must reflect the date and time spent for each service performed. Even if scoring and interpretation are completed on a different date from the testing, providers must submit only one claim for each psychological or neuropsychological test or neurobehavioral status exam performed. If necessary, providers can submit the claim with multiple details for each date of service. A claim must not be submitted until performance, interpretation, and reporting of the testing is complete.

Behavioral health testing and neurobehavioral status exams may be performed during an assessment by an APRN or physician assistant but will not be reimbursed separately.

Psychological testing (procedure codes 96130, 96131, 96136 and 96137) and neurobehavioral testing (procedure codes 96132, 96133, 96136, and 96137) may be reimbursed on the same date of service as procedure code 90791 or procedure code 90792.

Testing procedure codes 96116, 96121, 96130, 96131, 96132, 96133, 96136, and 96137 count towards the 30 per calendar year limitation.

Psychological testing (procedure codes 96130, 96131, 96136 and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) will not be reimbursed on the same date of service by the same provider.

Refer to: Section 24.3.1.3, "Inpatient Behavioral Health" in Chapter 24, "Hospital" for additional information about behavioral health services.

Chapter 29, "Outpatient Behavioral Health" for additional information about behavioral health services.

31.2.36 Sign Language Interpreting Services

Sign language interpreting services are available to CSHCN Services Program clients who are deaf or hard of hearing or to a parent or guardian of a person receiving CSHCN Services Program benefits, who is deaf or hard of hearing.

The sign language interpreting services must be requested by a physician and provided by a qualified interpreter. A physician's determination of the need for sign language interpreting services must give primary consideration to the needs of the individual who is deaf or hard of hearing.

Sign language interpreting services are benefits of the CSHCN Services Program. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, per provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from the CSHCN Services Program for providing this service.

Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels a through h) issued by either HHSC, the Office for Deaf and Hard of Hearing Services, the Board for Evaluation of Interpreters (BEI), or the National Registry of Interpreters for the Deaf (RID):

a) BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic).

b) BEI Basic and RID NIC (National Interpreter Certificate) Certified.

c) BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate).

d) BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter).

e) BEI Advanced and RID NIC Advanced.

f) BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal).

g) EI V/VI.

h) BEI Master; and RID NIC Master.

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by the CSHCN Services Program or its designee.

31.2.37 Skin Therapy

Procedure codes 96900, 96910, 96912, and 96913 are benefits of the CSHCN Services Program for the following diagnosis codes:

Diagnosis Codes							
A672	B070	B081	B550	B551	B552	B559	C8401
C8402	C8403	C8404	C8405	C8406	C8407	C8408	C8409
H02731	H02732	H02734	H02735	L100	L101	L102	L103
L104	L105	L1081	L1089	L120	L121	L122	L128
L130	L131	L138	L139	L14	L200	L2081	L2082
L2084	L2089	L209	L210	L211	L218	L219	L22
L230	L231	L232	L233	L234	L235	L236	L237
L2381	L2389	L239	L240	L241	L242	L243	L244
L245	L246	L247	L2481	L2489	L249	L250	L252
L258	L259	L270	L271	L272	L278	L279	L300
L302	L308	L309	L401	L560	L561	L562	L563
L564	L565	L570	L571	L572	L573	L574	L575
L580	L581	L589	L598	L599	L700	L701	L702
L703	L704	L705	L708	L730	L80	L811	L812
L813	L815	L816	L818				

31.2.38 Sleep Studies

Polysomnography, multiple sleep latency tests, and pediatric pneumograms are benefits of the CSHCN Services Program.

Sleep facilities that perform services for CSHCN Services Program clients must be accredited with the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Documentation of accreditation must be maintained in the facility and be available for review. Sleep facilities must also follow current AASM practice parameters and clinical

guidelines. Providers may refer to the AASM website at https://aasm.org/ for AASM facility certification requirements or to the JCAHO website at www.jointcommission.org for JCAHO facility accreditation information.

Sleep facility technicians and technologists must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

The sleep facility must have one or more supervision physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualifications of the non-physician staff who use the equipment.

31.2.38.1 Polysomnography

Polysomnography is the recording, analysis, and interpretation of the multiple simultaneous physiological measurements of sleep for 6 or more hours. The studies are performed to diagnose a variety of sleep disorders, such as sleep apnea, and are considered part of the clinical workup performed before the surgical procedure uvulopalatopharyngoplasty.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which includes a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), and a submental electromyogram (EMG).

Additional parameters of sleep include, but are not limited to:

- Airflow.
- Body positions.
- Continuous blood pressure monitoring.
- Electrocardiogram (ECG).
- Extended EEG monitoring.
- Extremity/motor activity movement.
- Gas exchange by oximetry.
- Gastroesophageal reflux.
- Penile tumescence.
- Snoring.
- Ventilation and respiratory effort.

For a study to be reported as polysomnography, sleep must be recorded and staged.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist or physician.

  Note: *Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is being provided.*

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (M.D. or D.O.).

- A polysomnographic technician provides comprehensive polysomnographic testing and analysis, and associated interventions under the general supervision of a polysomnographic technologist or clinical director (M.D. or D.O.).

  Note: *The supervising physician must be readily available to the performing technologist throughout the duration of the study but is not required to be in the building.*

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is restricted to the following diagnosis codes:

Diagnosis Codes							
E662	F5101	F5102	F5103	F5104	F5109	F5111	F5112
F5113	F5119	F513	F514	F515	F518	F519	F984
G253	G2589	G259	G26	G4700	G4701	G4710	G4711
G4712	G4713	G4714	G4719	G4720	G4721	G4722	G4723
G4724	G4725	G4726	G4727	G4729	G4730	G4731	G4733
G4734	G4735	G4736	G4737	G4739	G47411	G47419	G47421
G47429	G4750	G4751	G4752	G4753	G4754	G4759	G4761
G4769	G478	G479	J9610	J9611	J9612	R0600	R0609
R063	R0683	R0689	R069	R0901			

Polysomnography is payable to physicians in outpatient hospital and office settings. Procedure codes 95782, 95783, 95808, 95810, and 95811 are limited to one per day by any provider. When multiple procedure codes are billed on the same day, the most inclusive code is paid and all other codes are denied.

31.2.38.2 Multiple Sleep Latency Test

Multiple sleep latency tests involve the client being given a chance to sleep every 2 hours during normal wake time. Observations are made of the time taken to reach stages of sleep. This test measures the degree of daytime sleepiness and how soon rapid eye movement (REM) sleep begins. This test is a benefit for diagnosing narcolepsy.

Multiple sleep latency tests (procedure code 95805) are restricted to the following diagnosis codes:

Diagnosis Codes							
E662	G4700	G4710	G4711	G4712	G4720	G4733	G47411
G47419	G47421	G47429	G478	G479			

Multiple sleep latency tests are payable to physicians in outpatient hospital and office settings. Procedure code 95805 is limited to one per day by any provider. Sleep study procedure codes 95806 and 95807 are not a benefit of the CSHCN Services Program.

31.2.38.3 Pediatric Pneumogram

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

Procedure code 94772 is a benefit for CSHCN Services Program clients from birth through 12 months of age with one of the following diagnosis codes:

Diagnosis Codes							
K2080	K2081	K2090	K2091	K2100	K2101	K219	K220
P220	P228	P229	P270	P271	P278	P279	P282
P2830	P2831	P2832	P2833	P2839	P2840	P2841	P2842
P2843	P2849	P285	P2881	P2889	P84	R0600	R0609
R062	R063	R0681	R0682	R0683	R0689	R069	R6813

Pediatric pneumograms are payable to physicians in office, inpatient hospital, and outpatient hospital settings. A pediatric pneumogram is limited to two services per lifetime without authorization based on the diagnoses listed above. Authorization is required for more than two pneumograms. Requests for prior authorization must be submitted using the CSHCN Services Program Authorization and Prior Authorization Request form.

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

Pediatric pneumograms may be reimbursed on the same date of service as an apnea monitor (rented monthly) if documentation supports the medical necessity.

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

31.2.38.4 Home Sleep Study Test

Home sleep study tests are unattended studies that are performed in the client's home using a portable monitoring device. The portable monitoring device must meet AASM practice parameters and clinical guidelines.

