Texas Medicaid

Provider Procedures Manual

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Volume 2

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.

RADIOLOGY AND LABORATORY SERVICES HANDBOOK

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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.*

Refer to: "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.

Refer to: Subsection 3.7.4.17, "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).

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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. Providers that are certified only to perform waived tests must use modifier QW as indicated on the CMS website.

Refer to: The CLIA Regulations and Federal Register Documents page of 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

- CLIA updates can be submitted through a PEMS Maintenance-Licenses Transaction.

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.

Refer to: 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.

Refer to: The Categorization of Tests page of the CMS website at www.cms.gov for additional information.

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Providers that are certified only to perform waived tests 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.

Refer to: Subsection 9.2.42, "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.

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Refer to: 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.

Refer to: 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.

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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	= 50.0 0 / 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.

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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 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.

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for CBC procedure codes that may be reimbursed.

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2.2.7 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									
80143	80150	80151	80155	80156	80157	80158	80159	80161	80162
80163	80164	80165	80167	80168	80169	80170	80171	80173	80175
80176	80177	80178^	80179	80180	80181	80183	80184	80185	80186
80188	80189	80190	80192	80193	80194	80195	80197	80198	80199
80200	80201	80202	80203	80204	80210	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.

Chemistry procedure codes used for specimen validity testing (procedure codes 82540, 82550, 82552, 82553, 82554, 83986, and 84311) will be denied when submitted on the same date of service by the same provider, as procedure code G0480, G0481, G0482, G0483, or G0659.

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					
	G0480	**G0481**	**G0482**	**G0483**	**G0659**
80320	X		X	X	X
80321	X	X	X	X	
80323	X	X	X	X	X
80324	X	X	X	X	
80325	X				
80326	X	X	X	X	X
80327	X				
80328	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**					

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CPT Drug Assay Procedure Codes					
80329	X		X	X	X
80330	X			X	
80332	X		X	X	
80333	X			X	X
80335	X				
80336	X				
80337	X		X	X	X
80338	X				X
80339	X				X
80342	X				X
80345	X				X
80358	X				X
80363	X				X
80365	X				X
80368	X				X
80369	X				X
80370	X				X
80375	X				X
80377	X				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**					

2.2.7.1 Documentation Requirements

All services outlined in this section are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided.

2.2.8 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.

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2.2.9 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.

2.2.10 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.

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- 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

Refer to: Subsection B.1.1, "Routine HIV Testing Procedure Codes" in "Appendix B: HIV/AIDS" (*Vol. 1, General Information*) for additional information about HIV testing laboratory procedures.

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2.2.11 Microbiology

The following procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
Microbiology									
86703	86790	86794	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	87182	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^	87451
87467	87468	87469	87471	87472	87475	87476	87478	87480	87481
87482	87484	87485	87486	87487	87490	87491^	87492	87493	87494
87495	87496	87497	87498	87500	87501	87502^	87503+	87510	87511
+Add-on code **^QW Modifier**									
87512	87513	87516	87517	87520	87521^	87522	87523	87525	87526
87527	87528	87529	87530	87531	87532	87533	87534	87535	87536
87537	87538	87539	87540	87541	87542	87550	87551	87552	87555
87556	87557	87560	87561	87562	87563^	87564	87580	87581	87582
87590	87591^	87592	87593	87594	87631^	87632	87633^	87634^	87640
87641	87650	87651^	87652	87653	87660	87661	87662	87797	87798
87799	87800	87801^	87802	87803	87804^	87806^	87807^	87808^	87809^
87810	87812	87850	87880^	87899^	87900	87901	87902	87903	87904
87905	87906	87910	87912	87999	G0433^	G0499			
Molecular Testing									
87505	87506	87507	87623	87624	87625	87626	87627		

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
87154	87181	87182	87184	87185	87186	87188	87190	87206	87209
87210^	87252	87254	87300	87634^	87801^	87809^	87899^	87904	
^ QW Modifier									

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

2.2.11.1 Zika Virus Testing

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

Procedure code 87662 may be reimbursed up to two times on the same day by the same provider.

2.2.12 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.

2.2.13 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	82077	82085	82088	82103	82104	82105	82106
82107	82108	82120^	82127	82128	82131	82135	82136	82139	82140
***CLIA Waived test** **+Add-on code** **^ QW Modifier**									

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Procedure Codes									
82143	82150^	82154	82157	82160	82163	82164	82166	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	82642	82652	82653	82656	82657
82658	82664	82668	82670	82671	82672	82677	82679^	82681	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	83068	83069	83070	83080	83088
83090	83150	83491	83497	83498	83500	83505	83516^	83518	83519
83520	83521	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^	83722	83727	83735	83775	83785	83789
83825	83835	83857	83864	83872	83873	83874	83880^	83883	83884
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	84630	84681	84702	84703^	84704	84999	

Molecular Testing

***CLIA Waived test**
+Add-on code
^ QW Modifier

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Procedure Codes									
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.

