



Texas Medicaid Provider Procedures Manual

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Provider Handbooks

Radiology and Laboratory Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

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1 General Information

This information is intended for Texas Medicaid independent (freestanding) laboratories, radiological laboratories, and physiological laboratories. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Referto: “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

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

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Referto: Subsection 3.7.3.14, “Payment Window Reimbursement Guidelines” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for additional information about the payment window reimbursement guidelines.

2 Independent Laboratory

The requirements in this section apply to all providers who bill laboratory services.

2.1 Enrollment

Providers must meet the following requirements and submit a complete application in order to enroll as independent (freestanding) laboratory providers:

- The provider must be actively enrolled in Medicare as an independent laboratory.
- The independent laboratory must be independent from a physician's office or hospital.
- The independent laboratory must meet staff, equipment, and testing capability standards for certification by the Health and Human Services Commission (HHSC).

2.1.1 Clinical Laboratory Improvement Amendments (CLIA)

CLIA regulations set standards that are designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing.

The regulations concern all laboratory testing that is used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratory providers (including those located in physicians' offices), regardless of location, size, or type of laboratory, must meet certain standards based on the complexity of the tests they perform.

Providers must hold the appropriate CLIA certificates to perform certain tests as indicated in this handbook. For waived tests, providers must use modifier QW as indicated on the CMS website.

Referto: The Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov for the CLIA rules and regulations. The regulations are found at Title 42 Code of Federal Regulations, Part 493.

2.1.2 CLIA Requirements

To be eligible for reimbursement by Medicare and Medicaid, all providers that perform laboratory tests must do the following:

- Pay the applicable fee to CMS.
- Contact HHSC at 1-512-834-6650 to receive a CLIA registration or certification number. Submit CLIA applications to the following address:

Health Facility Licensing and Certification Division
HHSC
1100 West 49th Street
Austin, TX 78756

- Notify the Texas Medicaid & Healthcare Partnership (TMHP) of the assigned CLIA number at the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

TMHP monitors claims that are submitted by clinical laboratory providers to verify that the clinical laboratory has a CLIA number on file. If the provider does not have a CLIA number on file with TMHP, the laboratory services claims may be denied.

2.2 Services, Benefits, Limitations, and Prior Authorization

Texas Medicaid only covers professional and technical services that an independent laboratory is certified by CLIA to perform.

Provider documentation must be maintained in the client's medical record and must delineate the medical need for administering the laboratory test.

The physician is responsible for providing to the performing laboratory the clinical diagnosis code that is associated with the individual test so that the performing laboratory may bill Texas Medicaid directly for the analysis of the specimen.

Referto: The Current Procedural Terminology (CPT) manual for information regarding examples of laboratory codes. Correct use of CPT coding requires using the most specific laboratory code that matches the services provided, based on the code's description.

2.2.1 CLIA Certificates

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Referto: The CMS website at www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html for additional information.

For waived tests, providers must use modifier QW as indicated on the CMS website.

2.2.2 Laboratory Handling Fees and Reference Laboratories

2.2.2.1 Independent Laboratory Providers

An independent laboratory provider may be reimbursed for tests performed in the laboratory and for laboratory handling fees for tests that are forwarded to another laboratory (i.e., reference laboratory).

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for any laboratory tests.

An independent laboratory may only bill Texas Medicaid for tests referred to another independent or hospital laboratory if it performs at least one test that it is certified by CLIA to perform, and forwards a portion of the same specimen to the other laboratory to have one or more tests performed. The referring laboratory may then bill for tests it has performed on the specimen. When billing, the following information must be on the claim:

- Block 20: “Yes” box must be checked.
- Block 32: The name, address, and ZIP Code of the reference laboratory (i.e., the laboratory to which the specimen was referred).
- Block 24-J: The provider number of the reference laboratory must be included next to each procedure to be performed by the reference laboratory.

An independent laboratory that forwards a specimen to another laboratory (independent or hospital) may bill a handling fee (procedure code 99001) for collecting and forwarding the specimen to the other laboratory if the specimen is collected by routine venipuncture or catheterization.

2.2.2.2 Physician Providers

A physician may bill only one laboratory handling charge (procedure code 99000) per client visit when the specimen is collected by drawing a blood sample through venipuncture or collecting a urine specimen by catheterization, unless the specimen is divided and sent to different laboratories or there are different specimens collected and sent to different laboratories.

The claim must indicate the name and address of each laboratory where a specimen is sent for more than one laboratory handling charge to be paid.

Referto: Subsection 9.2.40, “Laboratory Services” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information about laboratory services reimbursed to physician providers.

2.2.2.3 Outpatient Hospital Providers

An outpatient hospital may be reimbursed for a laboratory handling charge (procedure code 99001) for each independent laboratory to where it sends specimens when the laboratory handling charge is not being billed through other methods.

2.2.2.4 Family Planning Laboratory Tests

Family planning agencies must use procedure code 99000 with a family planning diagnosis code to bill their laboratory handling charges for laboratory specimens sent out; modifier FP must be omitted. Providers may refer to the appropriate section in the provider manual for instructions for billing family planning services. As with procedure code 99000, only one handling fee may be charged for each laboratory to where the agency sends specimens, regardless of the number of specimens taken.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service.

Referto: Subsection 6.1, “Services, Benefits, Limitations, and Prior Authorization” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for the complete list of family planning diagnosis codes.

2.2.3 Nonclinical Laboratory Procedures

The reimbursement for nonclinical laboratory procedure codes can be found on the appropriate Texas Medicaid fee schedules on the TMHP website at www.tmhp.com.

2.2.4 Clinical Laboratory Procedures

The reimbursement for clinical laboratory procedures can be found on the appropriate [Texas Medicaid fee schedule](#). Fee schedules are available on the TMHP website at www.tmhp.com.

2.2.4.1 Repeat Procedures

Modifier 91 should be used for repeat clinical diagnostic tests as follows:

- Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider, regardless of the use of modifier 91, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 91, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures and services must be documented on appeal.

Providers may appeal claims that have been denied for documentation of time. Most procedure codes that initially required modifier 91 will continue to be audited for modifier 91.

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, including documentation of times for each repeated procedure.

2.2.5 Automated Laboratory Tests and Laboratory Paneling

The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined with any other automated tests that are billed for the client for the same date of service. The Texas Medicaid allowable fee for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same date of service.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test performed may be billed.

2.2.5.1 Fee Calculations for Automated Tests and Laboratory Panels

Automated test and laboratory panel procedure codes may be reimbursed according to the appropriate ATP level payment based on the total number of automated tests that are performed on the same day for the same client.

Referto: The “Clinical Laboratory, Automated Test Panels - Insert” [Texas Medicaid fee schedule](#) on the TMHP website at www.tmhp.com for the ATP level payment for automated test and lab panel procedure codes.

ATP Level Pricing

The amount that is allowed for each automated test and lab panel procedure code that is billed with the same date of service for the same client will be a percentage of the total ATP level payment. To calculate the automated test pricing, the following information is necessary:

- The number of automated tests that are billed for the client for the same date of service (including individual automated tests and all automated tests that are represented by the laboratory panels.) Procedure codes that are duplicated between panels are not counted more than once.
- The ATP pricing fee that corresponds to the number of automated tests that are billed for the client for the same date of service.
- The total billed amount for all automated test and laboratory panel procedure codes that are billed for the client for the same date of service.

The automated test pricing may be calculated as follows:

Step 1

A percentage for each automated test or lab panel detail is derived from dividing the billed amount (B/A) for each procedure by the total billed amount (TB/A) for all automated test and laboratory panel procedure codes with the same date of service for the same client.

Example:

| Automated Test | B/A | Percentage |
|----------------------------|-----------------|------------|
| Detail 1 Automated Test | = \$50.00 | = 29% |
| Detail 2 Automated Test | = \$25.00 | = 14% |
| Detail 3 Lab Panel | = \$100.00 | = 57% |
| Detail 4 Clinical Lab Test | = \$20.00 | = 0% |
| | TB/A = \$175.00 | |

Note: The TB/A is for automated test and laboratory panel procedure codes (details 1, 2, and 3 only). Detail 4 is not included in the calculations for the automated tests because it is a clinical lab procedure code and may be reimbursed as indicated on the fee schedule.

Calculations:

| | | | |
|----------|-------------------|--------------------|-------|
| Detail 1 | = 50.00 / 175.00 | = .285714285714... | = 29% |
| Detail 2 | = 25.00 / 175.00 | = .142857142857... | = 14% |
| Detail 3 | = 100.00 / 175.00 | = .571428571428... | = 57% |

Step 2

The detail allowed amount for each automated test (AT) procedure code will be the calculated percentage of the ATP level payment.