Home sleep study testing is a benefit of the CSHCN Services Program only when performed in conjunction with a comprehensive sleep evaluation that has been performed by a physician who is board-certified or board-eligible, as outlined in the AASM guidelines. Documentation of the comprehensive sleep evaluation must be kept in the client's medical record. The evaluation must indicate probability of moderate to severe obstructive sleep apnea to support medical necessity for home sleep study testing.

Procedure codes G0398, G0399, and G0400 are a benefit for CSHCN Services Program clients who are 18 years of age and older with suspected or proven simple, uncomplicated obstructive sleep apnea. Procedure codes G0398, G0399, and G0400 are restricted to diagnosis code G4733.

Home sleep study tests are payable to physicians in the office setting. Procedure codes G0398, G0399, and G0400 are limited to one per day and a combined total of two tests per rolling year, with any provider. If a client needs more than two tests in a rolling year, subsequent tests must be performed in a sleep facility.

31.2.39 Surgery

Surgical services, including surgical procedures involving an assistant surgeon or cosurgeon, are a benefit of the CSHCN Services Program.

Authorization of cosurgeon and assistant surgeon services is not required; however, all other authorization requirements associated with the surgical procedure must be met.

Reminder: *An authorization request can be submitted up to 95 days after the date of service. The completed authorization form can be attached to the paper claim.*

Specific surgical procedures, as specified throughout this section, require prior authorization. If a prior authorization is not obtained for the procedure, the facility's services, the surgeon's services, and the assistant surgeon's services are denied; however, anesthesia services may be paid.

Prior authorization must be obtained for procedures that are completed by a specialty team or in a specialty center. Criteria unique to specific surgical procedures must be satisfied as indicated in the appropriate sections below.

Unless otherwise stated, no additional reimbursement is provided to physicians who elect to use special instruments or advanced technology to accomplish a surgical procedure.

Surgical procedures may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.39.1 Anesthesia Administered by Surgeon

If the physician submits a surgical procedure and anesthesia for the same surgery for reimbursement, the anesthesia procedure code is denied as part of the surgical procedure.

31.2.39.2 Primary Surgeons

The primary surgeon is the lead surgeon who participates and directs the technical aspects of a surgical case.

Physicians cannot provide services as a surgeon and assistant surgeon, or as a surgeon and anesthesiologist during the same surgical procedure. A physician may bill as a surgeon and assistant surgeon on the same client, if two separate procedures are performed. Full payment is allowed for surgery, and the assistant surgical procedure may be reimbursed half of the reimbursement amount for an assistant surgery.

If the physician is an anesthesiologist who is billing for general anesthesia and a surgical procedure which is considered part of the anesthesia, the surgical procedure is not reimbursed.

31.2.39.3 Assistant Surgeons

An assistant surgeon assists the primary surgeon during a complex surgical procedure that warrants an assistant to safely and effectively accomplish the procedure.

Assistant surgeons may be reimbursed 16 percent of the prevailing fee for the surgical procedure performed.

The CSHCN Services Program follows the *Tax Equity and Fiscal Responsibility Act (TEFRA)* of 1982 regulation for assistant surgeons in teaching hospitals.

An assistant surgeon is not paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. These claims are paid only if modifiers 82 or 80 (assistant surgeon) and KX (documentation on file) are present on the claim. These modifiers should be used in the following situations:

- There are exceptional medical circumstances, such as emergency or life-threatening situations that require immediate attention.
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of their clients.
- The surgical procedure is complex and qualifies for more than one physician.
- Use modifier 82 when no qualified resident was available to assist with the surgery.

If the physician seeks an exception to the TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or be attached to the claim form:

> "I understand that Section 1842(b)(6)(D) of the *Social Security Act* generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP-CSHCN."

Payment to an assistant surgeon for multiple surgical procedures follows the same guidelines as payment to the primary surgeon.

If an assistant surgeon bills separate charges for local or regional anesthesia and assistant surgery on the same day, the anesthesia is included as part of the surgical procedure and not reimbursed separately.

31.2.39.4 Cosurgery

Cosurgery is a benefit of the CSHCN Services Program if the CMS fee schedule indicates that the procedure allows for cosurgeons.

When billing for cosurgery, each surgeon must bill the same procedure codes and modifier 62 (cosurgeon).

Cosurgery occurs when two surgeons, usually with different specialties or skills, work together as primary surgeons performing distinct parts of a single reportable procedure. Neither surgeon is acting as an assistant surgeon; both have comparable roles in the procedure. When two surgeons work together as primary surgeons performing distinct parts of the procedure, each surgeon should report their distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes for that procedure, as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the cosurgery once using the same procedure codes. If additional procedures (including add-on procedures) are performed during the same surgical session, separate codes may be reported without modifier 62 added.

Authorization is not specifically required for procedures using cosurgeons, although all other authorization requirements must be met. Prior authorization must be obtained for those procedures completed by a specialty team or in a specialty center. Criteria unique to specific surgical procedures must be satisfied as indicated in Section 31.2.39.11, "Cleft/Craniofacial Procedures" in this chapter and Section 31.2.42.2, "Transplants - Nonsolid Organ" in this chapter.

If a cosurgeon acts as an assistant in the performance of additional procedures during the same surgical session, those services can be reported using separate procedure codes with the modifier 80 or 81 (minimum assistant surgeon) added, as appropriate.

Each surgeon receives 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure's fee. Additional payment is not made for an assistant surgeon on the same procedure being reimbursed as cosurgery.

Claims submitted without the cosurgery modifier 62 are not considered cosurgery. Reimbursement for these claims is determined by other surgery reimbursement methodology.

> ***Note:*** *Each surgeon that performs cosurgery must bill only the appropriate procedure code for the specific surgery performed.*

The CSHCN Services Program does not reimburse for team surgery. Surgeons and assistant surgeons participating in a team surgery should bill for procedures they personally completed, and may be reimbursed based on the multiple surgery guidelines.

31.2.39.5 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral procedure code is not available, a unilateral procedure code must be used. The unilateral procedure code must be billed twice with a quantity of one for each procedure code. For all procedures, modifiers LT (left side), and RT (right side) must be used as appropriate.

Bilateral procedures performed on separate limbs are paid the full allowance for the major procedure and half the allowance for subsequent procedures performed on the same day, when medically justified.

31.2.39.6 Global Fees

The CSHCN Services Program uses global surgical periods to determine reimbursement for surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

The CSHCN Services Program will adhere to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period—Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period—Reimbursement includes the surgical procedure and all associated services provided on the day of the surgery through 10 days after the surgical procedure.
- 90-day Global Period—Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, and all associated services that are provided on the day of the surgery through 90 days after the surgical procedure.

Procedure codes that are designated as "Carrier Discretion" will have their global periods determined by the CSHCN Services Program.

> ***Note:*** *Note: All unlisted surgical procedure codes have a 42-day global period assigned by the CSHCN Services Program.*

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

Radiology and laboratory services related to the surgical procedure are not subject to the global period and are reimbursed separately.

31.2.39.6.1 Modifiers

To align with CMS, the CSHCN Services Program will add certain modifiers that are related to surgical services. For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

Modifiers Related to Surgical Fees									
24	25	54	55	56	57	58	62	76	77

Modifiers Related to Surgical Fees	
78	79

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the provider performing preoperative or postoperative care. Reimbursement for claims associated with modifiers 54, 55, and 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

31.2.39.6.2 Documentation Requirements

For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client's medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to:

- Progress notes.
- Operative reports.
- Laboratory reports.
- Hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

> ***Note:*** *Retrospective review may be performed to ensure documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.*

31.2.39.6.3 Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a separately identifiable service and are above and beyond the usual preoperative and postoperative care, may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to the CSHCN Services Program upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.

E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when they are billed with modifier 57. The client's medical record should clearly indicate when the initial decision to perform the procedure was made.