Refer to: 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 be denied if it is billed on the same day by the same provider as procedure code 81000, 81001, 81002, 81003, 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	E11A	E139	E7800	E78010	E78011	E78019
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**									

Refer to: 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.

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2.2.14 Additional Laboratory Services

2.2.14.1 Colorectal Cancer Screening

Refer to: Subsection 4.2.8, "Colorectal Cancer Screening" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.2.15.1.1, "Colorectal Cancer Screening" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.2 Cytopathology Studies

Refer to: 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 6.14, "Pap Smear (Cytopathology Studies)" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.3 Helicobacter pylori Testing

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

2.2.14.4 Laboratory Services for Clients on Dialysis

Refer to: Subsection 7.2.7, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.5 Prognostic Breast and Gynecological Cancer Studies

Refer to: Subsection 7.2.7, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.6 THSteps Outpatient Laboratory Services

Refer to: Subsection 4.3.12.6, "Laboratory Test" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

2.2.14.7 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.

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Refer to: 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 NPI is required for the billing and performing provider only. All paper claims must be submitted with an NPI and taxonomy code for the billing and performing provider. All other provider fields on the claim forms require an NPI only.

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.

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

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

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

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 NPI belongs to a laboratory, there is no need to submit the same NPI 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.

Refer to: 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.

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- 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/resources/rate-and-code-updates/rate-changes.

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 Genetic Testing

Genetic testing is the study of heredity covering an array of techniques, including analysis of human deoxyribonucleic acid (DNA), ribonucleic acid (RNA), or protein. Genetic testing may be a benefit of Texas Medicaid program when all of the following conditions of medical necessity are met:

- The client displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic).
- The result of the test will directly impact the treatment or management being delivered to the client.
- After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.
- Disease-specific criteria met.

Definition of medical necessity for genetic testing is also made in accordance with Chapter 1372 of Subtitle E, Title 8 of the Texas Insurance Code, which requires biomarker testing to include relevant genetic tests, supported by medical and scientific evidence as described by one or more of the criteria outlined below:

- A United States Food and Drug Administration (FDA) labeled indication for the test or an indicated test for a drug approved by the FDA.
- A national coverage determination made by the Centers for Medicare and Medicaid Services (CMS), or a local coverage determination made by a Medicare administrative contractor.
- Nationally recognized clinical practice guidelines.
- Consensus statement recommendations for specific clinical circumstances when biomarker testing may optimize clinical care outcomes.

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Genetic testing includes:

- Single-analyte tests
- Multiplex panel tests
- Whole genome sequencing (WGS) or whole exome sequencing (WES)

Providers may refer to the Texas Medicaid fee schedule for procedure codes that may be reimbursed for specific genetic testing.

Refer to: Subsection 2.2.1, "Online Fee Lookup (OFL) and Static Fee Schedules" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*)

The following procedure codes may be reimbursed for Genetic Testing services:

Procedure Codes									
0037U	0239U	0364U	0493U	0540U	81105	81106	81107	81109	81110
81111	81112	81120	81121	81161	81162	81163	81164	81165	81166
81167	81170	81177	81178	81179	81180	81181	81184	81185	81186
81200	81201	81202	81203	81205	81206	81207	81208	81209	81210
81212	81215	81216	81217	81218	81219	81220	81221	81222	81223
81224	81225	81226	81227	81229	81233	81235	81237	81238	81240
81241	81242	81243	81244	81245	81246	81247	81248	81249	81250
81251	81252	81253	81254	81255	81256	81257	81258	81259	81260
81261	81262	81263	81264	81265	81266	81267	81268	81269	81270
81272	81273	81275	81276	81278	81279	81287	81288	81290	81291
81292	81293	81294	81295	81296	81297	81298	81299	81300	81301
81302	81303	81304	81305	81307	81310	81313	81314	81315	81316
81317	81318	81319	81320	81321	81322	81323	81324	81325	81326
81327	81329	81330	81331	81332	81334	81336	81337	81340	81341
81342	81345	81349	81350	81351	81352	81353	81355	81361	81362
81363	81364	81370	81371	81372	81373	81374	81375	81376	81377
81378	81379	81380	81381	81382	81383	81400	81401	81402	81403
81404	81405	81406	81407	81408	81410	81411	81415	81416	81417
81420	81425	81426	81427	81443	81449	81450	81451	81455	81456
81457	81458	81459	81462	81463	81464	81507	81513	81514	81517
81519	81520	81528	81595	S3800	S3840	S3841	S3842	S3846	

Genetic testing is allowed once per lifetime, with some exception.