Example:

| Automated Test | Number of Automated Tests | Allowed Amount |
|----------------------------|---------------------------|----------------|
| Detail 1 Automated Test | = 1 | = \$3.10 |
| Detail 2 Automated Test | = 1 | = \$1.55 |
| Detail 3 Lab Panel | = 4 | = \$6.19 |
| Detail 4 Clinical Lab Test | = 0 | = Fee Schedule |
| ATP = 6 = \$10.84 | | |

Note: The total number of automated tests includes the individual automated test procedure codes and the number of automated tests that are represented by each panel procedure code that is billed. Automated tests that are duplicated between panels are not counted more than once.

Calculations:

| | | | |
|----------|----------------|------------------------------|----------|
| Detail 1 | = 29% of 10.84 | = (.285714285714...)X(10.84) | = \$3.10 |
| Detail 2 | = 14% of 10.84 | = (.142857142857...)X(10.84) | = \$1.55 |
| Detail 3 | = 57% of 10.84 | = (.571428571428...)X(10.84) | = \$6.19 |
| | | | \$10.84 |

Note: If a clinical laboratory procedure code is included in a panel, the fee schedule rate for the clinical laboratory procedure is added to the ATP rate, and the resulting sum is divided among the automated test and laboratory panel procedure codes that are billed for the date of service.

The total allowed amount for all laboratory services that are billed for the client for the same date of service will represent the ATP level pricing combined with any clinical laboratory test fee schedule pricing.

2.2.6 Breast Cancer Gene 1 and 2 (BRCA) Testing

Breast Cancer Gene 1 and 2 (BRCA) testing services are benefits of Texas Medicaid when billed with the following procedure codes:

| Procedure Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 81162 | 81211 | 81212 | 81213 | 81214 | 81215 | 81216 | 81217 |

Breast cancer gene 1, early onset (BRCA1) and breast cancer gene 2, susceptibility protein (BRCA2) are tumor repressor genes responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast and ovarian cancer, have been linked to other types of cancer such as pancreatic and prostate, and can be inherited from a person’s mother or father.

Note: Coverage of BRCA mutation analysis testing, including large rearrangement gene mutation analysis testing, are based on the National Comprehensive Cancer Network (NCCN) guidelines.

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

BRCA gene mutation analysis testing must be ordered based on familial medical history and the availability of previous familial gene mutation analysis testing results and only if the test results will affect treatment decisions or provide prognostic information.

Unaffected male or females with a family history of breast cancer, including diagnosis of ductal carcinoma in situ (DCIS), should only be considered for testing when the appropriate affected family member is unavailable. Clinical judgment should be used to determine if the client has a reasonable likelihood of a mutation, considering the client's current age and the age of the unaffected female relatives who link the client with the affected relatives.

It is mandatory that a client who is at risk for BRCA1, BRCA2, or BRCA large rearrangement genetic mutation receive genetic counseling before and after BRCA gene mutation testing.

BRCA gene mutation analysis testing (procedure codes 81162, 81211, 81212, 81213, 81214, 81215, 81216, and 81217) is limited to once per lifetime. Additional testing services may be considered for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing (procedure code 81211) on a case-by-case basis with prior authorization.

Note: Additional BRCA large rearrangement gene mutation analysis testing is not a benefit.

2.2.6.1 Genetic Counseling

Genetic counseling must be provided by a trained genetic counselor, nurse specialist in genetics, or other medical provider possessing expertise in genetic counseling that is not affiliated with the genetic testing laboratory for clients before and after BRCA gene mutation testing.

Both pre- and post-test counseling must provide the depth of content and time for the client to make an informed testing decision. The genetic counseling must be nondirective, and information about the purpose and nature of the tests must be provided to the client.

Pre-test genetic counseling must include:

- The risks and benefits of the specific genetic testing.
- The limitations of the specific genetic testing to be performed and the limitations of interpreting test results for an unaffected individual.

2.2.6.2 Documentation

Providers must maintain the following gene mutation analysis testing documentation in the client's medical record:

- The appropriateness of the genetic testing
- The client's specific high-risk criteria
- The benefit of the specific genetic testing to be performed
- Pre-testing genetic counseling, including all of the following:
 - Pre-test counseling date with the name and qualifications of the counseling professional
 - The risks, benefits, and limitations discussed with the client
 - The client's ability to understand the risks, benefits, and limitations and the client's informed choice to proceed with the specific gene mutation analysis testing as evidenced by the client's signature on a consent form specific to the genetic mutation testing to be performed.
- The client's BRCA1 and BRCA2 comprehensive gene mutation analysis testing results to support medical necessity for BRCA large rearrangement gene mutation analysis testing
- The client's BRCA large rearrangement gene mutation analysis testing results
- Post-testing genetic counseling, including all the following:
 - Post-test counseling date with the name and qualifications of the counseling professional
 - The client's ability to understand the results of the gene mutation analysis testing and the appropriate medical treatment resulting from the test results.

- The client's treatment plan and any treatment plan changes based on interpretation of the test results

The medical record is subject to retrospective review.

2.2.6.3 Prior Authorization for BRCA Testing

Prior authorization is not required for BRCA large rearrangement gene mutation analysis testing (procedure code 81213) when submitted with a negative test result for procedure code 81211.

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

- An individual (male or female) from a family with a known deleterious BRCA1/BRCA2 mutation
- A female with a personal history of breast cancer, including invasive or ductal carcinoma in situ (DCIS), diagnosed at age 45 years or younger
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age and of an ethnicity associated with higher mutation frequency, such as: Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent
- A female with a personal history of epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers, diagnosed at any age
- A male with a personal history of breast cancer, including DCIS, diagnosed at any age
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 50 years or younger, and has one of the following:
 - An additional primary (2 primary sites, including bilateral or clearly separate ipsilateral) tumors occurring either synchronously or asynchronously
 - At least one close blood relative with breast cancer at any age
 - An unknown or limited family history
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 60 years or younger with triple negative breast cancer
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age, and has one of the following:
 - At least one close blood relative with breast cancer diagnosed at age 50 years or younger
 - At least two close blood relatives with breast cancer at any age
 - At least one close blood relative with epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers
 - At least two close blood relatives with pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age
 - A close male blood relative with breast cancer at any age
- A male or female with a personal history of pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age regardless of ancestry with at least two close blood relatives with one of the following:
 - Breast cancer
 - Ovarian cancer, including fallopian tube and primary peritoneal cancers
 - Prostate cancer (Gleason score 7 or greater)

- Pancreatic cancer
- A male or female with a personal history of pancreatic cancer at any age and of an ethnicity associated with higher mutation frequency, such as Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent and one or more close blood relatives with pancreatic cancer
- A male or female with a family history of breast or ovarian cancer, including DCIS with one of the following:
 - At least one first or second degree blood relative meeting any of the criteria above; or
 - At least one third degree blood relative who has breast cancer, including DCIS, or ovarian cancer, including fallopian tube and primary peritoneal cancers, and at least two close blood relatives with one of the following:
 - Breast cancer, including DCIS, of which at least one with breast cancer was diagnosed at 50 years of age or younger
 - Ovarian cancer, including fallopian tube and primary peritoneal cancers

Note: The term “close blood relative” includes first-degree male or female relatives (e.g., parents, siblings), second-degree relatives (e.g., aunts, uncles, grandparents), and third-degree relatives (e.g., first cousins, great grandparents), from the same side of the family as the client.

Prior authorization for additional BRCA testing may be considered on a case-by-case basis by Medical Director review when testing criteria for these studies are met for clients who:

- Have previously been tested for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing and received negative results. Documentation of negative results for BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing are required for medically necessary BRCA large rearrangement gene mutation analysis testing.
- Results are not available and every reasonable effort has been made to obtain the results. Documentation of the specific efforts to obtain results from the client’s genetic testing physician or the testing laboratory must be included with the prior authorization request.
- BRCA1 and BRCA2 comprehensive sequencing or founder gene mutation analysis testing was obtained and interpreted before BRCA large rearrangement gene mutation analysis testing (procedure code 81213) was available.

A completed Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Request Form that has been signed and dated by the referring provider must be submitted.

A provider’s signature on a submitted document indicates that the provider certifies, to the best of the provider’s knowledge, the information in the document is true, accurate, and complete.