31.2.39.6.4 Intraoperative Services

Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

31.2.39.6.5 Postoperative Services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Follow-up visits (any place of service)
- Pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care
  - Platelet gel
  - Removal of operative packs
  - Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
  - Replacement of vascular access lines
  - Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
  - Changes or removal of tracheostomy tubes

Note: *Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.*

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of surgery, and modifier 54, which indicates that he or she was the surgeon
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care

Note: *Providers must not submit a claim for a procedure until after the client has been seen during a face-to-face follow-up visit.*

When transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider who assumes in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- The surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
- Documentation in the medical record must include all of the following:
  - A copy of the written transfer agreement
  - The dates the care was assumed and relinquished

- The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

When a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until at least one service has been provided.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication and was one of the following:

- It was planned at the time of the initial surgical procedure
- It is more extensive than the initial surgical procedure
- It is for therapy following an invasive diagnostic surgical procedure

Note: *Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).*

Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and, as a result, not separately billable; however, separate payment for such visits can be allowed if any of the following conditions apply:

- Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy following transplant surgery is covered separately from other postoperative services, so postoperative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery. This coverage applies regardless of the setting.
- Critical care is provided by the surgeon for a burn or trauma patient.
- The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. Documentation must substantiate the reasons for providing E/M services.

- Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
- Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

31.2.39.6.6 Return Trips to the Operating Room

Return trips to the operating room for a repeat surgical procedure may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifiers 76 and 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure should be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.

Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period, only the intraoperative portion will be reimbursed.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis
- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier
- When a different procedure is performed with the same diagnosis
- When a different procedure is performed with a different diagnosis

Billing with modifier 79 initiates a new global surgical period.

31.2.39.7 Multiple Surgeries

The CSHCN Services Program payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day, the major procedure (e.g., the highest paying procedure) is paid at the full amount allowed by Texas Medicaid. Secondary procedures performed on the same day are paid at half of the amount allowed by Texas Medicaid when medically justified.
- When a surgical procedure and a biopsy on the same organ or structure are performed on the same day, the procedures are reviewed and only the service with the higher of the allowed amounts may be reimbursed.

31.2.39.8 Second Opinions

CSHCN Services Program benefits include payment to physicians when a CSHCN Services Program client requests a second opinion regarding surgery. The claim must be coded with the appropriate office or hospital visit procedure code, and the notation "Client Initiated Second Opinion" must be noted in Block 24D of the CMS-1500 paper claim form.

31.2.39.9 Unlisted Surgical Procedure Code Considerations

Unlisted surgical procedure codes are commonly used when a matching description of a procedure performed *cannot* be found within HCPCS.

> ***Note:*** *All unlisted surgical procedure codes have a 42-day global period assigned by the CSHCN Services Program.*

Providers may use the procedure code that best matches the surgery performed. If an unlisted procedure code is used, the following must be included with the claim:

- A complete description of all procedures performed
- An operative report of procedures

Providers must verify whether a procedure requires authorization. Filing a claim correctly the first time helps ensure that the claim is processed in a timely manner.

Refer to: Section 31.2.1, "Authorization and Prior Authorization Requirements" in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

Section 31.2.39.11, "Cleft/Craniofacial Procedures" in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

Section 31.2.42.2, "Transplants - Nonsolid Organ" in this chapter for specific information on procedures that must be performed by an approved specialty team/center.

31.2.39.10 Circumcision

Circumcision (procedure codes 54150, 54160, and 54161) is a benefit of the CSHCN Services Program when medically necessary.

Conditions that may require circumcision include, but are not limited to, the following:

- Congenital obstructive urinary tract anomalies
- Neurogenic bladder
- Spina bifida
- History of recurrent urinary tract infections
- Vesicoureteral reflux of at least a Grade III
- Paraphimosis
- Phimosis causing urinary obstruction

Elective circumcision of a newborn male for cosmetic, routine, or ritual purposes is not a benefit of the CSHCN Services Program. The newborn period is defined as the first 28 days of life. Circumcision of a female of any age is not a benefit of the CSHCN Services Program.

Authorization is required for a circumcision. Documentation should include the diagnosis and the specific medical necessity for the circumcision.

Refer to: Section 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization requirements.

Procedure codes 54162 and 54163 are also a benefit of the CSHCN Services Program when medically necessary and do not require authorization.

When anesthesia or analgesia stronger than topical analgesia is used during the procedure, providers must follow applicable modifier guidelines and bill their usual and customary charges.

If a circumcision is billed in addition to a hypospadias or epispadias repair, the circumcision is denied as part of another procedure. A circumcision billed in addition to other surgical procedures on the male genital or urinary system is paid according to multiple surgery reimbursement guidelines. Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. Claims submitted by an assistant surgeon for a circumcision are denied.

31.2.39.11 Cleft/Craniofacial Procedures

Cleft and craniofacial services provided by a cleft and craniofacial (C/C) team or through a coordinated multidisciplinary team, including surgical interventions required to treat cleft lip, cleft palate, and craniofacial anomalies, are benefits of the CSHCN Services Program.

The CSHCN Services Program recognizes the standard of care needed to appropriately address the repair of C/C anomalies, as outlined in the guidelines prepared by the American Cleft Palate-Craniofacial Association (acpacares.org).

A comprehensive, multidisciplinary approach is medically necessary to meet all of the needs of clients who have complex medical conditions that require treatment by a broad range of medical specialists. The standard of care for the comprehensive repair or reconstruction of craniofacial anomalies for CSHCN Services Program clients requires a team approach by either a C/C team or an equivalent coordinated multidisciplinary team. The following exceptions to this requirement may be considered:

- A C/C or equivalent multidisciplinary team is not available in the area and the client is unable to travel. Medical record documentation must explain the reasons for which the client is unable to travel.
- A C/C or equivalent multidisciplinary team is not available in the area and the team approach cannot be coordinated over multiple locations. Medical record documentation must describe the attempts that were made to coordinate a team approach.
- A C/C or equivalent multidisciplinary team is available but the client or the client's parent or guardian refuses care from the team. Medical record documentation must document the reason that the client or the client's parent or guardian gave for refusing care from the team.

The C/C or equivalent coordinated multidisciplinary team must have surgical and medical specialists, including, but not limited to the following:

- Operating surgeon
- Orthodontist
- Speech-language pathologist
- At least one of the following specialists:
    - Otolaryngologist
    - Audiologist
    - Pediatrician
    - Geneticist
    - Social worker
    - Psychologist
    - General pediatric or prosthetic dentist

Each C/C or equivalent coordinated multidisciplinary team must identify the following:

- An administrator who is responsible for coordinating and maintaining C/C team records and ensuring that the C/C team adheres to CSHCN Services Program rules and regulations
- A team care coordinator to ensure that the focus of the service is client and family oriented, and that the client, family, and C/C team jointly develop a comprehensive treatment plan for the client

The comprehensive treatment plan must be maintained in the client's medical record and must be provided to the client and family, the referring physician, other collaborating providers, and the Department of State Health Services (DSHS) regional social worker upon request.

The plan will include the specific services that will be provided by the members of the C/C team, action steps, persons responsible, and time-frame objectives for meeting treatment outcomes.

Documentation of medical necessity must be kept in the client's medical record if the requested surgical procedure is being performed because of injury or other trauma that is not associated with the repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies.

The following procedure codes must be prior authorized:

Surgery and Assistant Surgery Procedure Codes									
20902	21120	21121	21122	21123	21125	21127	21137	21138	21139
21141	21142	21143	21145	21146	21147	21150	21151	21154	21155
21159	21160	21172	21175	21179	21180	21181	21182	21183	21184
21188	21193	21194	21195	21196	21198	21199	21206	21209	21210
21230	21244	21247	21255	21256	21260	21261	21263	21267	21268
21275	21299	40799	42210	61550	61552	61556	61557	61558	61559
62115	62117								

Surgery Only Procedure Codes									
14040	14041	14060	14061	15120	15121	15135	15136	15155	15156
15157	15240	15241	15260	15261	15576	21076	21077	21079	21080
21081	21082	21083	21084	21085	21086	21087	21088	21089	21100
21110	21208	21215	21235	21245	21246	21248	21249	21270	21280
21282	21295	21296	21497	30400	30410	30420	30435	30450	30460
30462	30465	30520	30540	30545	30560	30580	30600	30620	30630
40527	40650	40652	40654	40700	40701	40702	40720	40761	42145
42200	42205	42215	42220	42225	42226	42227	42235	42260	42280
42281	67950	67961	67966	67971	67973	67974	67975		

Documentation of medical necessity must be submitted with the prior authorization request form if the surgical procedure is to be performed for reasons unrelated to the repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies.