3.1 ClonoSEQ (procedure code 0364U)

Reimbursement for ClonoSEQ (procedure codes 0364U), the next generation sequencing (NGS) of tumor DNA to detect or quantify minimal residual disease (MRD) in clients with acute lymphocytic leukemia (ALL), chronic lymphocytic leukemia (CLL), or multiple myeloma is limited to claims with one of the following diagnoses. All other diagnoses will be denied.

Diagnosis Codes							
C9000	C9001	C9002	C9100	C9101	C9102	C9110	C9111

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Diagnosis Codes							
C9112							

Procedure code 0364U is limited to six times per rolling year by any provider. Additional tests may be reimbursed for the same client on appeal with medical necessity.

3.2 Enhanced Liver Fibrosis (ELF) (Procedure code 81517)

Reimbursement of ELF (procedure code 81517) for the detection and prognosis of liver fibrosis in clients with chronic liver diseases is limited to claims with one of the following diagnoses. All other diagnoses will be denied.

Diagnosis Codes							
K700	K7010	K7011	K702	K7030	K7031	K7040	K7041
K709	K710	K7110	K7111	K712	K713	K714	K7150
K7151	K716	K717	K718	K719	K7200	K7201	K7210
K7211	K7290	K7291	K730	K731	K732	K738	K739
K7400	K7401	K7402	K741	K742	K743	K744	K745
K7460	K7469	K750	K751	K752	K753	K754	K7581
K7589	K759	K760	K761	K762	K763	K764	K765
K766	K767	K7681	K7682	K7689	K769	K77	

Enhanced Liver Fibrosis (ELF) test more than twice per year is considered not medically necessary. Performance of this test within 6 months following a liver biopsy (or other test for liver fibrosis) is considered not medically necessary.

Documentation of medical necessity for a liver biopsy (procedure code 47000 or 47100) performed within 6 months following TE (procedure code 91200) or MRE (procedure code 76391) must be maintained in the client's records and is subject to retrospective review.

3.3 Documentation Requirements

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the equipment or supplies requested. Providers must maintain documentation of medical necessity in the client's medical record.

Documentation must support medical necessity for the procedure code and modifier billed. All services outlined in this handbook are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the services provided.

3.4 Authorization Requirements

Prior authorization is not required for genetic testing unless otherwise described. Certain genetic tests do require prior authorization. Providers can refer to the provider handbooks for the guidelines and requirements listed for a specific service.

Refer to: Subsection 5.5, "Prior Authorization Submission Methods" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*)

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must have an electronic date on the same page as the signature. Electronic signatures that are generated through an electronic medical

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record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client's medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization request must also attest that electronic signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

For tests requiring prior authorization, a completed Special Medical Prior Authorization (SMPA) Request Form must be signed, dated, and submitted by the ordering provider rendering direct care. Requests from laboratories will not be processed.

Note: *The provider is expected to share the authorization number with the lab submitting the claim.*

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

3.4.1 Authorization Requirements for Whole Genome Sequencing and Whole Exome Sequencing

WGS describes the sequencing of the entire human genome, including protein-coding regions (exons) and noncoding regions. WGS captures most genomic variation in a single test and is useful for clients who have rare disorders where hypothesis-driven approaches have failed to produce a diagnosis. WGS can identify or confirm the genetic etiology of a disorder in clients (procedure code 81425). When needed for additional diagnostic insight, comparator genomes can be used from a relative such as parents or siblings (procedure code 81426). Re-evaluation of the genome is also available when needed for additional diagnostic yield (procedure code 81427).

Procedure codes 81425 and 81427 may be a benefit once per lifetime with any provider. Procedure code 81426 may be a benefit up to a maximum of twice per lifetime.

WES is an alternative to WGS. It is a laboratory test used to determine the sequence of the protein coding regions of the genome. The exome is the part of the genome that encodes protein, where roughly 85% of variants are known to contribute to diseases in humans. WES can identify or confirm the genetic etiology of a disorder in clients (procedure code 81415). When needed for additional diagnostic insight, comparator genomes can be used from a relative, such as parents or siblings, (procedure code 81416). Re-evaluation of the genome is also available when needed for additional diagnostic yield (procedure code 81417).

Procedure codes 81415 or 81417 may be a benefit once per lifetime with any provider. Procedure code 81416 may be a benefit up to a maximum of twice per lifetime.