For comprehensive sequencing, the physician must indicate one of the following on the prior authorization request form:

- The client’s familial genetic history that supports medical necessity for the requested BRCA1 and BRCA2 comprehensive sequencing, founder gene mutation analysis, or known familial variant gene mutation analysis testing.
- Every reasonable effort was made to obtain the client’s familial genetic history and have been unable to obtain BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing results for the affected family member(s). Documentation of the specific efforts made to obtain the client’s familial genetic history must be submitted with the request.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested. Medical documentation that is submitted by the physician must verify the client's diagnosis or family history. Requisition forms from the laboratory are not sufficient for the establishment of a client's personal and family history.

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

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

2.2.7 Complete Blood Count (CBC)

A CBC and its components may be reimbursed by Texas Medicaid without prior authorization. The medical necessity for all laboratory services must be documented in the client's medical record, and the services must be referenced to an appropriate diagnosis code.

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBC tests should be individualized and based on client history, clinical indications, or proposed therapy, and will not be reimbursed for screening purposes.

When related CBC procedure codes are billed for the same date of service by the same provider, the first procedure code will be reimbursed and all other procedure codes will be denied.

Reticulocyte procedure codes may be reimbursed in addition to the CBC, hemogram, differential analysis, and platelet procedure codes indicated above.

Referto: The appropriate [Texas Medicaid fee schedule](#) on the TMHP website at www.tmhp.com for CBC procedure codes that may be reimbursed.

2.2.8 Drug Testing and Therapeutic Drug Assays

The following procedure codes for drug testing and therapeutic drug assays may be reimbursed by Texas Medicaid:

| Procedure Codes | | | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|--------|--------|-------|--|--|
| 80150 | 80155 | 80156 | 80157 | 80158 | 80159 | 80162 | 80163 | 80164 | 80165 | | |
| 80168 | 80169 | 80170 | 80171 | 80173 | 80175 | 80176 | 80177 | 80178^ | 80180 | | |
| 80183 | 80184 | 80185 | 80186 | 80188 | 80190 | 80192 | 80194 | 80195 | 80197 | | |
| 80198 | 80199 | 80200 | 80201 | 80202 | 80203 | 80299 | 80305^ | 80306 | 80307 | | |
| 80320 | 80321 | 80322 | 80323 | 80324 | 80325 | 80326 | 80327 | 80328 | 80329 | | |
| 80330 | 80331 | 80332 | 80333 | 80334 | 80335 | 80336 | 80337 | 80338 | 80339 | | |
| 80340 | 80341 | 80342 | 80343 | 80344 | 80345 | 80346 | 80347 | 80348 | 80349 | | |
| 80350 | 80351 | 80352 | 80353 | 80354 | 80355 | 80356 | 80357 | 80358 | 80359 | | |
| 80360 | 80361 | 80362 | 80363 | 80364 | 80365 | 80366 | 80367 | 80368 | 80369 | | |
| 80370 | 80371 | 80372 | 80373 | 80374 | 80375 | 80376 | 80377 | G0480 | G0481 | | |
| G0482 | G0483 | G0659 | | | | | | | | | |
| ^ QW Modifier | | | | | | | | | | | |

Note: The procedure codes above do not require prior authorization.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

Procedure codes G0480, G0481, G0482, G0483, and G0659 are limited to once per day by any provider.

The following CPT Drug Assay procedure codes will be denied when billed on the same date of service, by the same provider with the corresponding HCPCS Drug Assay procedure codes identified with an “X”:

| CPT Drug Assay Procedure Codes | The “80000” CPT procedure codes will be denied if they are billed with a corresponding HCPCS “G” code as indicated with an “X” below: | | | |
|--------------------------------|---|-------|-------|-------|
| | G0481 | G0482 | G0483 | G0659 |
| 80305^ | | | | X |
| 80306 | | | | X |
| 80307 | | | | X |
| 80320 | | X | X | X |
| 80321 | X | X | X | |
| 80323 | X | X | X | X |
| 80324 | X | X | X | |
| 80325 | | | | |
| 80326 | X | X | X | X |
| 80327 | | | | |
| 80328 | | | | |
| 80329 | | X | X | X |
| 80330 | | | X | |
| 80332 | | X | X | |
| 80333 | | | X | X |
| 80335 | | | | |
| 80336 | | | | |
| 80337 | | X | X | X |
| 80338 | | | | X |
| 80339 | | | | X |
| 80342 | | | | X |
| 80345 | | | | X |
| 80358 | | | | X |
| 80363 | | | | X |
| 80365 | | | | X |
| 80368 | | | | X |
| 80369 | | | | X |
| 80370 | | | | X |
| 80375 | | | | X |
| 80377 | | | | X |

(X) The “80000” CPT procedure code will be denied if billed with the HCPCS “G” procedure code indicated with an “X.”
 (Blank) There is no relationship between the “80000” CPT procedure code and the HCPCS “G” procedure code. Both procedure codes may be reimbursed if billed with the same date of service.
 ^ QW Modifier

2.2.9 Evocative and Suppression Testing

The following procedure codes for evocative and suppression testing may be reimbursed by Texas Medicaid:

| Procedure codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 80400 | 80402 | 80406 | 80408 | 80410 | 80412 | 80414 | 80415 | 80416 | 80417 |
| 80418 | 80420 | 80422 | 80424 | 80426 | 80428 | 80430 | 80432 | 80434 | 80435 |
| 80436 | 80438 | 80439 | | | | | | | |

Note: The procedure codes above do not require prior authorization.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.10 Genetic Testing for Colorectal Cancer

Genetic testing is provided to clients who have a first- or second-degree relative who has or has had colorectal cancer in order to determine if the client may have increased risk for developing colorectal cancer.

Note: A first-degree relative is defined as: sibling, parent, or offspring. A second-degree relative is defined as: uncle, aunt, grandparent, nephew, niece, or half-sibling.

Interpretation of gene mutation analysis results are part of the evaluation and management service and will not be reimbursed separately.

Genetic test results, when informative, may influence clinical management decisions. The documentation that is maintained in the client's medical record must reflect that the client or family member has been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions prior to the genetic testing. The testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record and made available upon request.

2.2.10.1 Documentation Requirements

Providers must maintain the following documentation in the client's medical record for genetic testing for colorectal cancer:

- Documentation of formal pre-test counseling, including assessment of the client's ability to understand the risks and limitations of the test.
- The client's informed choice to proceed with the genetic testing for colorectal cancer.

The provider must order the test based on the familial medical history and the availability of previous family testing results. The medical record is subject to retrospective review.

Referto: The appropriate [Texas Medicaid fee schedule](#) on the TMHP website at www.tmhp.com for genetic testing procedure codes that may be reimbursed.

2.2.10.2 Authorization Requirements

Prior authorization is required for gene mutation analysis. Prior authorized services may be reimbursed once per lifetime when billed by any provider. Additional services will not be prior authorized.

Prior authorization requests may be considered for Familial Adenomatous Polyposis (FAP) testing for clients of any age with well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care. The client for whom the request is made must have more than 20 polyps or a first-degree relative with FAP and a documented mutation.

Note: *Clients who are seven years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

Prior authorization requests may be considered for Hereditary Nonpolyposis Colorectal Cancer (HNPCC) testing for clients of any age. Testing for HNPCC is used to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers. Results of the test may influence clinical management decisions. The request must include one or more of the following criteria for testing:

- The client has three or more family members (at least one must be a first-degree relative) who have colorectal cancer, and FAP has been ruled out. Two successive generations were affected, and one or more of the relatives was diagnosed with colorectal cancer at 50 years of age or younger.
- The client has had two HNPCC cancers.
- The client has colorectal cancer and a first-degree relative who also has colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger or colorectal adenoma at 40 years of age or younger.
- The client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern on histology at 50 years of age or younger.
- The client has had signet-cell type colorectal cancer at 50 years of age or younger.
- The client has had colorectal adenoma at 40 years of age or younger.
- The client is an asymptomatic individual with a first- or second-degree relative with a documented HNPCC mutation.

Note: *Clients who are 20 years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

A provider's signature, including the prescribing provider's, on a submitted document indicates that the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete.

Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested. Medical documentation that is submitted by the physician must verify the client's diagnosis or family history.

Guidelines for MLH1 and MLH2 mutation testing are based on guidelines established by the American College of Medical Genetics and the American Gastroenterological Association.