Prior authorization is also required for orthodontic services that are performed in conjunction with C/C services.

Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

31.2.40 Diagnostic and Surgical/Reconstructive Breast Therapies

The following services are benefits of the CSHCN Services Program:

- Breast therapies
  - Diagnostic
  - Surgical
  - Reconstructive
  - Treatment of complications of breast reconstruction
  - External breast prostheses

- Corrective procedures

Surgical, reconstructive, and corrective procedures must be medically necessary.

Only new, unused durable medical equipment will be purchased for CSHCN clients.

Diagnostic and surgical/reconstructive breast therapies and corrective procedures include:

- Diagnostic procedures for the breast
- Mastectomy for the treatment of breast cancer
- Prophylactic mastectomy
- Mastectomy for gynecomastia
- Reconstructive procedures
- Treatment of complications of breast reconstruction
- External breast prostheses
- Corrective procedures

The following provider types, services and settings apply:

- Diagnostic and surgical/reconstructive breast therapies may be provided by physicians, physician assistants, and advanced practice registered nurses, in the office, outpatient and inpatient hospital settings.
- Corrective procedures may be provided by physicians, dentists, podiatrists, physician assistants, and advanced practice registered nurses, in office, inpatient and outpatient hospital settings.
- Breast prostheses which are considered DME and may be provided by DME providers in the home setting.

To be considered for reimbursement, a LT or RT modifier must be appropriately appended to the procedure codes submitted for diagnostic and surgical/reconstructive breast therapies, external breast prostheses, or corrective procedures.

31.2.40.1 Breast Therapies

31.2.40.1.1 Diagnostic Breast Procedures

Diagnostic breast procedures are a benefit of the CSHCN Services Program for a diagnosis of a condition or malignancy of the breast.

Diagnostic procedures may include:

- Puncture aspiration
- Mastotomy
- Injection procedure for ductogram or galactogram
- Percutaneous biopsy, with or without imaging guidance
- Incisional biopsy
- Nipple exploration

Excision of the following:

- Lactiferous duct fistula
- Benign or malignant breast lesion
- Chest wall tumor

The following procedure codes may be reimbursed for diagnostic procedures:

Procedure Codes									
19000	19001	19020	19030	19081	19082	19083	19084	19085	19086
19100	19101	19110	19112	19120	19125	19126	19281	19282	19283
19284	19285	19286	19287	19288	21601	21602	21603		
***Procedure code 21603 is limited to one procedure per lifetime.**									

The following procedure codes are add-on codes and must be billed with the appropriate primary procedure code, on the same day, by the same provider:

Add-on Procedure Codes								
19001	19082	19084	19086	19126	19282	19284	19286	19288

31.2.40.2 Surgical Breast Procedures

31.2.40.2.1 Mastectomy

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, or segmentectomy) is a benefit of the CSHCN Services Program when it is medically necessary to remove a breast or portion of a breast for conditions including, but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

The following mastectomy procedure codes are benefits of the CSHCN Services Program for male and female clients of all ages:

Procedure Codes	Limitations
Partial Mastectomy	
19301, 19302	One left breast per lifetime One right breast per lifetime
Simple, Subcutaneous, Radical, and Modified Radical Mastectomy	
19303 19305, 19306, 19307	One left breast per lifetime One right breast per lifetime

31.2.40.2.2 Prophylactic Mastectomy

Prophylactic mastectomy is a benefit of the CSHCN Services Program and is limited to clients who are at moderate or high-risk for the development of breast cancer and have one or more of the following conditions:

- Personal history
  - Current or previous history of breast cancer
  - Lobular carcinoma in situ (LCIS)
  - Radiation therapy to the chest before the age of 30
- Family history of breast or ovarian cancer in mother, sister, or daughter

- Presence of any of the following genetic mutations:
  - Breast cancer gene 1 (BRCA1)
  - Breast cancer gene 2 (BRCA2)
  - Tumor protein 53 (TP 53)
  - Phosphatase and tensin homolog (PTEN)

Note: *The above risk factors are identified by the National Cancer Institute and the National Comprehensive Cancer Network.*

Documentation that supports medical necessity for the procedure must be maintained in the client's medical record and must indicate the following:

- The client is moderate-to-high risk, as previously defined
- As a candidate for prophylactic mastectomy, the client has undergone counseling from a health professional other than the operating surgeon. The counseling must include assessment of the following:
  - The client's ability to understand the risks and long-term implications of the surgical procedure
  - The client's informed choice to proceed with the surgical procedure

31.2.40.2.3 Mastectomy for Gynecomastia

Surgery to correct gynecomastia is a benefit of the CSHCN Services Program for males who are 20 years of age or younger, when the criteria is met.

Procedure code 19300 may be reimbursed when billing for a mastectomy for pubertal gynecomastia.

31.2.40.2.4 Breast Reconstruction

Breast reconstruction is a benefit of the CSHCN Services Program when performed to correct or repair abnormal structures of the breast caused by one or more of the following:

- Mastectomy or a history of complications of mastectomy
- Tumor or disease (e.g., following a primary mastectomy procedure in order to establish symmetry with a contralateral breast or following bilateral mastectomy)
- Congenital defect
- Developmental abnormality
- Infection
- Trauma or injury to the chest wall

Breast reconstruction may be performed using one of the following:

- Implants (saline or silicone)
- Tissue transfers, including, but not limited to:
  - Latissimus dorsi flap
  - Transverse rectus abdominis myocutaneous (TRAM) flap
  - Deep inferior epigastric perforator (DIEP) flap
  - Superficial inferior epigastric artery (SIEA) flap
- Nipple or areola reconstruction
- Reduction mammaplasty

- Mastopexy
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

Breast reconstruction may be performed as single or multiple, staged procedures (e.g., tissue expansion followed by implants, nipple or areola reconstruction). Nipple-areola pigmentation, commonly known as medical tattooing, is the final stage of breast reconstruction surgery. All of the following criteria must be met for breast reconstruction following a medically necessary mastectomy.

- The client is eligible for CSHCN Services Program at the time of the breast reconstruction.
- The client has a documented history of a mastectomy.
- The client meets age and gender criteria for the requested procedure.

The following procedure codes may be reimbursed for breast reconstruction:

Procedure Code	Client Gender and Ages	Limitation
11920	Male and female clients	Two procedures per lifetime
11921	Male and female clients	Two procedures per lifetime
11922	Male and female clients	Two procedures per lifetime
11970	Male and female clients	
11971	Male and female clients	
19316	Female clients	
19318	Female clients	
19325	Female clients	
19340	Female clients	
19342	Female clients	
19350	Male and female clients	
19355	Male and female clients	
19357	Female clients	
19361	Male and female clients	
19364	Male and female clients	
19367	Male and female clients	
19368	Male and female clients	
19369	Female clients	
19396	Female clients	
S2068	Male and female clients	

Tattooing (procedure codes 11920, 11921, and 11922) is limited to clients with a documented history of a breast reconstruction performed while the client was eligible for the CSHCN Services Program.

Denied claims for tattooing may be appealed with supporting documentation stating the date of breast reconstruction.

Denied claims for breast reconstruction may be appealed with supporting documentation which includes the date of mastectomy.

31.2.40.2.5 Excision or Destruction of Benign Lesions

The client must have a documented history of mastectomy or a history of complications of mastectomy performed while eligible for the CSHCN Services Program.

Documentation supporting medical necessity for treatment of a benign lesion, cyst, or lipoma must be maintained in the client's medical record and identify that the lesion requiring treatment is one or more of the following:

- Inflamed
- Infected
- Irritated
- Bleeding
- Increasing in size
- Obstructing vision
- Interfering with oral function
- Located in an area that could affect motion or function

When a lesion is suspicious for malignancy, documentation supporting medical necessity for excision or destruction of the lesion must be maintained in the client's medical record.

For blepharoplasty procedures (procedure codes 15820, 15821, 15822, and 15823) additional documentation of medical necessity must be submitted with both of the following:

- Photographs of the eyelid problem
- Visual field measurements

Excision or destruction of multiple lesions, cysts, or lipomas are reimbursed according to the multiple surgery payment guidelines. Initial or follow-up visits billed in addition to a lesion excision and/or destruction for the same diagnosis are subject to global surgery payment criteria.