Prior authorization is required for WGS and WES, and they are considered medically necessary when all the following criteria are met for individuals under 21 years of age:

- Pre-test genetic counseling is required for any individual undergoing WGS or WES.
- The individual has been evaluated by a physician board-certified in one of the following fields:
  - Medical genetics
  - Maternal-fetal medicine
  - Neonatology
  - Neurology

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    - Developmental Pediatrics
- The evaluation may be one of the following:
    - In person
    - Via synchronous audio-visual telemedicine in consultation with a consulting physician who has personally examined the individual
- A three-generation pedigree must be completed, as appropriate.
- The ordering physician must conduct a mandatory pre-test and commits to conducting post-test follow-up counseling.
- Test results are expected to directly impact clinical decision-making and/or clinical outcome for the client being tested.
- No other causative circumstances (e.g., environmental exposures, injury, prematurity, infection) can explain symptoms.
- A genetic etiology is considered the most likely explanation for the phenotype, based on either of the following:
    - Multiple congenital abnormalities affecting unrelated organ systems, or two of the following:
        - Abnormality affecting at minimum a single organ system.
        - Profound global developmental delay, intellectual disability, symptoms of a complex neuro-developmental disorder, and/or severe neuropsychiatric condition.
        - Family history strongly suggestive of a genetic etiology, including consanguinity.
        - Period of unexplained developmental regression.
        - Biochemical findings suggestive of an inborn error of metabolism where targeted testing is not available.
- Clinical presentation does not fit a well-described syndrome for which single-gene or targeted panel testing (e.g., when comparative genomic hybridization [CGH]/chromosomal microarray analysis [CMA]) is available.
- The differential diagnosis list and/or phenotype warrant testing of multiple genes and one of the following:
    - WGS is more practical than the separate single gene tests or panels that would be recommended based on the differential diagnosis.
    - WGS results may preclude the need for multiple and/or invasive procedures, follow-up, or screening that would be recommended in the absence of testing.

Conditions that may be considered to qualify for WGS or WES include, but are not limited to, the following:

- Unexplained or global developmental delay
- Moderate, severe, or profound intellectual disability diagnosed before 21 years of age.
- Epileptic encephalopathy with onset before 3 years of age.
- Clinical history strongly suggests a genetic cause and two or more of the following features are present:
    - Congenital anomaly
    - Significant hearing or visual impairment diagnosed before 21 years of age

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- Laboratory abnormalities suggestive of an inborn error of metabolism (IEM)
- Autism spectrum disorder neuropsychiatric condition (e.g., bipolar disorder, schizophrenia, obsessive-compulsive disorder)
- Hypotonia or hypertonia in infancy
- Dystonia, ataxia, hemiplegia, neuromuscular disorder, movement disorder, or other neurologic abnormality
- Unexplained developmental regression, unrelated to autism or epilepsy
- Growth abnormality (e.g., failure to thrive, short stature, microcephaly, macrocephaly, or overgrowth)
- Persistent and severe immunologic or hematologic disorder
- Dysmorphic features
- Consanguinity
- Other first- or second-degree family member(s) with similar clinical features

Re-evaluation for WGS (procedure code 81427) and WES (procedure code 81417) of a previously obtained sequence (procedure code 81425 for WGS and procedure code 81415 for WES) is considered medically necessary when the above criteria for WGS or WES and any of the following conditions are met:

- Onset of additional symptoms that broadens the phenotype assessed during the original exome/genome evaluation.
- Birth or diagnosis of a similarly affected first-degree relative that has expanded the clinical picture.
- New scientific knowledge suggests a previously unknown link between the individual's findings and specific genes/pathogenic or likely pathogenic variants, and at least 18 months have passed since the last analysis.

WES is an alternative to WGS. Only one of the two tests is allowed per lifetime for those who meet the medical criteria for WGS and WES. It is the responsibility of the ordering providers to choose which test to perform for those who met the medical criteria for WGS and WES.

3.4.2 Authorization Requirements for Expanded Carrier Screening (ECS)

ECS is genetic testing performed to identify individuals who are at risk of having children with an inherited recessive (both parents must have the variant to pass the disorder to children or X-linked disorder [variant only occurs in the X chromosome]). Carriers are typically asymptomatic but can pass the disorder-causing genetic variant(s) to their children. Carrier screening may be performed in the preconception or prenatal periods. Risk-based carrier screening is performed in individuals with an increased risk to be a carrier of a specific disorder based on population carrier frequency, family history and/or ethnicity and typically tests for a single gene, or a small number of genes, known to have the disorder-causing variant(s).

ECS uses a panel test that screens for many genes simultaneously (5 genes up to 100s of genes) for disorders that are present in the general population and may have increased frequency in specific populations. The genes tested in an ECS panel vary by laboratory and may not all test for the same genes.

A targeted screening approach may be appropriate instead of ECS. Instances when targeted screening would be appropriate include but are not limited to:

- The individual or their reproductive partner is a known carrier for one or more conditions being screened.