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

2.2.11 Hematology and Coagulation

The following hematology and coagulation procedure codes may be reimbursed by Texas Medicaid:

| Procedure Codes | | | | | | | | | |
|--------------------|-------|--------|-------|-------|--------|--------|--------|--------|-------|
| 85002 | 85004 | 85007 | 85008 | 85009 | 85013* | 85014^ | 85018^ | 85025^ | 85027 |
| 85032 | 85041 | 85044 | 85045 | 85046 | 85048 | 85049 | 85055 | 85060 | 85097 |
| 85130 | 85170 | 85175 | 85210 | 85220 | 85230 | 85240 | 85244 | 85245 | 85246 |
| 85247 | 85250 | 85260 | 85270 | 85280 | 85290 | 85291 | 85292 | 85293 | 85300 |
| 85301 | 85302 | 85303 | 85305 | 85306 | 85307 | 85335 | 85337 | 85345 | 85347 |
| 85348 | 85360 | 85362 | 85366 | 85370 | 85378 | 85379 | 85380 | 85384 | 85385 |
| 85390 | 85396 | 85397 | 85400 | 85410 | 85415 | 85420 | 85421 | 85441 | 85445 |
| 85460 | 85461 | 85475 | 85520 | 85525 | 85530 | 85536 | 85540 | 85547 | 85549 |
| 85555 | 85557 | 85576^ | 85597 | 85598 | 85610^ | 85611 | 85612 | 85613 | 85635 |
| 85651* | 85652 | 85660 | 85670 | 85675 | 85705 | 85730 | 85732 | 85810 | 85999 |
| G0306 | G0307 | | | | | | | | |
| * CLIA Waived Test | | | | | | | | | |
| ^ QW Modifier | | | | | | | | | |

Note: The procedure codes above do not require prior authorization.

The following procedure codes are limited to one per day by the same provider:

| Procedure Codes | | | | | | |
|-----------------|-------|-------|-------|--------|--------|-------|
| 85027 | 85347 | 85397 | 85520 | 85576^ | 85610^ | 85730 |
| ^ QW Modifier | | | | | | |

Procedure codes 85460 and 85461 may be reimbursed for female clients who are 10 through 55 years of age.

Procedure code 85004 will deny if billed on the same day by the same provider as procedure code 85007.

Procedure code 85660 is limited to once per lifetime, any provider. An additional test may be considered on appeal with documentation indicating the provider was unaware the client was tested previously or was unable to obtain client's medical records.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.12 Human Immunodeficiency Virus (HIV) Drug Resistance Testing

Standard treatment regimens for HIV therapy require a combination of three or more drugs. Standard therapy continues if a reduction in viral load is achieved. Incomplete virus suppression favors the development of a drug resistance and jeopardizes the success of future therapy. Testing for drug resistance as a prerequisite to further therapy is indicated under such circumstances.

To ensure accurate testing results, the client must be on appropriate antiretroviral therapy at the time of testing or have discontinued the drug regimen within the past four weeks.

Testing for antiretroviral drug resistance is indicated in certain clinical situations. These indications include any of the following:

- Individuals who have an initial (new onset) acute HIV infection, to determine if a drug-resistant viral strain was transmitted and to plan a drug regimen accordingly.

- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500 and less than 1,000 copies/ml.
- HIV-infected pregnant women before initiation of therapy.
- HIV-infected pregnant women entering pregnancy with HIV RNA levels at or below 400 copies/ml while the women are on therapy.

Documentation must be maintained in the client’s medical record to support medical necessity for the HIV drug-resistance testing. Specific documentation requirements are dependent on the rationale for the testing. Documentation must include, but is not limited to, the date the drug regimen was initiated, the dosage and frequency of the prescribed medication, and laboratory tests that support all of the following:

- Acute HIV infection, with identification of the specific viral strain
- Virological failure during antiretroviral therapy with HIV RNA levels greater than 500 and less than 1,000 copies/ml
- Positive pregnancy results in an HIV positive female client
- HIV RNA levels of 400 copies/ml or less during pregnancy

HIV drug-resistance testing is not recommended when one of the following criteria is met:

- The drug regimen has been discontinued for more than four weeks
- The viral load is less than 500 copies/ml

Referto: Subsection C.1.1, “Routine HIV Testing Procedure Codes” in “Appendix C: HIV/AIDS” (*Vol. 1, General Information*) for additional information about HIV testing laboratory procedures.

2.2.13 Microbiology

The following microbiology procedure codes may be reimbursed by Texas Medicaid:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|--------|--------|-------|--------|--------|-------|--------|--------|
| 86703 | 86790 | 87003 | 87015 | 87040 | 87045 | 87046 | 87070 | 87071 | 87073 |
| 87075 | 87076 | 87077^ | 87081 | 87084 | 87086 | 87088 | 87101 | 87102 | 87103 |
| 87106 | 87107 | 87109 | 87110 | 87116 | 87118 | 87140 | 87143 | 87147 | 87149 |
| 87150 | 87152 | 87153 | 87158 | 87164 | 87166 | 87168 | 87169 | 87172 | 87176 |
| 87177 | 87181 | 87184 | 87185 | 87186 | 87187+ | 87188 | 87190 | 87197 | 87205 |
| 87206 | 87207 | 87209 | 87210^ | 87220 | 87230 | 87250 | 87252 | 87253 | 87254 |
| 87255 | 87260 | 87265 | 87267 | 87269 | 87270 | 87271 | 87272 | 87273 | 87274 |
| 87275 | 87276 | 87278 | 87279 | 87280 | 87281 | 87283 | 87285 | 87290 | 87299 |
| 87300 | 87301 | 87305 | 87320 | 87324 | 87327 | 87328 | 87329 | 87332 | 87335 |
| 87336 | 87337 | 87338^ | 87340 | 87341 | 87350 | 87380 | 87385 | 87389^ | 87390 |
| 87391 | 87400 | 87420 | 87425 | 87427 | 87430 | 87449^ | 87450 | 87451 | 87471 |
| 87472 | 87475 | 87476 | 87480 | 87481 | 87482 | 87485 | 87486 | 87487 | 87490 |
| 87491 | 87492 | 87493 | 87495 | 87496 | 87497 | 87498 | 87500 | 87501 | 87502^ |
| 87503+ | 87510 | 87511 | 87512 | 87516 | 87517 | 87520 | 87521 | 87522 | 87525 |
| 87526 | 87527 | 87528 | 87529 | 87530 | 87531 | 87532 | 87533 | 87534 | 87535 |
| + Add-on code | | | | | | | | | |
| ^ QW Modifier | | | | | | | | | |

| Procedure Codes | | | | | | | | | |
|-----------------|--------|--------|--------|--------|-------|-------|--------|--------|--------|
| 87536 | 87537 | 87538 | 87539 | 87540 | 87541 | 87542 | 87550 | 87551 | 87552 |
| 87555 | 87556 | 87557 | 87560 | 87561 | 87562 | 87580 | 87581 | 87582 | 87590 |
| 87591 | 87592 | 87631^ | 87632 | 87633^ | 87640 | 87641 | 87650 | 87651^ | 87652 |
| 87653 | 87660 | 87661 | 87797 | 87798 | 87799 | 87800 | 87801 | 87802 | 87803 |
| 87804^ | 87806^ | 87807^ | 87808^ | 87809^ | 87810 | 87850 | 87880^ | 87899^ | 87900 |
| 87901 | 87902 | 87903 | 87904 | 87905^ | 87906 | 87910 | 87912 | 87999 | G0433^ |
| G0499 | | | | | | | | | |
| + Add-on code | | | | | | | | | |
| ^ QW Modifier | | | | | | | | | |

Note: The procedure codes above do not require prior authorization.

The following procedure codes are limited to one per day by the same provider:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|--------|-------|-------|-------|--------|--------|--------|-------|
| 86790 | 86794 | 87015 | 87046 | 87071 | 87075 | 87076 | 87077^ | 87081 | 87088 |
| 87101 | 87102 | 87106 | 87107 | 87140 | 87147 | 87149 | 87150 | 87152 | 87153 |
| 87181 | 87184 | 87185 | 87186 | 87188 | 87190 | 87206 | 87209 | 87210^ | 87252 |
| 87254 | 87300 | 87634^ | 87662 | 87798 | 87801 | 87809^ | 87899^ | 87904 | |
| ^ QW Modifier | | | | | | | | | |

Procedure code G0433 will be denied if billed on the same day by the same provider as procedure code 86703.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation’s “Choosing Wisely” lists to determine appropriateness of laboratory tests.

2.2.13.1 Zika Virus Testing

Procedure codes 86794 and 87662 may be used to bill for Zika virus testing.

2.2.14 Organ or Disease-Oriented Panels

The following organ or disease-oriented panel procedure codes may be reimbursed by Texas Medicaid:

| Procedure Codes | | | | | | | | | |
|-----------------|--------|-------|--------|--------|-------|--------|--------|-------|-------|
| 80047^ | 80048^ | 80050 | 80051^ | 80053^ | 80055 | 80061^ | 80069^ | 80074 | 80076 |
| 80081 | | | | | | | | | |
| ^ QW Modifier | | | | | | | | | |

Note: The procedure codes above do not require prior authorization.

