Texas Medicaid

Provider Procedures Manual

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Volume 2

Provider Handbooks

Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

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

MEDICAL AND NURSING SPECIALISTS, PHYSICIANS, AND PHYSICIAN ASSISTANTS

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1 General Information

The information in this handbook is intended for Texas chiropractors, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), podiatrists, geneticists, maternity service clinics, physicians, and physician assistants. The handbook provides information about Texas Medicaid's benefits, policies, and procedures.

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 healthcare 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 may also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare 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*).

Subsection 2.2, "Provider Enrollment and Responsibilities" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

For information on Advanced Practice Registered Nurses (APRNs), refer to:

Section 3, "Certified Nurse Midwife (CNM)" in this handbook.

Subsection 4.1, "Enrollment" in this handbook for information about CRNAs.

Subsection 5.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for information about geneticists.

Subsection 8.1, "Enrollment" in this handbook for information about NPs and CNSs

Section 9, "Physician" in this handbook.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the 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.

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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 Chiropractic Manipulative Treatment (CMT)

2.1 Enrollment

To enroll in Texas Medicaid, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

2.2 Services, Benefits, Limitations, and Prior Authorization

CMT performed by a chiropractor licensed by the Texas State Board of Chiropractic Examiners is a benefit of Texas Medicaid.

CMT is limited to an acute condition or an acute exacerbation of a chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day. The 12-month period consists of 12 consecutive months, beginning with the date the client receives the first treatment.

If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute.

CMT is not a benefit of Texas Medicaid for maintenance therapy when:

- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- The chiropractic treatment becomes supportive rather than corrective in nature.

CMT may be reimbursed when billed using procedure codes 98940, 98941, or 98942.

Procedure codes 98940, 98941, and 98942 must be submitted with the AT modifier. The AT modifier is used to identify treatment provided for an acute condition or an exacerbation of a chronic condition that persists for 180 days or less from the start date of treatment. Providers may file an appeal for a claim denied beyond the 180 days of treatment with documentation supporting that further clinical improvement can be reasonably expected, maximal improvement has not been reached, and further improvement has not ceased.

Procedure code 98940 will be denied as part of another service when billed for the same date of service as 98941 or 98942 by any provider.

Procedure code 98941 will be denied as part of another service when billed for the same date of service as 98942 by any provider.

Texas Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by themselves or by others under their orders or directions. Additionally, braces or supports, even though ordered by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) and supplied by a chiropractor are not reimbursable items.

CMT is reimbursed only for a diagnosis of subluxation of the spine. The level of subluxation must be indicated by the appropriate diagnosis codes listed below:

Diagnosis Codes							
M9900	M9901	M9902	M9903	M9904	M9905	M9908	

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2.2.1 Prior Authorization

Prior authorization is not required for CMT services.

2.3 Documentation Requirements

Manipulations must be provided in accordance with an ongoing, written treatment plan that supports medical necessity of an acute condition or an acute exacerbation of a chronic condition.

Documentation that supports medical necessity for the treatment plan includes all of the following:

- Diagnosis
- Region(s) treated
- Degree of severity
- Impairment characteristics
- Physical examination findings, X-ray, or other pertinent findings
- Specific statements of short- and long-term goals
- A reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and/or the techniques utilized

The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Chiropractic services must be submitted to TMHP in an approved electronic claims 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 them.

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

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

Subsection , "Section 6: Claims Filing" in "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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

The Medicaid rates for chiropractic manipulative treatment (CMT) are reimbursed in accordance with 1 TAC §355.8085. See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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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.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

Refer to: 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.

3 Certified Nurse Midwife (CNM)

3.1 Provider Enrollment

To enroll in Texas Medicaid, a CNM must be licensed as a registered nurse and as an advanced practice registered nurse (APRN) by the Texas Board of Nursing (BON), and be authorized to practice as a nurse-midwife. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

The American Midwifery Certification Board (AMCB) is responsible for the certification requirements of CNMs.