Refer to: Section 31.2.39.6, "Global Fees" in this chapter and Section 31.2.39.7, "Multiple Surgeries" in this chapter for additional information about global surgery and multiple surgery fees.

31.2.40.2.6 Treatment for Complications of Breast Reconstruction

The following procedure codes are benefits of the CSHCN Services Program for the treatment of complications of breast reconstruction:

Procedure Codes				
19328*	19330*	19370*	19371*	19380
*** A benefit for female clients only**				

Regardless of the client's eligibility at the time of the original breast reconstruction, the treatment of complications is considered for reimbursement when medical criteria are met.

31.2.40.2.7 Reduction Mammaplasty

Procedure code 19318 may be reimbursed with prior authorization for reduction mammaplasty. This procedure is limited to two per lifetime.

31.2.40.2.8 External Breast Prostheses

External breast prostheses must be provided by a durable medical equipment (DME) provider to a female client with a history of a medically necessary mastectomy procedure.

External breast prostheses may be reimbursed if the client has a documented history of breast surgery in the past.

Refer to: Chapter 17, "Durable Medical Equipment (DME)" for breast prosthesis benefits and limitations.

31.2.40.3 Prior Authorization and Authorization Requirements

All prior authorization and authorization requests must be submitted with documentation of medical necessity.

Prior authorization requests must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form. Prior authorization requests that do not contain required information are considered incomplete and will be denied. The requesting provider may be asked for additional information to clarify or support the authorization request.

Prior authorization requests for external breast prostheses must be submitted using the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and Instructions.

Requests must include the physician's original signature and the date signed. Stamped signatures and dates will not be accepted. Requests will be considered incomplete without this information.

Requests for DME quantities exceeding limitations must be prior authorized by the CSHCN medical director and must be submitted with documentation of medical necessity.

Procedure code 15828 requires prior authorization. All requests must be reviewed by the CSHCN Services Program Medical Director or designee.

31.2.40.4 Prior Authorization and Authorization Requirements for Mastectomy, Breast Reconstruction, and External Prostheses

Prior authorization is not required when:

- The client is 18 years of age or older, meets gender criteria and the procedure is a mastectomy or breast reconstruction, or
- The client is 18 years of age or older, meets gender criteria, and the request is for one of the following external breast prosthesis procedure codes:

Procedure Codes					
L8000	L8001	L8002	L8015	L8020	L8030

- Partial mastectomy, procedure codes 19301 and 19302 are exceptions. Procedure codes 19301 and 19302 are eligible for reimbursement regardless of the client's age, and therefore they do not require prior authorization.

Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client does not meet criteria
- Mastectomy for pubertal gynecomastia
- Unlisted breast procedure code 19499
- Tattooing for clients without an established history of breast reconstruction during eligibility for the CSHCN Services Program
- External breast prosthesis procedure codes L8035 and L8039

31.2.40.4.1 Mastectomy and Breast Reconstruction

Prior authorization for mastectomy, prophylactic mastectomy, or breast reconstruction is required for one or more of the following:

- The client is 17 years of age or younger, or
- The client does not meet the gender criteria for the requested procedure, as required by the CSHCN Services Program, or
- The client does not have an established history of related services while eligible for the CSHCN Services Program.

Documentation for a mastectomy must be submitted for conditions, including but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

31.2.40.4.2 Breast Reconstruction

Documentation must be submitted which identifies one or more of the following:

- Mastectomy or a history of complications of mastectomy
- Tumor or disease (e.g., following a primary mastectomy procedure in order to establish symmetry with a contralateral breast or following bilateral mastectomy)
- Congenital defect
- Developmental abnormality
- Infection
- Trauma or injury to the chest wall

31.2.40.4.3 Mastectomy for Gynecomastia

Prior authorization is required for procedure code 19300, which indicates mastectomy for pubertal gynecomastia. The following documentation must be submitted with all prior authorization requests:

- Gynecomastia is classified as Grade II, III or IV per the American Society of Plastic Surgeons classification.
- Puberty is at or near completion, as evidenced by documentation of the following:
  - 95 percent of adult height based on bone age, and
  - Tanner stage V
- Glandular breast tissue confirming true gynecomastia is documented on physical examination or mammography.
- Hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas and hypogonadism, have been excluded by appropriate laboratory testing. If present, hormonal causes must have been treated for at least one year and are resolved, as supported by appropriate laboratory test results.
- Medical documentation must be submitted with a prior authorization request for a client that has used gynecomastia inducing drugs or other substances, when identified as the cause of gynecomastia. The documentation must indicate that the client has been off the drugs or other substances for a minimum of one year and must include the dates that the client has been off such substances.

- Psychological and psycho-social effects which were identified in the pre-surgical history and physical.
- Identification of left breast, right breast or both breasts, which require mastectomy.

31.2.40.4.4 Reduction Mammaplasty

Prior authorization is required for procedure code 19318, which indicates reduction mammaplasty.

When requesting prior authorization for procedure code 19318, the following documentation must be submitted with all prior authorization requests:

- Surgeons are required to include the following information documenting medical necessity when requesting prior authorization:
  - Client's name and CSHCN Services Program client number,
  - Complete history and physical, including height, weight, and breast size
  - Description of functional debility caused by the condition
  - Preoperative photographs (both front and side views)
  - Description of past treatments and outcomes
  - Number of grams of tissue to be removed from each side
  - Requesting surgeon's National Provider Identifier (NPI) number, and
  - Name and address of facility where services are to be performed and the provider's NPI.

31.2.40.4.5 Unlisted Procedure

Prior authorization is required for procedure code 19499, which indicates an unlisted breast procedure.

When requesting a prior authorization for procedure code 19499, the following documentation must be submitted to determine coverage:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A CPT or HCPCS procedure code, which is comparable to the procedure being requested
- Documentation this procedure is not investigational or experimental
- Place of service the procedure is to be performed, and
- The provider's intended fee for this procedure.

Prior authorization requests must be submitted using a CSHCN Services Program Authorization and Prior Authorization Request form.

Prior authorization requests that do not contain the required information are considered incomplete and will be denied.

31.2.40.4.6 Breast Prostheses

Prior authorization requests for external breast prostheses must be submitted using the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and Instructions.

External breast prostheses of the same type will be considered for coverage at any time, through the prior authorization process, if it is lost, stolen, or irreparably damaged.

An external breast prosthesis that is a replacement or a different type will be considered for coverage at any time, through the prior authorization process, if the prosthesis is needed due to a change in the client's medical condition.

Prior authorization is required for procedure codes L8035 and L8039 when the request is for new or replacement external breast prosthesis. The following documentation of medical necessity must be submitted with the prior authorization request:

- The client's diagnosis
- Prior treatment for this diagnosis, and
- Medical necessity of the requested prosthesis.

When requesting a prior authorization for procedure code L8039, the following additional information must also be submitted in order to determine coverage:

- A clear, concise description of the prosthesis which is requested
- Reason for recommending this particular prosthesis
- A CPT or HCPCS procedure code, which is comparable to the prosthesis requested
- Documentation that this prosthesis is not investigational or experimental
- Provider's place of service, and
- The provider's intended fee for this prosthesis.

31.2.40.5 Documentation Requirements

In addition to documentation requirements outlined in the Prior Authorization and Authorization Requirements section, the following requirements apply:

- All services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided, and
- Services not supported by documentation are subject to recoupment.

31.2.40.6 Reconstructive and Corrective Procedures (Not Related to Breast Therapies)

Reconstructive and corrective procedures are performed on structures of the body for any of the following purposes:

- Improving or restoring bodily functions
- Correcting significant deformity resulting from:
  - Disease
  - Trauma
  - Previous surgical procedure
  - Congenital or developmental anomalies

Excision or destruction of a benign lesion, cyst, or lipoma is a benefit only when the lesion is:

- Inflamed
- Infected
- Irritated
- Bleeding
- Increasing in size
- Obstructing vision
- Interfering with oral function
- Located in an area that could affect motion or function

Excision or destruction of a lesion may be a benefit when there is suspicion of malignancy.