Procedure codes 80055 and 80081 are limited to female clients who are 10 through 55 years of age. Only one service for procedure code 80055 or one service for procedure code 80081 will be reimbursed per pregnancy to the same provider.

Procedure code 80061 is limited to once per rolling year, by any provider, when performed as part of a preventative care medical checkup.

The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined; including any other automated tests billed for the client for the same date of service (DOS). The Texas Medicaid allowable fee for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same DOS.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test may be billed.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.15 Pharmacogenetics

Referto: Subsection 9.2.41, "Pharmacogenetics" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

2.2.16 * Urinalysis and Chemistry

The following urinalysis and chemistry procedure codes may be reimbursed by Texas Medicaid for once per day:

| Procedure Codes | | | | | | | | | |
|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Urinalysis | | | | | | | | | |
| 81000 | 81001 | 81002* | 81003^ | 81005 | 81007^ | 81015 | 81020 | 81025* | 81050 |
| 81099 | | | | | | | | | |
| Chemistry | | | | | | | | | |
| 82009 | 82010^ | 82013 | 82016 | 82017 | 82024 | 82030 | 82040^ | 82042 | 82043^ |
| 82044^ | 82045 | 82075 | 82085 | 82088 | 82103 | 82104 | 82105 | 82106 | 82107 |
| 82108 | 82120^ | 82127 | 82128 | 82131 | 82135 | 82136 | 82139 | 82140 | 82143 |
| 82150^ | 82154 | 82157 | 82160 | 82163 | 82164 | 82172 | 82175 | 82180 | 82190 |
| 82232 | 82239 | 82240 | 82247^ | 82248 | 82252 | 82261 | 82270* | 82271^ | 82272* |
| 82274^ | 82286 | 82300 | 82306 | 82308 | 82310^ | 82330^ | 82331 | 82340 | 82355 |
| 82360 | 82365 | 82370 | 82373 | 82374^ | 82375 | 82376 | 82378 | 82379 | 82380 |
| 82382 | 82383 | 82384 | 82387 | 82390 | 82397 | 82415 | 82435^ | 82436 | 82438 |
| 82441 | 82465^ | 82480 | 82482 | 82485 | 82495 | 82507 | 82523^ | 82525 | 82528 |
| 82530 | 82533 | 82540 | 82542 | 82550^ | 82552 | 82553 | 82554 | 82565^ | 82570^ |
| 82575 | 82585 | 82595 | 82600 | 82607 | 82608 | 82610 | 82615 | 82626 | 82627 |
| 82633 | 82634 | 82638 | 82652 | 82656 | 82657 | 82658 | 82664 | 82668 | 82670 |
| 82671 | 82672 | 82677 | 82679^ | 82693 | 82696 | 82705 | 82710 | 82715 | 82725 |
| 82726 | 82728 | 82731 | 82735 | 82746 | 82747 | 82757 | 82759 | 82760 | 82775 |
| 82776 | 82784 | 82785 | 82787 | 82800 | 82803 | 82805 | 82810 | 82820 | 82930 |
| 82938 | 82941 | 82943 | 82945 | 82946 | 82947^ | 82948 | 82950^ | 82951^ | 82952^ |
| 82955 | 82960 | 82963 | 82965 | 82977^ | 82978 | 82979 | 82985^ | 83001^ | 83002^ |
| 83003 | 83009 | 83010 | 83012 | 83013 | 83014 | 83015 | 83018 | 83020 | 83021 |
| 83026* | 83030 | 83033 | 83036^ | 83037^ | 83045 | 83050 | 83051 | 83060 | 83065 |
| *CLIA Waived test | | | | | | | | | |
| +Add-on code | | | | | | | | | |
| ^ QW Modifier | | | | | | | | | |

| Procedure Codes | | | | | | | | | |
|-----------------------------|-------|--------|--------|--------|--------|--------|--------|--------|--------|
| 83068 | 83069 | 83070 | 83080 | 83088 | 83090 | 83150 | 83491 | 83497 | 83498 |
| 83500 | 83505 | 83516^ | 83518 | 83519 | 83520 | 83525 | 83527 | 83528 | 83540 |
| 83550 | 83570 | 83582 | 83586 | 83593 | 83605^ | 83615 | 83625 | 83630 | 83631 |
| 83632 | 83633 | 83634 | 83655^ | 83661 | 83662 | 83663 | 83664 | 83670 | 83690 |
| 83695 | 83698 | 83700 | 83701 | 83704 | 83718^ | 83719 | 83721^ | 83727 | 83735 |
| 83775 | 83785 | 83789 | 83825 | 83835 | 83857 | 83864 | 83872 | 83873 | 83874 |
| 83880^ | 83883 | 83885 | 83915 | 83916 | 83918 | 83919 | 83921 | 83930 | 83935 |
| 83937 | 83945 | 83950 | 83951 | 83970 | 83986^ | 83992 | 83993 | 84030 | 84035 |
| 84060 | 84066 | 84075^ | 84078 | 84080 | 84081 | 84085 | 84087 | 84100 | 84105 |
| 84106 | 84110 | 84112 | 84119 | 84120 | 84126 | 84132^ | 84133 | 84134 | 84135 |
| 84138 | 84140 | 84143 | 84144 | 84145 | 84146 | 84150 | 84152 | 84153 | 84154 |
| 84155^ | 84156 | 84157 | 84160 | 84163 | 84165 | 84166 | 84181 | 84182 | 84202 |
| 84203 | 84206 | 84207 | 84210 | 84220 | 84228 | 84233 | 84234 | 84235 | 84238 |
| 84244 | 84252 | 84255 | 84260 | 84270 | 84275 | 84285 | 84295^ | 84300 | 84302 |
| 84305 | 84307 | 84311 | 84315 | 84375 | 84376 | 84377 | 84378 | 84379 | 84392 |
| 84402 | 84403 | 84425 | 84430 | 84431 | 84432 | 84436 | 84437 | 84439 | 84442 |
| 84443^ | 84445 | 84446 | 84449 | 84450^ | 84460^ | 84466 | 84478^ | 84479 | 84480 |
| 84481 | 84482 | 84484 | 84485 | 84488 | 84490 | 84510 | 84512 | 84520^ | 84525 |
| 84540 | 84545 | 84550^ | 84560 | 84577 | 84578 | 84580 | 84583 | 84585 | 84586 |
| 84588 | 84590 | 84591 | 84597 | 84600 | 84620 | 84630 | 84681 | 84702 | 84703^ |
| 84704 | 84999 | | | | | | | | |
| Molecular Testing | | | | | | | | | |
| 83006 | | | | | | | | | |
| Ophthalmology and Optometry | | | | | | | | | |
| 83861^ | | | | | | | | | |
| *CLIA Waived test | | | | | | | | | |
| +Add-on code | | | | | | | | | |
| ^ QW Modifier | | | | | | | | | |

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Referto: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

For waived tests, providers must use modifier QW as indicated on the CMS website.

Texas Medicaid limits reimbursement for the procedure codes listed in the table above to one per day without a modifier and one per day with a modifier when billed by the same provider.

Procedure code 84583 will deny if billed on the same day by the same provider as procedure codes 81000, 81005, or 81020.

Procedure codes 82013, 82105, 82106, 82677, 83080, 84163, and 84704 are limited to one per 210 days when billed by any provider.

Procedure code 83698 is limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|------|-------|-------|------|------|------|
| E1165 | E119 | E139 | E7800 | E7801 | E781 | E782 | E783 |
| E7841 | E7849 | E785 | I2584 | | | | |

Procedure code 83698 is limited to two per rolling year when billed by any provider. Claims submitted for procedure code 83698 that are in excess of two per year may be considered on appeal with documentation of any of the following:

- Medical necessity for the additional test.
- The provider was unable to obtain the previous records from a different provider.
- The provider was new to treating the client and was not aware the client had received the test.

Procedure codes 82757, 84066, 84152, and 84154 are limited to male clients.

Procedure codes 82120, 84135, and 84138 are limited to female clients.

The following procedure codes are restricted to females who are 10 through 55 years of age:

| Procedure Codes | | | | | | | | | |
|--------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 81025* | 82106 | 82143 | 82731 | 83632 | 83661 | 83662 | 83663 | 83664 | 84112 |
| 84163 | | | | | | | | | |
| *CLIA waived tests | | | | | | | | | |

Referto: Subsection 9.2.26.8, “*Helicobacter Pylori (H. pylori)*” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for information about limitations on procedure codes 83009, 83013, and 83014.