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- The individual or their reproductive partner has a first- or second-degree relative who is affected with a condition being screened.
- The individual or their reproductive partner has a first-degree relative with offspring affected with the condition being screened.
- The individual or their reproductive partner are members of a population known to have a carrier frequency rate that exceeds the threshold for American College of Medical Genetics and Genomics Tier 1 risk-based screening.

ECS (procedure code 81443) is limited to once per lifetime with any provider.

Prior authorization may be granted for ECS (procedure code 81443) when the following criteria are met:

- ECS is considered medically necessary when all the following criteria are met for females ages 10-55 years who are pregnant or considering pregnancy.
- Pre-test genetic counseling from one of the following is required for any individual undergoing ECS:
  - Board-certified physician in:
    - Medical genetics
    - Maternal-fetal medicine
    - Obstetrics/Gynecology
    - Family Medicine
  - Board-certified genetic counselor
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, or Certified Nurse Midwife with training and expertise in genetics and genetic counseling
- Knowledge of the pathogenic variant(s) may be used for the management of:
  - Pregnancy or antenatal interventions
  - Delivery or other care planning for the potentially affected fetus of a pregnant individual
  - Pre-conception family planning
- The ECS panel should screen for conditions:
  - With childhood onset.
  - Which can be diagnosed prenatally.
  - With a well-defined phenotype.
  - Known to cause cognitive or physical impairment.
  - With a known pathogenic or likely pathogenic gene variant.
- The ECS panel does not include genes associated with known adult-onset conditions, including but not limited to, hereditary cancers, dementia, or blood clotting disorders (e.g., hereditary breast and ovarian cancer, Lynch Syndrome, Alzheimer's Disease, Huntington's Disease, or Factor V Leiden).
- The ECS panel must include sequencing of at least 15 genes including:
  - Conditions in American College of Medical Genetics and Genomics (ACMG) Tier 2, with a carrier frequency of 1 in 100 or greater
  - Conditions in ACMG Tier 1

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- X-linked conditions

Note: *A first-degree relative is defined as a blood relative with whom an individual shares approximately 50% of his/her genes, including the individual's parents, full siblings, and children. A second-degree relative is defined as a blood relative with whom an individual shares approximately 25% of his/her genes, including the individual's grandparents, grandchild, uncle, aunt, niece, nephew, or half-sibling.*

3.4.3 Prior Authorization Requirements for FoundationOne

FoundationOne tests are next-generation sequencing (NGS) to analyze hundreds of cancer-related genes and identify the four main classes of genomic alterations (base substitutions, insertions/deletions, copy number alterations, and gene rearrangements/fusions for clients with advanced solid tumor).

FoundationOne CDx test (procedure code 0037U) identifies alterations in 324 genes as well as genomic signatures, including microsatellite instability, tumor mutational burden, and positive homologous recombination deficiency status on DNA isolated from solid tumor tissue samples.

FoundationOne liquid CDx test (procedure code 0239U) using plasma, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations.

FoundationOne, either CDx or liquid CDx, may be a benefit of Texas Medicaid program when all of the following criteria are met:

- The test is ordered by an oncologist.
- Used for advanced tumors.
- The test is intended to assist physicians in identifying treatment options and providing information about potential targeted therapies to better inform treatment decisions.
- The test for the intended use as a broad molecular profiling tool to identify biomarkers present in the tumor are not considered as medical necessary. It must be conducted for FDA-approved therapies as companion test.

FoundationOne testing, either CDx or liquid CDx, is allowed once per lifetime for one type of cancer to guide targeted therapy.

Only one of the two tests (procedure code 0037U or procedure code 0239U) is allowed for those who meet the medical necessity criteria for FoundationOne. It is the responsibility of the ordering provider to choose which test to perform for those who meet the medical criteria for FoundationOne.

3.4.4 Prior Authorization Requirements for Transplant Rejection Testing

Transplant Rejection testing involves an immune response to a transplanted organ. The client's immune system recognizes the donated organ as "foreign," thereby initiating an immune response as if the transplanted organ was a foreign antigen. This response may cause the transplanted organ to fail. Gene expression profiling tests and serum cell-free DNA evaluation are possible ways to monitor organ transplant rejection.