The following procedure codes may be reimbursed for corrective procedures:

Procedure Codes									
10040	11200	11201	11300	11301	11302	11303	11305	11306	11307
11308	11310	13111	11312	11313	11400	11401	11402	11403	11404
11406	11420	11421	11422	11423	11424	11426	11440	11441	11442
11443	11444	11446	11760	11762	11960	15781	15782	15783	15786
15787	15788	15789	15792	15793	15820	15821	15822	15823	15830
15847	17000	17003	17004	17106	17107	17108	17110	17111	17311
17312	17313	17314	17315	21555	21740	21742	21743	21930	21931
22900	22901	22902	22903	23071	23073	23075	23076	23077	23078
24071	24073	24075	24076	24077	24079	25075	26115	27043	27045
27047	27048	27049	27327	27328	27337	27339	27618	27619	27634
28039	28041	28043	28045	28313	40818	54660			

The following procedure codes are add-on codes and must be billed with the appropriate primary procedure code, on the same day, by the same provider:

Add-on Procedure Codes							
11201	15777	15787	15847	17003	17312	17314	17315

31.2.40.7 Prior Authorization and Authorization for Corrective Procedures

31.2.40.7.1 Oral Procedures

Procedures that are performed as part of cleft-craniofacial surgery require prior authorization.

Refer to: Section 31.2.39.11, "Cleft/Craniofacial Procedures" in this chapter for information about CSHCN Services Program cleft-craniofacial benefits and limitations.

31.2.40.7.2 Dermatological and Blepharoplasty Procedures

Extractions, dermabrasion, and chemical peel, and blepharoplasty procedures (procedure codes 10040, 15781, 15782, 15783, 15788, 15789, 15792, 15793, 15820, 15821, 15822, and 15823) require prior authorization, and must meet one of the following criteria:

- Correction or repair of severe disfigurement due to disease or accidental injury (photographic documentation is required), or
- Restoration of physical function resulting from disease or accidental injury (specific function must be detailed in prior authorization request).

31.2.40.7.3 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits for panniculectomy and abdominoplasty procedures.

Panniculectomy and abdominoplasty procedures are limited to once per lifetime, by the same provider.

Panniculectomy and abdominoplasty procedure codes 15830 and 15847 require prior authorization. The following documentation supporting medical necessity must be submitted with all prior authorization requests:

- Photographic documentation that the panniculus hangs below the level of the pubis,

- The panniculus is the result of weight loss of at least 75 pounds that has been sustained for over one year, and
- Documentation of one or more of the following conditions which directly impairs physical function:
  - Interference with ambulation, urination or other activities of daily living, or
  - Recurring persistent fungal and bacterial panniculitis that is refractory to good personal hygiene and documented optimal medical management including topical anti-infectives, and at least three systemic medication treatments.

31.2.40.7.4 Noncovered Services

The following services are not a benefit of the CSHCN Services Program:

- Alteration of a natural, undamaged, or unimpaired body part, except as specifically outlined in this chapter.

The following cosmetic procedures are not a benefit of the CSHCN Services Program:

- Rhytidectomies (procedure codes 15824, 15825, 15826, and 15829)
- Excisions of excessive skin and subcutaneous tissue (includes lipectomy) (procedure codes 15832, 15833, 15834, 15835, 15836, 15837, and 15839)
- Suction assisted lipectomies (procedure codes 15877, 15878, and 15879)
- Cryotherapy for acne (procedure code 17340)
- Chemical exfoliation (procedure code 17360)
- Electrolysis epilation (procedure code 17380)

31.2.40.8 Rhizotomy

Rhizotomy for clients with spastic cerebral palsy is a benefit of the CSHCN Services Program.

Rhizotomies (procedure codes 63185 and 63190) must be prior authorized.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only Form.

Rhizotomies are a benefit when submitted for reimbursement with one of the following diagnosis codes:

Diagnosis Codes						
G800	G801	G802	G808	G809	G835	G8389

Documentation of whether or not the client has spastic cerebral palsy with no athetosis or fluctuations in muscle tone, but does have underlying muscle strength, must be included with the prior authorization request form.

Either electromyography or intraoperative neurophysiology testing is paid, but not both during the same procedure, when performed on the same day.

PT and occupational therapy (OT) are benefits up to three times a week (each) for a period of 1 year postoperatively.

31.2.40.9 Septoplasty

Septoplasty (procedure code 30520) that is not related to the repair or reconstruction of a cleft lip, cleft palate, or craniofacial anomaly may be prior authorized with documentation to support medical necessity.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only

CSHCN Services Program Prior Authorization and Authorization Request for Outpatient Surgery—For Outpatient Facilities and Surgeons

31.2.41 Therapeutic Apheresis

Therapeutic apheresis does not require authorization.

Reimbursement for procedure codes 36511, 36512, 36513, 36514, and 36516 is limited to the following diagnosis codes:

Diagnosis Codes							
C8800	C8801	C8820	C8821	C8830	C8831	C8880	C8881
C9000	C9002	C9010	C9012	C9020	C9022	C9030	C9032
C9100	C9102	C9110	C9112	C9130	C9132	C9140	C9142
C9150	C9152	C9160	C9162	C9190	C9192	C91A0	C91A2
C91Z0	C91Z2	C9200	C9202	C9210	C9220	C9230	C9232
C9240	C9242	C9250	C9252	C9260	C9262	C9290	C9292
C92A0	C92A2	C92Z0	C92Z2	C9300	C9302	C9310	C9312
C9330	C9332	C9390	C9392	C93Z0	C93Z2	C9400	C9402
C9420	C9422	C9430	C9432	C9440	C9442	C9480	C9482
C9500	C9502	C9510	C9512	C9590	C9592	D45	D472
D473	D474	D5700	D5701	D5702	D5703	D5704	D5709
D571	D5720	D57211	D57212	D57213	D57214	D57218	D57219
D5780	D57811	D57812	D57813	D57818	D57819	D588	D589
D590	D5910	D5911	D5912	D5913	D5919	D592	D5930
D5931	D5932	D5939	D594	D599	D6182	D65	D682
D68311	D688	D690	D691	D692	D693	D6941	D6942
D6949	D696	D698	D699	D72828	D740	D748	D749
D750	D751	D7589	D759	D761	D762	D763	D77
D890	D8940	D8941	D8942	D8943	D8949	D892	E0842
E0942	E1042	E1142	E7800	E78010	E78011	E78019	E7841
E7849	G603	G610	G6181	G6182	G6189	G620	G621
G622	G6281	G6282	G63	G64	G650	G7000	G7001
G731	I00	I010	I012	I018	I019	I773	I776
I7789	K716	K7200	K7201	K7581	K759	K760	K762
K7689	K77	L100	L101	L102	L103	L104	L105
L1081	L1089	L109	L900	L940	L941	L943	M05011

Diagnosis Codes							
M05012	M05021	M05022	M05031	M05032	M05041	M05042	M05051
M05052	M05061	M05062	M05071	M05072	M0509	M05411	M05412
M05421	M05422	M05431	M05432	M05441	M05442	M05451	M05452
M05461	M05462	M05471	M05472	M0549	M05611	M05612	M05621
M05622	M05631	M05632	M05641	M05642	M05651	M05652	M05661
M05662	M05671	M05672	M0569	M069	M08011	M08012	M08021
M08022	M08031	M08032	M08041	M08042	M08051	M08052	M08061
M08062	M08071	M08072	M0809	M080A	M083	M08411	M08412
M08421	M08422	M08431	M08432	M08441	M08442	M08451	M08452
M08461	M08462	M08471	M08472	M0848	M084A	M08832	M08841
M08842	M08851	M08852	M08861	M08931	M08932	M08941	M08942
M08951	M08952	M08961	M08962	M089A	M310	M3110	M3111
M3119	M320	M3210	M3219	M328	M3300	M3301	M3302
M3309	M3310	M3311	M3312	M3319	M3320	M3321	M3322
M3329	M3390	M3391	M3392	M3399	M340	M341	M342
M3481	M3482	M3483	M3489	N000	N001	N002	N003
N004	N005	N006	N007	N008	N00A	N00B1	N00B2
N010	N011	N012	N013	N014	N015	N016	N017
N018	N01A	N02B1	N02B2	N02B3	N02B4	N02B5	N02B6
N02B9	N032	N034	N035	N037	N03A	N040	N0420
N0421	N0422	N0429	N044	N045	N046	N047	N048
N049	N04A	N04B1	N04B2	N052	N053	N054	N055
N056	N058	N059	N05A	N08	N171	N172	T8690
T8691	T8692	T8699					

Other diagnoses may be considered upon appeal with documentation of medical necessity.