Refer to: The HHSC website at www.healthytexaswomen.org for information about family planning and the locations of family planning clinics that receive funding from the HHSC Family Planning Program.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. All enrollment and re-enrollments are completed through the Provider Enrollment and Management System (PEMS). PEMS portal and upon initial enrollment and upon re-enrollment, the CNM must complete the Physician's Letter of Agreement form that affirms the CNM's referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the CNM and the physician. The collaborating physician does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1252 (3), if the collaborating physician or group is not a participating provider in Texas Medicaid, the CNM must inform clients of their potential financial responsibility. If the arrangement is changed or canceled, the CNM must notify TMHP and submit a PEMS Existing Enrollment request to update the agreement within 10 business days of the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

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Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment in Texas Medicaid.

Subsection 4.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about enrollment in the THSteps Program.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

3.1.1 Enrollment in Texas Health Steps (THSteps)

CNMs may enroll as providers of THSteps medical checkups for newborns and adolescent females.

3.2 Services, Benefits, Limitations, and Prior Authorization

CNM providers may be reimbursed for family planning, obstetrical, neonatal, and primary care services.

3.2.1 Deliveries

CNM providers may be reimbursed for procedure code 59409, 59410, 59612, or 59614 for delivery services.

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

3.2.2 Newborn Services

Routine newborn care may be reimbursed to CNM providers.

Refer to: Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.2.47, "Newborn Services" in this handbook for additional guidelines and limitations.

3.2.3 Prenatal and Postpartum Services

CNM and physician providers are limited to a combined total of 20 outpatient prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity.

Postpartum care provided after discharge must be billed using procedure code 59430. Only one postpartum visit is allowed per pregnancy.

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

3.2.4 Laboratory and Radiology Services

Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.

3.2.5 Prior Authorization

Prior authorization is not required for any of these services except delivery in the home. For prior authorization of a home delivery and the related supplies (procedure code S8415), the CNM must submit a written request for prior authorization during the client's third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third

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trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Documentation must also include a plan for access to emergency transport for mother and neonate, if needed. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization will be denied.

3.2.6 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including CNM services.

CNM services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.2.7 Claims Filing and Reimbursement

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

CNM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

According to 1 TAC §355.8161(a), the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

> ***Note:*** *CNM providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps National Provider Identifier (NPI) as the billing provider.*

Physicians who submit a claim using the physician's own NPI for services provided by a CNM must submit modifier SB on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a CNM if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by a CNM.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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.

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Refer to: Subsection 4.1, "General Medicaid Eligibility" in "Section 4: Client Eligibility" (*Vol. 1, General Information*) for information about crossover payments.

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

Subsection 6.1, "Claims Information" in "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*).

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.

4 Certified Registered Nurse Anesthetist (CRNA)

4.1 Enrollment

To enroll in Texas Medicaid, a CRNA must be licensed as a registered nurse (RN) and as an APRN by the Texas BON and must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An RN under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as acceptable documentation of appropriate licensure and certification for enrollment.

Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider's Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Services, Benefits, Limitations, and Prior Authorization

Medically necessary services that are performed by a CRNA are benefits if the services are within the scope of the CRNA's practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice and to the extent allowed by state law; and are provided under one of the following conditions:

- There is no physician anesthesiologist on the medical staff of the facility where the services are provided (e.g., rural settings).
- There is no physician anesthesiologist available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician, dentist, or podiatrist who performs the procedure that requires the services specifically requests the services of a CRNA.
- The eligible client who requires the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to the policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

Texas Medicaid does not reimburse the CRNA for equipment, drugs, or supplies.

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Refer to: Subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information about drugs, equipment and supplies.

4.2.1 Prior Authorization

Services performed by a CRNA are subject to the same prior authorization guidelines as services performed by other provider types.

4.3 Documentation Requirements

All services require documentation to support the medical necessity of the services rendered, including CRNA services. CRNA 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

All CRNA services must be billed with a CRNA individual NPI or a CRNA group NPI. No payment for CRNA services will be made under a hospital or physician NPI.

CRNA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim 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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 9.2.7.9.3, "CRNA, AA, and Other Qualified Professional Services" in this handbook for more information on billing for CRNA services.