2.2.17 Additional Laboratory Services

2.2.17.1 Colorectal Cancer Screening

Referto: Subsection 4.2.8, “Colorectal Cancer Screening” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)*.

Subsection 9.2.15.2, “Colorectal Cancer Screening” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.2 Cytopathology Studies

Referto: Subsection 9.2.26.4, “Cytopathology Studies—Other Than Gynecological” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

Subsection 6.15, “Pap Smear (Cytopathology Studies)” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.3 Helicobacter pylori Testing

Referto: Subsection 9.2.26.8, “*Helicobacter Pylori (H. pylori)*” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.4 Laboratory Services for Clients on Dialysis

Referto: Subsection 6.2.9, “Laboratory and Radiology Services” in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.5 Prognostic Breast and Gynecological Cancer Studies

Referto: Subsection 6.2.9, “Laboratory and Radiology Services” in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.6 THSteps Outpatient Laboratory Services

Referto: Subsection 5.3.11.6, “Laboratory Test” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.7 Authorization Requirements

Prior authorization is not required for most laboratory services. Providers may refer to the specific sections for those services that require authorizations.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including independent laboratory services. Independent laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.

Independent laboratory documentation must include the physician’s signed and dated order for the laboratory tests. The specific tests ordered by the physician must be listed on the order. The test results must also be included in the documentation.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service using a family planning diagnosis code.

Referto: Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for information about Medicaid Title XIX Family Planning Services.

Subsection 6.1, “Services, Benefits, Limitations, and Prior Authorization” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for information about the Texas Women’s Health Program.

A National Provider Identifier (NPI) is required for all claims. In addition, for paper claims, the Texas Provider Identifier (TPI) is required for the billing and performing provider only. NPI-only is required for all other fields.

Providers must submit independent laboratory services to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers must purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

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

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

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

2.4.1.1 Electronic Filing for Laboratory Providers

Referring provider information is always required on laboratory claims. Failure to submit this data will result in a claim rejection on the TMHP Electronic Data Interchange (EDI).

When the place of service is 6, and the billing provider identifier belongs to a laboratory, there is no need to submit the same provider identifier in the facility ID field. This notation causes the claim to suspend processing unnecessarily, and may cause a delay in the disposition of the claim. For questions about the electronic fields, contact the commercial software vendor or the TMHP EDI Help Desk at 1-888-863-3638.

2.4.2 Reimbursement

The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8085 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for clinical laboratory services cannot exceed the Medicare payment for that service.

As the result of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, independent laboratories are not directly reimbursed by Texas Medicaid when providing tests to clients who are registered as hospital inpatients. Hospital reimbursements (i.e., inpatient DRG reimbursement) include payment for all pathology and laboratory services, including those sent to referral laboratories. Hospital-based and referral laboratory providers must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. These services are not billable to Medicaid-covered clients.

Referto: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*).

Texas Medicaid pays up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider.

- Providers who perform the technical service and interpretation must bill for the total component.
- Providers who perform only the technical service must bill for the technical component.
- Providers who perform only the interpretation must bill for the interpretation component.

Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied. Claims are paid based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations.

3 Radiological and physiological laboratory services

3.1 Enrollment

To enroll in Texas Medicaid, physiological laboratory, portable X-ray supplier, independent diagnostic testing facility (IDTF), and radiological laboratory providers must be actively enrolled in Medicare.

3.1.1 Enrollment Criteria for Mammography Providers

All mammography providers, including those providing stereotactic biopsies, must be certified by the Bureau of Radiation Control (BRC).

Additionally, the Department of State Health Services (DSHS) issues mammography certification to providers who render mammography services. Providers can submit this certification to the TMHP Provider Enrollment Department in lieu of certification issued by the Food and Drug Administration (FDA), because a mammography certification issued by DSHS is recognized by the FDA. TMHP will also accept mammography certification issued by the FDA. The certificate will contain the BRC certification number, dates of issue and expiration, type of service, and Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program provider identifiers.

Providers must check the expiration date of their mammography certification and submit an updated mammography certification prior to the expiration date. The certifications may be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795
Fax: 1-512-514-4214

3.2 Services, Benefits, Limitations, and Prior Authorization

The following high-technology radiology services may be reimbursed by Texas Medicaid with prior authorization:

- Cardiac nuclear imaging
- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Functional MRI (fMRI)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET) scan imaging

Note: *Providers and facilities are required to use the lowest possible radiation dose that is consistent with acceptable image quality for cardiac nuclear imaging, CT, and PET examinations of all clients. It is recommended that providers and facilities use national standards such as those established by the American College of Radiology in their ACR Practice Guidelines and Technical Standards manual.*

Radiology interpretations in any place of service will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.

Note: *The 3-dimensional (3-D) obstetric ultrasound is not a benefit of Texas Medicaid.*

Referto: PA section for exceptions to prior authorization.

3.2.1 Cardiac Nuclear Imaging

Cardiac nuclear imaging is a benefit of Texas Medicaid and may be reimbursed using the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 78414 | 78428 | 78451 | 78452 | 78453 | 78454 | 78466 | 78468 | 78472 | 78473 |
| 78481 | 78483 | 78494 | 78496 | | | | | | |

The cardiac nuclear imaging study may be reimbursed separately from the diagnostic radiopharmaceutical.

Referto: The [online fee lookup \(OFL\)](#) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.1.1 Authorization Requirements

Authorization is required for cardiac nuclear imaging.

Referto: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in this handbook.

3.2.2 Computed Tomography and Magnetic Resonance Imaging

CT, CTA, MRI, fMRI, and MRA services are benefits of Texas Medicaid.

The following procedure codes may be reimbursed with prior authorization for CT, CTA, MRI, fMRI, and MRA radiology services:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 70336 | 70450 | 70460 | 70470 | 70480 | 70481 | 70482 | 70486 | 70487 | 70488 |
| 70490 | 70491 | 70492 | 70496 | 70498 | 70540 | 70542 | 70543 | 70544 | 70545 |
| 70546 | 70547 | 70548 | 70549 | 70551 | 70552 | 70553 | 70554 | 70555 | 71250 |
| 71260 | 71270 | 71275 | 71550 | 71551 | 71552 | 71555 | 72125 | 72126 | 72127 |
| 72128 | 72129 | 72130 | 72131 | 72132 | 72133 | 72141 | 72142 | 72146 | 72147 |
| 72148 | 72149 | 72156 | 72157 | 72158 | 72159 | 72191 | 72192 | 72193 | 72194 |
| 72195 | 72196 | 72197 | 72198 | 73200 | 73201 | 73202 | 73206 | 73218 | 73219 |
| 73220 | 73221 | 73222 | 73223 | 73225 | 73700 | 73701 | 73702 | 73706 | 73718 |
| 73719 | 73720 | 73721 | 73722 | 73723 | 73725 | 74150 | 74160 | 74170 | 74174 |
| 74175 | 74176 | 74177 | 74178 | 74181 | 74182 | 74183 | 74185 | 75557 | 75559 |
| 75561 | 75563 | 75565 | 75571 | 75572 | 75573 | 75574 | 75635 | 76376 | 76377 |
| 76380 | 76390 | 76497 | 76498 | 77011 | 77058 | 77059 | 77084 | | |

Texas Medicaid may reimburse the total component for procedure codes 76497 and 76498 when the service is rendered in the office and outpatient hospital setting by radiation treatment center providers.

The professional component may be reimbursed when the service is rendered in the office, inpatient hospital, or outpatient hospital setting by physician providers.

The technical component will be a benefit when rendered in the office setting by physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers.

Procedure codes 76497 and 76498 will be a benefit when rendered in the outpatient hospital setting by radiation treatment center providers.

The following revenue codes must be billed with the most appropriate corresponding procedure code for CT, CTA, MRI, fMRI, and MRA radiology services rendered by outpatient hospital providers:

| Revenue Codes | | | | | | | |
|---------------|-----|-----|-----|-----|-----|-----|-----|
| 350 | 351 | 352 | 359 | 610 | 611 | 612 | 619 |

The addition of post 3-D reconstruction (procedure codes 76376 and 76377) CT, CTA, MRI, and MRA studies must be prior authorized. No additional payment will be made in absence of prior authorization.

3.2.2.1 Functional MRI (fMRI)

Texas Medicaid considers fMRI medically necessary when it is being used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.

Neurofunctional testing procedure code 96020 must be reported in conjunction with brain fMRI procedure code 70555. Procedure code 96020 is informational and will not be reimbursed separately.