Transplant Rejection testing is considered medically necessary when all of the following are met:

- The transplant rejection test must provide information about at least one of the two following clinical status determinations:
  - Active Rejection (AR) status, or
  - Cellular or Antibody-mediated rejection (ACR or AMR) status
- The intended use of the transplant rejection test must be:

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  - To assist in the evaluation of adequacy of immunosuppression, wherein a non-invasive or minimally invasive test can be used in lieu of a tissue biopsy in a client for whom information from a tissue biopsy would be used to make a management decision regarding immunosuppression, or
  - As a rule-out test for AR in validated populations of clients with clinical suspicion of rejection with a non-invasive or minimally invasive test to make a clinical decision regarding obtaining a biopsy, or
  - For further evaluation of allograft status for the probability of allograft rejection after a physician assessed pretest, or
  - To assess rejection status in clients that have received a biopsy, but the biopsy results are inconclusive or limited by insufficient material.
- For a given client encounter, only one molecular transplant rejection test for assessing allograft status may be performed unless a second transplant rejection test, meeting all the criteria established herein, is reasonable and necessary as an adjunct to the first test.

For heart transplant recipients who are 15 years of age or older and who are 55 or more days post-transplant, the use of procedure code 81595 is considered medically necessary at the following frequency:

- Every month for clients who are 2–12 months post-transplant.
- Every three months for clients who are greater than 12 months post-transplant.
- Every six months for clients who are greater than 36 months post-transplant.

For heart transplant clients who are 15 years of age or older and who are 28 or more days post-transplant, the use of donor-derived, cell-free DNA tests procedure codes 0493U and 0540U is considered medically necessary at the following frequency:

- Every month for clients who are 1–12 months post-transplant.
- Every three months for clients who are greater than 12 months post-transplant.
- Every six months for clients who are greater than 36 months post-transplant.

For any other organ transplant not listed above (e.g., lungs, liver), the use of donor-derived cell-free DNA tests is considered not medically necessary.

For any other organ transplant not listed above (e.g., kidneys, lungs, liver), the use of peripheral blood gene expression profiling tests is considered not medically necessary.

To assess for rejection and injury in transplanted organs, mRNA expression profiling of biopsied tissue from a transplanted organ is considered not medically necessary.

To assist in the detection of moderate grade 2R/grade 3 heart transplant rejection, the measurement of volatile organic compounds is considered not medically necessary.

3.5 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	81163	81164	81165	81166	81167	81212	81215	81216	81217

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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, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217) is limited to once per lifetime.

The ordering provider is responsible for ordering the appropriate BRCA test (e.g., BRCA1 versus BRCA2) based on medical necessity of the testing criteria and genetic counseling results. If a client's BRCA test has a positive result, any further BRCA testing services requested with documentation of medical necessity will be considered on a case-by-case basis by Medical Director review for prior authorization.

Procedure codes 81162 and 81163 are for comprehensive BRCA gene mutation analysis testing. Procedure 81162 may only be used for clients who meet the criteria for both BRCA comprehensive and BRCA large rearrangement gene mutation analysis testing.

3.5.1 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 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.

3.5.2 Documentation

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

- The appropriateness of the genetic testing

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- 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 previous BRCA comprehensive gene mutation analysis testing results to support medical necessity for ordering BRCA gene mutation analysis testing
- 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.

3.5.3 Prior Authorization for BRCA Testing

Prior authorization is required for initial BRCA testing (procedure codes 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217).

For clients with a known familial BRCA variant, targeted testing for BRCA1 (procedure code 81215) and BRCA2 (procedure 81217) for the specific variant must be performed before utilizing more comprehensive tests.

If the client is of Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent, testing for the three known founder variants (procedure code 81212) should be performed first.

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

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    - 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 BRCA sequencing gene mutation analysis testing and received negative results. Documentation of negative results for all previous BRCA1 sequencing gene mutation analysis testing is required.
- Every reasonable effort and documentation of the specific efforts made to obtain the previous BRCA sequencing gene mutation analysis test results from the client's genetic testing physician or the testing laboratory.

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A completed Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Request Form that has been signed and dated by the ordering 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 (procedure codes 81162 or 81163), the ordering 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 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 ordering physician must provide correct and complete information, including accurate medical necessity of the services requested. Medical documentation that is submitted by the ordering 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 ordering 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.

3.6 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.

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

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Refer to: The appropriate Texas Medicaid fee schedule on the TMHP website at www.tmhp.com for genetic testing procedure codes that may be reimbursed.

3.6.2 Authorization Requirements

Prior authorization is required for gene mutation analysis. A completed Special Medical Authorization (SMPA) Request Form, signed and dated by the provider rendering direct care, must be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. 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.*

The ordering 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.

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.

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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.

3.7 Pharmacogenetics

Refer to: Subsection 9.2.43, "Pharmacogenetics" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*)

3.8 Exclusions

The following services are not benefits of the Texas Medicaid Program:

- Genetic testing that is not supported by medical and scientific evidence as outlined in S.B. 989 Biomarker, or that does not show evidence of clinical utility. Clinical utility is defined under S.B.989 Biomarker Sec. 1372.003(a)(1-5), as a test result that provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.
- Genetic testing that does not predominately address the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

4 Radiological and physiological laboratory services

4.1 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.