4.4.1.1 Interpreting the R&S Report

The Billed Qty field on the Remittance and Status (R&S) Report reflects only the number of time units TMHP processes. The Relative Value Units (RVUs) assigned for the procedure code are not shown in the Billed Qty field.

4.4.2 Reimbursement

A CRNA is reimbursed the lesser of either the CRNA's billed charges or 92 percent of the reimbursement for the same service paid to a physician (M.D. or D.O.) other than an anesthesiologist in accordance with 1 TAC §355.8221. A CRNA under the supervision of an anesthesiologist is reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

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Texas Medicaid implemented mandated rate reductions for certain services. The 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.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

Refer to: Subsection 9.2.7.8, "Reimbursement Methodology" in this handbook for more information about flat fees and time based fees.

5 Geneticists

5.1 Enrollment

5.1.1 Geneticists

Geneticists may enroll in Texas Medicaid as both a physician or physician group and as a geneticist. Enrollment as a geneticist allows enhanced reimbursement for specific procedure codes when a claim is submitted using the geneticist NPI.

A provider of genetic services that wishes to enroll in Texas Medicaid as a geneticist must complete the required Medicaid provider enrollment process through PEMS and enter into a written agreement with HHSC.

Prior to enrollment, applicant qualifications for the provision of genetic services are verified and approved by DSHS. Verification and approval are administered through the Newborn Screening Unit. Basic contract requirements are as follows:

- The provider must be a clinical geneticist (MD or DO) who is board eligible or board certified by the American Board of Medical Geneticists (ABMG).

  Note: *Board eligible providers are required to provide documentation reflecting completion of education requirements in a residency program in genetics.*

- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including the clinical geneticist and at least one of the following: nurse, social worker, medical geneticist, or genetic counselor.
- Upon DSHS approval, National Plan and Provider Enumeration System (NPPES) issues an NPI and a performing NPI for the provision of genetic services.
- Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

5.2 Services, Benefits, Limitations, and Prior Authorization

Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response. Genetic services may be provided by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and typically include one or more of the following:

- Comprehensive physical exams
- Diagnosis, management, and treatment for clients with genetically-related health problems
- Evaluation of family histories for the client and the client's family members
- Genetic risk assessment

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- Genetic laboratory tests

Refer to: Section 3, "Genetic Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

- Interpretation and evaluation of laboratory test results
- Education and counseling of clients, their families, and other medical professionals on the causes of genetic disorders
- Consultation with other medical professionals to provide treatment

5.2.1 Family History

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

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

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

5.2.2 Genetic Counseling

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

Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to discuss the client's needs.

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

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

5.2.3 Genetic Counselors

Genetic counselor services may be billed by a physician when the genetic counselor is under physician supervision and is an employee of the physician. Services provided by independent genetic counselors are not a benefit of Texas Medicaid.

5.2.4 Genetic Evaluation and Counseling by a Geneticist

A provider enrolled in Texas Medicaid as a geneticist may bill the following evaluation and management codes and receive an enhanced reimbursement. All other procedure codes must be billed under the geneticist's individual, group, or laboratory NPI.

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Procedure Code	Limitations
96041	None
99213	None
99214	None
99215	One per year, any provider
99244	One every three years, per provider
99245	One every three years, per provider
99254	One every three years, per provider
99255	One every three years, per provider
99402	One per pregnancy, per provider*
99404	One every three years, per provider
*** Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies a claim.**	

One office or other outpatient consultation, performed by a geneticist, (procedure code 99244 or 99245) may be considered for reimbursement if procedure code 99244, 99245, 99254, or 99255 has not been submitted by and reimbursed to that geneticist in the previous three years.

Inpatient or observation consultations, performed by a geneticist, (procedure code 99254 or 99255) may be reimbursed once every three years regardless of whether an office consultation has been reimbursed in the previous three years.

5.2.5 Prior Authorization

Prior authorization is not required for services billed by a geneticist.

5.3 Documentation Requirements

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

5.4 Claims Filing and Reimbursement

5.4.1 Claims Information

Genetic services must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

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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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5.4.2 Reimbursement

Genetic services providers are reimbursed according to the established allowable maximum fee schedule. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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.