Therapeutic apheresis with extracorporeal affinity column adsorption and plasma reinfusion may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber® LA 15) or the protein A immunoadsorption columns (such as Prosorba®).

Claims for apheresis services must be submitted with procedure codes 36511, 36512, 36513, 36514, and 36516, as appropriate.

Therapeutic apheresis requires direct supervision by a physician.

Procedure codes for therapeutic apheresis may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

31.2.42 Transplants

31.2.42.1 Renal (Kidney) Transplant

Renal transplants are a benefit for CSHCN Services Program clients when the projected costs of the transplant and follow-up care are less than the cost of continuing dialysis treatments. The estimated cost of the renal transplant over a 1-year period versus the cost of renal dialysis for 1 year at the requesting facility must be both documented and reviewed.

Clients who have not previously applied for Medicare and Kidney Health Care coverage and are anticipating the need for a renal transplant must apply for Medicare and Kidney Health Care coverage.

Renal transplants may only be considered for reimbursement when performed in a Medicaid-approved, CSHCN Services Program-enrolled transplant center facility, certified by the United Network of Organ Sharing (UNOS).

Refer to: Section 2.1.7, "Transplant Specialty Centers" in Chapter 2, "Provider Enrollment and Responsibilities."

For any client who is 18 years of age or older, the transplant team must also provide a plan of care to be implemented after the client reaches 21 years of age and is no longer eligible for services through the CSHCN Services Program.

Renal transplants must be prior authorized, and approval is subject to the availability of funds. Only an initial and one subsequent renal transplant may be reimbursed for a client as a lifetime benefit.

Documentation supporting the prior authorization request must include the following:

- The CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant form
- A recent and complete history and physical
- A statement of the client's status including why a transplant is being recommended at this time
- Documentation of the cost effectiveness of the transplant versus continued dialysis

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

Nationally, hospital stays for renal transplants are 5 to 10 days followed by outpatient follow-up; therefore, no additional hospital days beyond the 60 per year allowed by the CSHCN Services Program may be authorized without an appeal documenting medical necessity.

If the transplant is not prior authorized, services directly related to the transplant within 3 days preoperative and during the 6 weeks postoperative period are denied for the surgeon, assistant surgeon, or facility. The anesthesiologist may be reimbursed.

The following procedure codes must be used to bill for physician services related to the renal transplant:

Surgery and Assistant Surgery Procedure Codes									
50300	50320	50323	50325	50327	50328	50329	50340	50360	50365
50370	50380	50547							

Anesthesia Procedure Code
00868

Radiology Procedure Code
76776

Procedure codes 50323, 50325, 50327, 50328, and 50329 are payable under the organ recipient, and may only be reimbursed when procedure code 50360 or 50365 has been paid for the same date of service.

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

Reimbursement for renal transplants includes the cost of the transplant services and one of the following:

- The cost of procuring a cadaveric organ and services associated with procurement from an organ procurement organization (OPO) designated by the Secretary of Health and Human Services. Documentation validating the organ's source must accompany the claim.
- Donor costs for living donors. Donor costs must be included on the client's inpatient hospital claim and may only be reimbursed if another source of payment is not available. Donor costs for CSHCN Services Program clients who also have Medicaid will not be reimbursed.

A maximum amount of $200,000 per client may be reimbursed for a transplant hospitalization. All hospital charges for patient care (inpatient hospital only) during the time of the hospital stay are applied to the $200,000 limit. Donor costs are included in this $200,000 limit.

Renal transplant recipients are eligible for follow-up care (outside the $200,000 limit) immediately following hospital discharge.

31.2.42.2 Transplants - Nonsolid Organ

Stem cell transplants and post-transplantation cellular infusions must be performed in a Texas facility that is a designated children's hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transplantation Network (OPTN), UNOS, or the National Marrow Donor Program (NMDP). TMHP maintains a current list of approved centers.

Refer to: Section 2.1.7, "Transplant Specialty Centers" in Chapter 2, "Provider Enrollment and Responsibilities."

The following surgery procedure codes should be used to submit claims for reimbursement of transplantation and post-transplantation cellular infusion procedures:

Procedure Codes								
38206	38230	38232	38240	38241	38242	38243	38999	S2142

Stem cell transplants and post-transplantation cellular infusions must be prior authorized. Prior authorization must be obtained by both the facility and the physician.

Providers may fax prior authorization requests to 1-512-514-4222.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

CSHCN Services Program Prior Authorization Request for Stem Cell or Renal Transplant Form and Instructions.

The CSHCN Services Program does not authorize the following:

- Experimental or investigational services, supplies, or procedures
- Human leukocyte antigen (HLA)-typing of possible donors

The CSHCN Services Program may cover post-transplantation cellular infusions and only autologous and matched related and matched nonrelated allogenic transplants.

The CSHCN Services Program will recognize the following covered indications for allogenic stem cell transplants:

- Bone marrow disorders
- Hemoglobinopathies
- Immunodeficiency disorders

- Inherited metabolic disorders
- Leukemias
- Lymphomas
- Multiple myeloma/plasma cell disorders
- Platelet function disorder

The CSHCN Services Program will recognize the following covered indications for autologous stem cell transplants:

- Brain tumors
- Germ cell tumors
- Leukemias
- Lymphomas
- Multiple myeloma/plasma cell disorders
- Small round blue cell tumors of childhood

Indications for post-transplantation cellular infusions include the following:

- Stem cell infusion for failure to graft (autologous)
- Donor leukocyte infusion for persistent or relapsed malignant disease (allogenic)
- Donor hematopoietic progenitor cell (HPC) boost infusion for relapse and post-transplantation cytopenias (allogenic)

Post-transplantation cellular infusions must be prior authorized separately with evidence of previous stem cell transplantation.

Stem cell transplants and post-transplantation cellular infusions may be considered for other conditions if documentation provides clinical evidence of the efficacy for the condition.

Coverage is limited to an initial transplant and one subsequent transplant, for a total of two transplants per lifetime regardless of payer. Indications for re-transplantation include the following:

- Relapse of disease
- Failure to engraft or poor graft function
- Graft rejection

The subsequent transplant must be prior authorized separately from the initial transplant.

31.2.42.2.1 Physician Reimbursement

Physicians may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

If approved, a letter with the authorization number is sent to the physician (when applicable) and to the hospital where the procedure is to be performed. This authorization number must be placed in Block 23 of the CMS-1500 paper claim form.

Note: *A benefit of up to 60 inpatient days may be granted to a client, to begin the date of an approved stem cell transplant. Any days remaining from the standard 60 inpatient day limit may be added to the 60 days for the transplant if the $200,000 limit for the transplant maximum amount has not been exceeded. Donor costs must be included on the client's inpatient hospital claim for the transplant and are included in the $200,000 limit for the transplant maximum amount. If prior authorization is received for a second stem cell trans-*

plant after a client has already received an initial transplant, an additional benefit of up to 60 inpatient days may be reimbursed for an additional maximum amount of $200,000, beginning with the actual first day of the second transplant.

31.2.43 Wound Care Management

Wound care management includes first- and second-line therapies.

The following services are not a benefit of the CSHCN Services Program:

- Infrared therapy
- Ultraviolet therapy
- Topical hyperbaric oxygen therapy
- Low-energy ultrasound wound cleanser (MIST therapy)
- Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
- Electrical stimulation and electromagnetic therapy
- More than 10 applications of skin substitute grafts per episode of wound care in a 12- week period of care per rolling year, which will begin on the first day of the first skin substitute application
- Separately billed repeated use of the skin substitute product after 12 weeks for a single wound or episode
- Skin substitute grafting for partial thickness loss with the retention of epithelial appendages as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting
- Skin substitute products not billed concurrently with procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 are not separately reimbursed.