4.1.1 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 can be uploaded to the Provider Enrollment and Management System (PEMS).

4.2 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)

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- Computed tomography angiography (CTA)
- Functional MRI (fMRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance elastography (MRE)
- Magnetic resonance imaging (MRI)
- 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 (ACR) 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.*

Refer to: PA section for exceptions to prior authorization.

4.2.1 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.

Refer to: 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.

4.2.1.1 Authorization Requirements

Authorization is required for cardiac nuclear imaging.

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in this handbook.

4.2.2 Computed Tomography, Magnetic Resonance Imaging, and Related Services

CT, CTA, fMRI, MRA, MRE, MRI, and ultrasound transient elastography (TE) services are benefits of Texas Medicaid.

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

Procedure Codes									
70336	70450	70460	70470	70471	70472	70473	70480	70481	70482
70486	70487	70488	70490	70491	70492	70496	70498	70540	70542

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Procedure Codes									
70543	70544	70545	70546	70547	70548	70549	70551	70552	70553
70554	70555	71250	71260	71270	71271	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	75577	75580	75635	76376	76377	76380	76390	76391	76497
76498	77011	77046	77047	77048	77049	77084			

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, fMRI, MRA, MRE, and MRI 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, MRA, and MRI studies must be prior authorized. No additional payment will be made in absence of prior authorization.

4.2.2.1 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.

4.2.2.2 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

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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.

4.2.2.2.1 Laser Interstitial Thermal Therapy (LITT)

Laser interstitial thermal therapy (LITT) is an iMRI procedure used when a patient has one of the following diagnoses and is not a surgical candidate:

- Relapsed brain metastasis
- Acute cerebrovascular insufficiency
- Radiation Necrosis
- Secondary malignant neoplasm of brain

LITT therapy is billed under procedure codes 61736 or 61737, and requires prior authorization.

4.2.2.3 Magnetic Resonance Elastography (MRE)

MRE is a diagnostic tool for assessing hepatic fibrosis by relying on visualization of the passage of acoustic waves through liver tissue while the patient is undergoing magnetic resonance imaging (MRI). MRE combines MRI imaging with low-frequency vibrations to create a visual map (elastogram) that identifies stiffness of the liver.

MRE (procedure code 76391) may be reimbursed for diagnosis or monitoring of liver fibrosis or cirrhosis in clients suspected of having, or who have been diagnosed with chronic liver disease.

Performance of MRE may be reimbursed two times per rolling year. Performance of MRE may not be reimbursed within 6 months following a liver biopsy or TE, as it is not medically necessary.

4.2.2.4 Ultrasound Transient Elastography (TE)

TE is a noninvasive device that uses a patented ultrasound-controlled attenuation parameter (CAP) technology, and aspartate-aminotransferase (AST) values to detect or monitor liver fibrosis. TE involves the analysis of ultrasonographic wave propagation and tissue deformation in patients suspected of having or diagnosed with chronic liver disease. TE is used to measure the presence and extent of liver fibrosis.

TE (procedure code 91200) may be reimbursed for the diagnosis or monitoring of liver fibrosis or cirrhosis in clients suspected of having, or who have been diagnosed with chronic liver disease.

Reimbursement for procedure code 91200 is limited to the following diagnosis codes:

Diagnosis Codes									
K710	K7110	K7111	K712	K713	K714	K7150	K7151	K716	K717
K718	K719	K7400	K7401	K7402	K742	K7581	K760		

Performance of TE may be reimbursed up to two times per rolling year. Performance of TE may not be reimbursed within 6 months following a liver biopsy or MRE, as it is not medically necessary.

TE may be inappropriate and ineffective in clients with obesity, ascites, or narrow intercostal spaces.

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4.2.2.5 Authorization Requirements and Flexibility

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

Note: *Intraoperative MRI (iMRI) does not require prior authorization, except for LITT (procedure codes 61736 and 61737), which does require prior authorization. TE does not require prior authorization (procedure code 91200).*

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in this handbook.

If the ordering physician or radiologist determines that a CT, CTA, fMRI, MRA, MRE, or MRI 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
70471	70482	70481
70472	70480	70488
70473	70487	70486
70492	70491	70490
70543	70542	70540
70546	70545	70544
70549	70548	70547
70553	70552	70551
71270	71260	71250
71552	71551	71271
72127	72126	71550
72130	72129	72125
72133	72132	72128
72156	72142	72131
72157	72147	72141
72158	72149	72146
72194	72193	72148
72197	72196	72192
73202	73201	72195

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Level 1 (High)	Level 2 (Moderate)	Level 3 (Low)
73220	73219	73200
73223	73222	73218
73702	73701	73221
73720	73719	73700
73723	73722	73718
74170	74160	73721
74178	74177	74150
74183	74182	74176
75559	75557	74181
75563	75561	

4.2.3 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.