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.

6 Licensed Midwife (LM)

6.1 Provider Enrollment

To enroll in Texas Medicaid, an LM must be licensed as a midwife by the Texas Department of Licensing and Regulation (TDLR).

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

An LM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. All enrollment and re-enrollments are completed through the PEMS portal and upon initial enrollment and upon re-enrollment, the LM must complete the Physician's Letter of Agreement form that affirms the LM's referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the LM and the physician.

If the arrangement is changed or canceled, the LM must notify TMHP and submit a PEMS Existing Enrollment request to update the agreement within 10 business days after the change or cancellation.

The referral physician or group does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1253(c), if the referral physician or group is not a participating provider in Texas Medicaid, the LM must inform clients of their potential financial responsibility.

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment in Texas Medicaid.

6.2 Services, Benefits, Limitations, and Prior Authorization

LM providers may be reimbursed for obstetrical and newborn care services provided in a freestanding birthing center that is also enrolled as a Texas Medicaid provider.

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6.2.1 Deliveries

LM providers may be reimbursed for procedure code 59409 for delivery services.

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

6.2.2 Newborn Services

Newborn care procedure codes 99460 and 99463 may be reimbursed to LM providers.

Refer to: Subsection 9.2.47, "Newborn Services" in this handbook for additional guidelines and limitations.

6.2.3 Prenatal Services

LM providers must include modifier TH with the appropriate evaluation and management procedure code (99202, 99211, or 99212) for prenatal services.

LM providers are limited to a total of 20 outpatient prenatal care visits, performed in a birthing center, per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.

If a client is discharged before delivery, LM providers may submit procedure code 99221, 99222, or 99223 for labor services only. Clinical documentation that clearly demonstrates the level of medical decision-making (i.e., moderate or complex) must be included in the client's medical record. All medical documentation is subject to retrospective review. Services that are not supported by the medical documentation are subject to recoupment.

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

6.2.4 Prior Authorization

Prior authorization is not required for services billed by an LM.

6.2.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including LM services.

LM services are subject to retrospective review and recoupment if documentation does not support the service billed.

6.2.6 Claims Filing and Reimbursement

LM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

According to 1 TAC §355.8161 (b), the Medicaid rate for LMs is 70 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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Texas Medicaid implemented mandated rate reductions for certain services. The 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.

7 Maternity Service Clinics (MSC)

7.1 Provider Enrollment

To enroll in Texas Medicaid, MSCs must submit a complete application and meet the following requirements:

- Must be a facility that is not an administrative, organizational, or financial part of a hospital.
- Must be organized and operated to provide maternity clinic services to outpatients.
- Must comply with all applicable federal, state, and local laws and regulations.
- Must employ or have a contractual agreement or formal arrangement with a licensed MD or DO who assumes professional responsibility for the services provided to the clinic's patients.
- Must adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of State Health Services, unless otherwise specified by the department or its designee.
- Must ensure that services provided to each patient are commensurate with the patient's risk assessment and are documented in the patient's medical record.

The supervising physician's license information must be provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days.

Medicare certification is not a prerequisite for MSC enrollment.

7.1.1 Physician Responsibility

To meet the requirement to assume professional responsibility for the services provided to the clinic's clients, the supervising physician must do the following:

- See the client at least once
- Prescribe the type of care to be provided or approve the client's plan of care (POC)
- Periodically review the need for continued care (if the services are not limited by the prescription)

The physician must base the POC on a risk assessment completed by the physician or by licensed, professional clinic staff. The assessment must be based on findings obtained through a health history, laboratory or screening services, and a physical examination.

7.1.2 Case Management Services to High-Risk Individuals

An MSC that wants to bill and receive reimbursement for case management services to high-risk individuals including infants, pregnant adolescents, and women must meet the eligibility criteria for case management services. To be considered for reimbursement for case management for these clients, the MSC must enroll as a group in Case Management for Children and Pregnant Women, and each eligible case manager must enroll as a performing provider.

Refer to: Section 3, "Case Management for Children and Pregnant Women" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for case management services provider eligibility criteria.