31.2.43.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Cleaning, antibiotics, and pressure off-loading
- Compression
- Debridement
- Dressings may include wet and dry dressings (Dressings applied to the wound are considered part of the service for wound debridement)
- Whirlpool for burns

31.2.43.1.1 Compression

Compression therapy is an important component in the standard of care for treatment of venous ulcers. An Unna boot may be used as part of compression therapy to promote healing, control edema, increase blood return to the heart, and reduce infection. Compression or off-loading performed as part of wound care management may be reimbursed when billed with procedure codes 29445, 29580, or 29581.

Professional services for the wound care management procedure codes addressed in this section, including wound debridement, and Unna boot strapping may be provided by a physical or occupational therapist, if determined to be within the provider's scope of practice, but will be reimbursed only to the CSHCN-enrolled supervising physician or the billing advanced practice registered nurse (APRN).

31.2.43.1.2 Debridement

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion
- Mechanical debridement

The following procedure codes are a benefit for wound debridement:

Procedure Codes									
11000	11001	11042	11043	11044	11045	11046	11047	16020	16025
16030	97597	97598	97602						

The procedure code submitted on the claim must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

Wound debridement procedure codes 11042, 11043, 11044, 11045, 11046, and 11047 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates
- Acne surgery
- Destruction of warts
- Burn debridement

31.2.43.2 Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic Stage 3 or 4 wounds and is a benefit only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second-line wound care measures as indicated by the client's medical condition. Second-line wound care therapy includes the following:

- Application of metabolically active skin equivalents/skin substitutes
- Pulsatile jet irrigation
- Whirpool

31.2.43.2.1 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage 3 or 4 wounds when other forms of treatment have failed. To cleanse a wound bed, pulsatile-jet irrigation uses lavage, which increases impaired circulation and removal of waste from the lymphatic system. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

Professional services for selective wound debridement (procedure codes 97597 and 97598) may also be reimbursed to a licensed physical therapist or physical therapy group when the service is determined to be within the provider's scope of practice and the service is prescribed by a supervising physician or qualified non-physician provider who is enrolled in the CSHCN Services Program.

31.2.43.2.2 Application of Metabolically Active Skin Equivalents and Wound Preparation

Metabolically active skin equivalents/skin substitutes may be a benefit when provided in accordance with the material's Food and Drug Administration (FDA) approved package label and applied according to the manufacturer's instructions for use. Skin substitutes are used for partial- or full- thickness wounds, which do not involve tendon, muscle, joint capsule, or exposed bone or sinus tracts, and are applied to wounds that have demonstrated failed or insufficient response to conservative wound care measures.

The application of skin substitutes may be a benefit for the treatment of chronic Stage 3 or 4 wounds that have failed to respond to standard wound care treatment after 30 days. A failed response is defined as a wound that has increased in size or depth, or has not changed in baseline size or depth, and shows no measurable signs of healing improvements after 30 days of appropriate wound-care measures.

Use of the appropriate specific skin substitute product(s) for the episode of each documented wound is expected. Compliance with the FDA assessments and submitted guidelines for the specific skin substitute product(s) used is expected.

Wound care services that include the use of skin substitutes must be provided in accordance with the FDA-approved package label and applied according to the manufacturer's instructions for use. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental and or investigational.

Procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 are a benefit for the application of skin substitute grafts.

Procedure codes 15002, 15003, 15004, 15005, 15040, and 15050 are a benefit for surgical wound preparation.

31.2.43.3 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, including the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
- Wound location
    - Wound measurements, which includes length, width, and depth, any tunneling and/or undermining
    - Wound color, drainage (type and amount), and odor, if present
    - The prescribed wound care regimen, which includes frequency, duration, and supplies needed
    - Treatment for infection, if present

- All previous wound care therapy regimens, if appropriate
- The client's use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

All wound care management services are subject to retrospective review.

All wound treatments involving the application of skin substitutes must include, but are not limited to, documentation of the following:

- Wound treatments are accompanied by the appropriate adjunctive measures, and identify the specific adjunctive therapies being provided to the client as part of the wound treatment regimen.
- All wounds must be free of infection, necrotic tissue, or exudate and any underlying conditions that compromise wound healing. The documentation in the client's record must reflect the conditions have been treated and resolved.
- Clients who use tobacco will have ceased smoking or have refrained from systemic tobacco intake for at least 4 weeks prior to beginning skin substitute applications and during the conservative wound care.
- Adequate circulation/oxygenation to support tissue growth/wound healing must be present as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30 millimeters of mercury [mmHg]).
- The wound has a skin deficit at least 1.0 square centimeter in size.
- For diabetic foot ulcers, the client's medical record reflects a diagnosis of Type 1 or Type 2 diabetes. Partial or full thickness ulcers must have a clean granular base without tendon and or muscle involvement, bone exposure, or sinus tracts.
- Documentation of the wound's response to the treatment is required at least every 30 days for each treatment episode. The documentation requirements must include measurements of the initial wound, measurements at the completion of appropriate wound care every 30 days, and measurements immediately prior to placement and with each subsequent placement of the skin substitute.

Documentation maintained in the client's medical record must support the need for skin substitute applications and the product used.

31.3 Claims Information

To avoid claim denials, providers billing as a group *must* use the performing provider identifier number on their claims.

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

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

Physicians who submit a claim using the physician's own provider identifier for services provided by an APRN or physician assistant must submit one of the following modifiers on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit:

- SA - Services were provided by an APRN
- U7 - Services were provided by a physician assistant

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4 *, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

31.3.1 General Medical Record Documentation Requirements

The CSHCN Services Program routinely performs a retrospective review of all providers. This review may include comparing services billed to the client's medical record. The provider must document the following information in the client's medical record:

- Service
- Date the service was rendered
- Any pertinent information about the client's condition that supports the need for the service
- Care provided

Note: *If a provider bills for an office visit, the client's medical record must contain documentation for that date of service about the client's complaint, physician's findings, and any physician orders. If the visit is a follow-up office visit, the client's progress relating to the previous condition must be documented for the date of service billed. If billing for a hospital visit, whether it is a routine hospital visit or other type of hospital visit, documentation of that visit must be part of the client's medical record and must be written in the physician's orders or the client's progress notes.*

The following are general requirements for all providers. Mandatory requirements not present in the client's medical record subject the associated services to recoupment.

Note: *This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.*

Requirement	Mandatory/Desirable
All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.	Mandatory
Each page of the medical record documents the client's name and CSHCN Services Program identification number.	Mandatory
Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.	Mandatory

Requirement	Mandatory/Desirable
The selection of E/M codes (levels of service) is supported by the client's clinical record documentation. The AMA's CPT descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.	Mandatory
Necessary follow-up visits specify the time of return by at least the week or month.	Mandatory
The history and physical documents the presenting complaint with appropriate subjective and objective information, e.g., medical and surgical history, current medications and supplements, family history, social history, diet, pertinent physical examination measurements and findings, etc.	Mandatory
The services provided are clearly documented in the medical record with all pertinent information about the client's condition to substantiate the need for the services.	Mandatory
Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans.	Mandatory
Unresolved problems are noted in the record.	Mandatory
Immunizations are noted in the record as complete or up-to-date.	Mandatory
Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.	Desirable

31.4 Reimbursement

Physicians may be reimbursed for most physician services according to the Texas Medicaid Reimbursement Methodology (TMRM).

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an APRN or physician assistant if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. The 92 percent reimbursement rate will not apply to laboratory services, radiology services, and injections provided by an APRN or physician assistant.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

Refer to: Section 31.2.5, "Anesthesia Services" in this chapter for more information about anesthesia services that may be reimbursed according to relative value units (RVUs).

31.4.1 Physician Services in Outpatient Hospital Setting

31.4.1.1 Reimbursement Reduction

Nonemergent and nonurgent services provided by physician providers in an outpatient setting (POS 5) may be reimbursed at 60 percent of the allowed amount. The 40 percent reduction in reimbursement will be based upon the emergency department service that is submitted on the claim.

Note: *Rural hospital outpatient imaging services may be reimbursed at 65 percent of the allowed amount for nonemergent services provided by physician providers in an outpatient setting (POS 5).*

31.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.