Refer to: 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.

4.2.3.1 Authorization Requirements

Prior authorization is required for PET imaging services.

Refer to: Subsection 4.2.6, "Authorization Requirements for Cardiac Nuclear Imaging Services, CT, CTA, fMRI, MRA, MRE, MRI, and PET" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.4 Radiology/Diagnostic Imaging

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

Procedure Codes									
33880	33881	33882	33883	33886	74775				

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

4.2.4.1 Authorization Requirements

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

4.2.5 Physician-Performed Radiology Services

Refer to: Subsection 9.2.65, "Radiology Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

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

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 cardiac nuclear imaging services, CT, CTA, fMRI, MRA, MRE, MRI, and PET:

Condition	Authorization Requirements
Emergency department visit	Authorization is not required for emergency department radiology services that are rendered during an emergency department visit. • 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	Authorization is not required for radiology services rendered during outpatient observation. • 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	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. Prior authorization is required for outpatient nonemergent (i.e., those studies that are planned or scheduled) cardiac nuclear imaging services, CT, CTA, fMRI, MRA, MRE, MRI, and PET scan. ***Important:*** *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.* 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. ***Refer to:*** Subsection 4.2.6.1, "Retroactive Authorization" in this handbook.

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Condition	Authorization Requirements
Outpatient urgent condition	Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures. 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. ***Refer to:*** Subsection 4.2.6.1, "Retroactive Authorization" in this handbook. ***Note:*** *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.*
Outpatient emergent condition	Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures. 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 use) 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: • 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 The physician must determine that a medical emergency, which imminently threatens life or limb exists and that the medical emergency requires advanced diagnostic imaging. ***Refer to:*** Subsection 4.2.6.1, "Retroactive Authorization" in this handbook.
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

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Refer to: Subsection 4.2.2.5, "Authorization Requirements and Flexibility" in this handbook for information about authorization flexibility for CT, CTA, fMRI, MRA, and MRI procedures.

4.2.6.1 Retroactive Authorization

A request for retroactive authorization for an emergent or urgent cardiac nuclear imaging service, CT, MR, or PET 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).

Documentation of medical necessity for a liver biopsy (procedure code 47000 or 47100) performed within 6 months following TE (procedure code 91200) or MRE (procedure code 76391) must be maintained in the client's records and is subject to retrospective review.

4.2.6.2 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 A 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.

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Section B 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 NPI.

Refer to: 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.

4.2.6.3 Methods of Submission

Authorization requests for cardiac nuclear imaging studies, CT, CTA, fMRI, MRA, MRE, MRI, and PET for Texas Medicaid clients must be submitted to TMHP. Providers can submit authorizations to TMHP:

- By fax to 833-912-1129
- By mail to:

Texas Medicaid & Healthcare Partnership
Radiology Prior Authorization
12365A Riata Trace Parkway
Austin, TX 78727

Requests for retroactive authorization may be submitted by fax or mail.

4.2.7 Additional Radiology and Physiological Laboratory Services

4.2.7.1 Ambulatory Electroencephalogram

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

4.2.7.2 Brachytherapy

Refer to: Subsection 9.2.64.1, "Brachytherapy" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.3 Diagnostic Doppler Sonography

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

4.2.7.4 Electrocardiograms

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

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

Refer to: 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*).

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4.2.7.6 Esophageal pH Probe Monitoring

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

4.2.7.7 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

Refer to: Subsection 9.2.15.4, "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.

4.2.7.8 Nonsurgical Vision Services

Refer to: Subsection 4.3.6.2, "Ophthalmic Ultrasound" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.9 Obstetric Services

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

4.2.7.10 Radiation Therapy Services

Refer to: Subsection 9.2.64, "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.

4.2.7.11 Screening and Diagnostic Studies of the Breast

Refer to: Subsection 9.2.15.3, "Mammography (Screening and Diagnostic Studies of the Breast)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.2.7.12 Sleep Studies

Refer to: Subsection 9.2.72, "Sleep Studies" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

4.3 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.

4.4 Claims Filing and Reimbursement

4.4.1 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.

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

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

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

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

4.4.1.1 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.

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

4.4.1.2 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.

Refer to: 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*).

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4.4.2 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.

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

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/resources/rate-and-code-updates/rate-changes.

4.4.2.1 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.

5 Claims Resources

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)

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

6 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.

7 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
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing
Radiology Prior Authorization Request Form

8 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

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