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7.2 Services, Benefits, Limitations, and Prior Authorization

Services billed by an MSC are those provided by a physician or by licensed, professional clinic staff and are determined to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do not include deliveries.

MSCs are limited to 20 prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation must reflect the need for increased visits and is subject to retrospective review.

Procedure codes in the following table are for prenatal and postpartum care visits:

Procedure Codes						
59430*	99202-TH	99203-TH	99204-TH	99205-TH	99211-TH	99212-TH
99213-TH	99214-TH	99215-TH				
*** Procedure code 59430 is not submitted with modifier TH** **Note: The prenatal visits must be billed with modifier TH**						

Providers must bill the most appropriate new or established prenatal visit code or postpartum visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

An MSC may be reimbursed for prenatal and postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for prenatal care and not separately reimbursed. Services other than prenatal and postpartum care visits will be denied. MSCs that are enrolled in Case Management for Children and Pregnant Women as a group may be reimbursed for these services under the group NPI assigned to their facility.

Medical services must be furnished on an outpatient basis by the physician or by licensed, professional clinic staff under the direction of the physician and must be within the staff's scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic and ensure through approval of the POC that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

Providers submitting charges for high-risk prenatal care must document the high-risk diagnosis on the claim form and document the condition in the client's medical record.

7.2.1 Initial Prenatal Care Visit Components

The following initial prenatal care visit components should be completed as early as possible in the client's pregnancy.

7.2.1.1 History

History includes OB-GYN, present pregnancy, medical and surgical, substance use, environmental, nutritional, psychosocial (including violence), and family support system.

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7.2.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

7.2.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC NPI. These services may be ordered by MSC personnel and provided by a reference laboratory.

MSCs must supply the client's Medicaid number and the MSC NPI to the reference laboratory when laboratory services are requested.

The laboratory services requested by an MSC may include, but are not limited to, the following:

- Hemoglobin, hematocrit, or complete blood count (CBC)
- Urinalysis
- Blood type and Rh
- Antibody screen
- Rubella antibody titer
- Serology for syphilis
- Hepatitis B surface antigen
- Cervical cytology
- Other laboratory tests

The following tests may be performed at the initial prenatal care visit, as indicated:

- Pregnancy test
- Gonorrhea test
- Urine culture
- Sickle cell test
- Tuberculosis (TB) test
- Chlamydia test

As stated in the Health and Safety Code §81.090, screening for Hepatitis B virus infection, HIV, and Syphilis must be performed at the initial prenatal care visit. In addition, HIV testing must be performed in the third trimester. HBV and Syphilis must be performed at labor and delivery.

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

7.2.1.4 Assessment

Assessment includes pregnancy, general health, medical, and psychosocial.

7.2.1.5 Plan

Plan includes pregnancy, preventive health, medical, and referral as indicated.

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7.2.1.6 Education and Counseling

Education and counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health. The education and counseling should also include the need for a medical home and information about THSteps medical and dental checkups for the client.

The complete physical examination may be completed at the second visit if the MSC's routine involves a two-stage initial evaluation.

7.2.2 Subsequent Prenatal Care Visits

The following is a recommended guide for the frequency of subsequent prenatal visits for a regular pregnancy:

- One visit every 4 weeks for the first 28 weeks of pregnancy.
- One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy.
- One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, CNMs, and MSCs are limited to 20 prenatal care visits per pregnancy and 1 postpartum care visit per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:

- Interim History
- Problems
- Maternal status
- Fetal status

7.2.2.1 Physical Examination

The physical examination must include the following:

- Weight and blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

7.2.2.2 Laboratory Tests

Required laboratory tests include the following:

- Urinalysis for protein and glucose every visit

  Note: *The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.*

- Hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy
- Repeated antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)
- Gestational diabetes screen at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load
- Blood sample for HBsAg screening at the first examination and visit followed by a second blood sample for HBsAg screening on admission for delivery
- Other laboratory tests as indicated by the medical condition of the client

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7.2.3 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 59430. A maximum of 1 postpartum visit is allowed per pregnancy.

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

7.2.4 Prior Authorization

Prior authorization is not required for services rendered in MSCs.