3.2.2.2 Intraoperative MRI (iMRI)

Indications for intracranial neurosurgical procedures using intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep brain stimulators

Only one iMRI procedure code may be billed per operative session. Procedure codes 70557, 70558, and 70559 must not be billed in conjunction with procedure code 61751, 77021, or 77022.

Intraoperative MRI procedure codes 70557, 70558, and 70559 that are billed with modifier 26 may be reimbursed to physician providers for interpretation.

Procedure codes 75559 and 75563 must be billed in conjunction with stress testing procedure codes 93015, 93016, 93017, and 93018.

3.2.2.3 Authorization Requirements and Flexibility

Authorization is required for CT, CTA, MRI, fMRI, and MRA procedures.

Note: *Intraoperative MRI (iMRI) does not require prior authorization.*

Referto: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in this handbook.

If the ordering physician or radiologist determines that a CT, CTA, MRI, fMRI, or MRA procedure that is different from the authorized procedure is required or that additional procedures are required, the following will apply:

- The procedure performed is less complex than the procedure authorized but of the same modality (e.g., an MRI with contrast is prior authorized and the actual procedure performed is an MRI without contrast). Full reimbursement is allowed for the billed procedure.

- The authorized procedure is performed and an additional higher-level procedure of the same modality is deemed medically necessary within the same authorization period. A separate authorization is required. The additional procedure must be prior authorized separately and submitted on a separate claim.
- The procedure billed is more complex than the procedure authorized but of the same modality. No authorization update will result in reimbursement according to the rate of the lesser authorized code. For full reimbursement of the more complex procedure, the authorization requires an update.

The following table includes the recognized relationships for authorization flexibility:

| Level 1 (High) | Level 2 (Moderate) | Level 3 (Low) |
|----------------|--------------------|---------------|
| 70470 | 70460 | 70450 |
| 70482 | 70481 | 70480 |
| 70488 | 70487 | 70486 |
| 70492 | 70491 | 70490 |
| 70543 | 70542 | 70540 |
| 70546 | 70545 | 70544 |
| 70549 | 70548 | 70547 |
| 70553 | 70552 | 70551 |
| 71270 | 71260 | 71250 |
| 71552 | 71551 | 71550 |
| 72127 | 72126 | 72125 |
| 72130 | 72129 | 72128 |
| 72133 | 72132 | 72131 |
| 72156 | 72142 | 72141 |
| 72157 | 72147 | 72146 |
| 72158 | 72149 | 72148 |
| 72194 | 72193 | 72192 |
| 72197 | 72196 | 72195 |
| 73202 | 73201 | 73200 |
| 73220 | 73219 | 73218 |
| 73223 | 73222 | 73221 |
| 73702 | 73701 | 73700 |
| 73720 | 73719 | 73718 |
| 73723 | 73722 | 73721 |
| 74170 | 74160 | 74150 |
| 74178 | 74177 | 74176 |
| 74183 | 74182 | 74181 |
| 75559 | 75557 | |
| 75563 | 75561 | |

3.2.3 Positron Emission Tomography (PET) Scan Imaging

PET scan imaging services are benefits of Texas Medicaid and may be reimbursed using the following procedure codes:

| Procedure Codes | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|
| 78608 | 78811 | 78812 | 78813 | 78814 | 78815 | 78816 |

Procedure codes 78459, 78491, and 78492 are not reimbursed by Texas Medicaid.

The PET scan procedure may be reimbursed separately from the diagnostic radiopharmaceutical.

Referto: The [online fee lookup \(OFL\)](#) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.3.1 Authorization Requirements

Prior authorization is required for PET imaging services.

Referto: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.4 Radiology/Diagnostic Imaging Policy

Radiography and fluoroscopy radiology/diagnostic imaging may be reimbursed by Texas Medicaid using the following procedure codes:

| Procedure Codes | | | | |
|-----------------|-------|-------|-------|-------|
| 74775 | 75956 | 75957 | 75958 | 75959 |

Procedure code 74775 may be reimbursed for services rendered to clients who are 20 years of age and younger.

The procedure code in Column A must be billed with the procedure codes in Column B by the same provider with the same date of service to be reimbursed:

| Column A | Column B |
|----------|----------------|
| 75956 | 33880 |
| 75957 | 33881 |
| 75958 | 33883 or 33884 |
| 33884 | 33883 |
| 75959 | 33886 |

Texas Medicaid may reimburse the professional interpretation component only when the physician bills procedure codes 75956, 75957, 75958, or 75959. The professional and technical service may be reimbursed to the inpatient hospital through the DRG reimbursement.

3.2.4.1 Authorization Requirements

Prior authorization is not required for the radiology/diagnostic imaging procedure codes in this section.

3.2.5 Physician-Performed Radiology Services

Referto: Subsection 9.2.62, “Radiology Services” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.6 Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services

Prior authorization is not required for emergency department services, outpatient observation services, or inpatient hospital radiology services.

Prior authorization is required for outpatient nonemergent services (i.e., those that are planned or scheduled). Prior authorization must be obtained before the service is rendered.

The following table summarizes the authorization requirements for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging services:

| Condition | Authorization Requirements |
|---|---|
| Emergency department visit | <p>Authorization is not required for emergency department radiology services that are rendered during an emergency department visit.</p> <ul style="list-style-type: none"> For professional claims, the appropriate radiology procedure code must be billed with modifier U6. The facility may be reimbursed using the appropriate, corresponding emergency services revenue code. |
| Outpatient observation | <p>Authorization is not required for radiology services rendered during outpatient observation.</p> <ul style="list-style-type: none"> For professional claims, the appropriate radiology procedure code must be billed with modifier U6. The facility may be reimbursed using the appropriate, corresponding outpatient observation revenue code. |
| Nonemergent condition: planned or scheduled radiology service | <p>Texas Medicaid defines a nonemergent condition as a symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical, or diagnostic studies prior to diagnosis and treatment.</p> <p>Prior authorization is required for outpatient nonemergent (i.e., those studies that are planned or scheduled) CT, CTA, MRI, fMRI, MRA, PET scan, and cardiac nuclear imaging services.</p> <p>Important: <i>The authorization number must be on the claim when it is submitted to TMHP for reimbursement. Only one authorization is allowed per claim. For the most accurate and efficient claims processing, TMHP recommends that the procedure code that is submitted on the claim match the procedure code that is authorized. Providers are encouraged to contact TMHP and update the prior authorization if the ordering physician or radiologist changes the actual procedure that is performed. Providers have 14 calendar days after the day on which the study was completed to update the prior authorization.</i></p> <p>Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization.</p> <p>Referto: Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.</p> |

| Condition | Authorization Requirements |
|-------------------------------|---|
| Outpatient urgent condition | <p>Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures.</p> <p>Texas Medicaid defines an urgent condition as a symptom or condition that is not an emergency, but requires further diagnostic work-up or treatment within 24 hours to avoid a subsequent emergent situation.</p> <p>Referto: Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.</p> <p>Note: <i>Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization.</i></p> |
| Outpatient emergent condition | <p>Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures.</p> <p>Texas Medicaid defines an emergent condition as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in at least one of the following:</p> <ul style="list-style-type: none"> • Placing the recipient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction to any bodily organ or part <p>The physician must determine that a medical emergency, which imminently threatens life or limb exists and that the medical emergency requires advanced diagnostic imaging.</p> <p>Referto: Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.</p> |
| Inpatient hospital | Authorization is not required for inpatient hospital radiology services. |

Prior authorization of nonemergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the service and must be maintained in the client’s medical record, both by the ordering physician (i.e., the physician who orders the study) and the performing facility.

Nationally-accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for urgent, emergent, and nonemergent services. These include, but are not limited to:

- American College of Radiology (specifically, their Appropriateness Criteria)
- American Academy of Neurology
- American Academy of Orthopedic Surgeons
- American College of Cardiology

- American Heart Association
- National Comprehensive Cancer Care Network

Referto: Subsection 3.2.2.3, “Authorization Requirements and Flexibility” in this handbook for information about authorization flexibility for CT, CTA, MRI, fMRI, and MRA procedures.

3.2.6.1 Retroactive Authorization

A request for retroactive authorization for an emergent or urgent CT, MR, PET, or cardiac nuclear imaging service must be submitted no later than 14 calendar days after the day on which the study was completed.

Retroactive authorization of urgent or emergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained in the client’s medical record, both by the ordering physician (i.e., the physician ordering the study) and the performing facility.

Retroactive authorization for outpatient urgent services is considered when all of the following criteria are met:

- The physician who renders the imaging service determines, during the provision of prior-authorized services, that additional or alternate procedures are medically indicated.
- The urgent condition requires additional or alternate advanced diagnostic imaging.

Retroactive authorization for outpatient emergent services is considered when all of the following criteria are met:

- The physician determines that a medical emergency that imminently threatens life or limb exists.
- The medical emergency requires advanced diagnostic imaging.

Retroactive authorization is not required when a prior-authorized CT or MR procedure is changed by the ordering physician or radiologist to a lesser procedure of the same modality (e.g., MRI with contrast is authorized and the actual procedure performed is MRI without contrast).

3.2.6.2 Request Form and Documentation

Regardless of method of submission, the ordering physician must complete and retain the Radiology Prior Authorization Request Form with an original signature in the client’s medical record.

Providers must submit the form with the request information related to the medical necessity for the service, including all of the following:

- Diagnosis
- Treatment history
- Treatment plan
- Medications that the client is currently taking
- Previous imaging results

Providers may also be asked to provide additional documentation as necessary during the authorization process.

Section 1 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the ordering physician before requesting prior authorization, regardless of the method of request for authorization.

Section 2 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the physician who performs the service prior to requesting retroactive authorization for urgent or emergent studies.

Residents, physician assistants (PAs), and nurse practitioners (NPs) may order radiological procedures; however, the ordering or referring clinician must sign the authorization form and provide the group or supervising provider's provider identifier.

The Radiology Decision Support Tool is provided by eviCore as a resource for providers. eviCore uses the evidence-based guidelines to authorize advanced imaging services for TMHP, and these guidelines help providers determine the most appropriate treatment option for the client related to advanced imaging services. The documents include the recognized clinical guidelines for CT, CTA, MR, MRA, PET, and cardiac nuclear imaging studies.

Referto: Section 3, "Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)*.

Section 9, "Physician" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information on MRI and contrast material.

The [Radiology Prior Auth Services](http://www.tmhp.com) page of the TMHP website at www.tmhp.com for the Radiology Decision Support Tool.

3.2.6.3 Methods of Submission

Authorization requests for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging studies for Texas Medicaid clients must be submitted to eviCore. eviCore is the TMHP subcontractor for high-tech radiology services. Providers can submit authorizations to eviCore:

- Online at www.tmhp.com, on the [Radiology Prior Auth Services page](http://www.tmhp.com), or on the eviCore website at www.medsolutionsonline.com
- By telephone to 1-800-572-2116
- By fax to 1-800-572-2119
- By mail to:

Texas Medicaid & Healthcare Partnership
730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

All prior authorization requests for outpatient urgent or emergent radiology services should be made by telephone in order to ensure a timely response. Requests for retroactive authorization may be submitted online using the eviCore prior authorization portal, or by telephone, fax, or mail.

Requests for authorization that are submitted by fax or mail must be submitted using the Radiology Prior Authorization Request Form.

3.2.7 Additional Radiology and Physiological Laboratory Services

3.2.7.1 Ambulatory Electroencephalogram

Referto: Subsection 9.2.26.2, "Ambulatory Electroencephalogram (Ambulatory EEG)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.2 Brachytherapy

Referto: Subsection 9.2.61.1, "Brachytherapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.3 Diagnostic Doppler Sonography

Referto: Subsection 9.2.27, “* Diagnostic Doppler Sonography” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.4 Electrocardiograms

Referto: Subsection 9.2.26.6, “Electrocardiogram (ECG)” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.5 Electromyography (EMG) and Nerve Conduction Studies (NCS)

Referto: Subsection 9.2.26.7, “Esophageal pH Probe Monitoring” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information.

Subsection 4.2.10, “Electrodiagnostic (EDX) Testing” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.6 Esophageal pH Probe Monitoring

Referto: Subsection 9.2.26.7, “Esophageal pH Probe Monitoring” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.7 Mammography Services

The following procedure codes will be denied if the provider does not have a BRC mammography certification on file:

| Procedure Codes | | |
|-----------------|-------|-------|
| 77032 | 77053 | 77054 |

Referto: Subsection 9.2.15.5, “Prognostic Breast and Gynecological Cancer Studies” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information about mammography services.

3.2.7.8 Nonsurgical Vision Services

Referto: Subsection 4.3.5.4, “Ophthalmic Ultrasound” in the *Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.9 Obstetric Services

Referto: Section 4, “Obstetric Services” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.10 Radiation Therapy Services

Referto: Subsection 9.2.61, “Radiation Therapy” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for information about radiation therapy, including brachytherapy and stereotactic radiosurgery.

3.2.7.11 Screening and Diagnostic Studies of the Breast

Referto: Subsection 9.2.15.4, “Mammography (Screening and Diagnostic Studies of the Breast)” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.12 Sleep Studies

Referto: Subsection 9.2.68, “Sleep Studies” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including radiological and physiological laboratory services. Radiological and physiological laboratory services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.4 Claims Filing and Reimbursement

3.4.1 Claims Information

Claims for radiological and physiological laboratory services and portable X-ray supplier services must include the referring or ordering provider. Radiological and physiological laboratory services and portable X-ray supplier services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

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

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

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

3.4.1.1 Diagnosis Requirements

A diagnosis is not required with a provider’s request for payment except when providing the following services:

- Ambulatory Electroencephalogram (A/EEG)
- Arteriogram
- Cardiac nuclear imaging
- Chest X-ray
- Computed tomography imaging (CT)
- Echography
- Electrocardiogram (ECG)
- Functional MRI (fMRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Mammographies, noninvasive diagnostic studies
- Positron emission tomography (PET) scan
- Polysomnographies
- Venographies

Claims for all services provided to clients who are eligible for “Emergency Care Only” must have a diagnosis to be considered for reimbursement. As with all procedures billed to Texas Medicaid, most baseline screening or comparison studies are not a benefit.

Referto: Section 9, “Physician” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information on these services.

3.4.1.2 Modifier Requirements for Type of Service Assignment

For the radiology, physiological lab, and X-ray procedures in this chapter, providers must bill modifier 26 for the interpretation component or modifier TC for the technical component. No modifier is necessary for the total component.

Referto: Subsection 6.2.5, “Modifier Requirements for TOS Assignment” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

Subsection 6.3.2, “Type of Service (TOS)” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

3.4.2 Reimbursement

Radiological and physiological laboratory and portable X-ray supplier providers are reimbursed in accordance with 1 TAC §355.8085. Providers can refer to the [Online Fee Lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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

Texas Medicaid pays only up to the amount allowed for the total component for the same procedure submitted for reimbursement by the same provider for the same client with the same date of service. Providers who perform the technical service and the interpretation must bill the total component. Providers who perform only the technical service must bill the technical component, and those who perform only the interpretation must bill the interpretation component. The total component and the technical or interpretation component for the same procedure are not reimbursed separately when billed by any provider with the same date of service; the first claim may be reimbursed and the additional claim(s) will be denied. Claims are considered for reimbursement based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure with the same date of service for the same client, regardless of provider, the claim for the total component is denied. The same is true if a total component has already been paid and claims are received for the individual components.

Radiology and physiological laboratory and portable X-ray services are not payable when the client is in an inpatient setting. The reimbursement for these services are included in the diagnosis-related group (DRG) payment.

Imaging services submitted by outpatient hospital providers may be reimbursed a flat fee.

Imaging services procedure codes can be found on the TMHP fee schedule website titled, “Hospital Outpatient Imaging Services.”

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

3.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4 Claims Resources

| Resource | Location |
|--|--|
| Acronym Dictionary | “Appendix D: Acronym Dictionary” (<i>Vol. 1, General Information</i>) |
| Automated Inquiry System (AIS) | Subsection A.10, “TMHP Telephone and Fax Communication” in “Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>) |
| CMS-1500 Paper Claim Filing Instructions | Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>) |
| State, federal, and TMHP contact information | “Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>) |
| TMHP electronic claims submission information | Subsection 6.2, “TMHP Electronic Claims Submission” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>) |
| TMHP Electronic Data Interchange (EDI) information | “Section 3: TMHP Electronic Data Interchange (EDI)” (<i>Vol. 1, General Information</i>) |

5 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

6 Forms

The following linked forms can also be found on the [Forms](#) page of the Provider section of the TMHP website at www.tmhp.com:

| Forms |
|---|
| Radiology Prior Authorization Request Form |
| Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing |

7 Claim Form Examples

The following linked claim form examples can also be found on the [Claim Form Examples](#) page of the Provider section of the TMHP website at www.tmhp.com:

| Claim Form Examples |
|---|
| Independent Laboratory |
| Office Visit with Lab and Radiology |
| Radiological/Physiological Laboratory and Portable X-Ray Supplier |