7.3 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client's 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

7.4 Claims Filing and Reimbursement

MSC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim 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.

MSCs are reimbursed in accordance with 1 TAC §355.8085. Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

8 Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)

For other APRNs, see Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in this handbook for information regarding CRNAs, and Section 3, "Certified Nurse Midwife (CNM)" in this handbook for information about certified nurse midwives (CNMs).

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8.1 Enrollment

To enroll in Texas Medicaid, an NP or CNS must be licensed as a registered nurse and as an APRN by the Texas BON. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

Refer to: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 3, "Certified Nurse Midwife (CNM)" in this handbook for more information on CNM enrollment.

Section 4, "Certified Registered Nurse Anesthetist (CRNA)" in this handbook for more information on CRNA enrollment.

APRNs may be included as primary care providers in the provider network for Medicaid and CHIP programs (both fee-for-service and managed care), regardless of whether the physician supervising the APRN is enrolled in Medicaid or in the provider network.

8.1.1 Enrollment in Texas Health Steps (THSteps)

APRNs, including NPs, and CNSs, who are recognized by the Texas BON can enroll as THSteps providers and provide checkup services within their scope of practice. Specific information is found in the Children's Services Handbook.

Refer to: Subsection 4.2.1, "THSteps Medical Provider Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on enrollment procedures.

8.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for NPs and CNSs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own NPI for services provided by an NP or CNS must submit modifier SA on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

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Benefit limitation information for services can be found in Section 9, "Physician" in this handbook, the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*), and the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Payment for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

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

Section 9, "Physician" in this handbook.

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on THSteps services.

Subsection 9.3, "Collaborative Care Model (CoCM)" in this handbook for information about CoCM services.

8.2.1 Prior Authorization

Services performed by an NP or CNS are subject to the same prior authorization guidelines as services performed by other provider types.

8.3 Documentation Requirements

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

8.4 Claims Filing and Reimbursement

8.4.1 Claims Information

APRN services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim 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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.4.2 Reimbursement

According to 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. When NPs or CNSs bill Medicaid directly for services they performed, they must use their individual NPI. If the services are performed by the NP or CNS but billed by a physician or physician group, the billing provider is the physician or physician group. Physicians may be reimbursed 92 percent of the established reimbursement rate for services

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provided by an NP or CNS if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by an NP or CNS.

Note: *NP and CNS providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps NPI as the billing provider.*

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

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.

9 Physician

9.1 Enrollment

9.1.1 Physicians and Doctors

To enroll in Texas Medicaid to provide medical services, physicians (MD or DO), doctors of dental surgery [DDS], and doctors of podiatric medicine (DPM) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: *The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.*

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

9.2 Services, Benefits, Limitations, and Prior Authorization

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided, based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim. The level of service provided and documented must be medically necessary, based on the clinical situation and needs of the client.

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To receive reimbursement, providers must document the following information in the client's medical record:

- The service
- The date rendered
- Pertinent information about the client's condition supporting the need for the service
- The care given

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physician supervision that are within the scope of practice of their profession as defined by state law.

9.2.1 Electronic Signatures in Prior Authorizations

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

9.2.2 Teaching Physician and Resident Physician

The roles of the teaching physician and resident physician occur in the context of an accredited graduate medical education (GME) training program.

The teaching physician is the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being submitted for reimbursement; the physician must be affiliated and in good standing with an accredited GME program and must possess all appropriate licensure.

Physician services must be performed personally by the teaching physician or by the person to whom the physician has delegated the responsibility. The level of supervision required may be direct or personal.

In all cases, the client's medical record must clearly document that the teaching physician provided identifiable supervision of the resident. As defined below, the supervision must be direct or personal depending on the setting and the clinical circumstances:

- Direct supervision means that the teaching physician must be in the same office, building, or facility when and where the service is provided and must be immediately available to furnish assistance and direction.
- *Personal supervision* means that the teaching physician must be physically present in the room when and where the service is being provided.

Personal supervision by the teaching physician is required during the key portions of all major surgeries and the key portions of all other physician services billed to Texas Medicaid if the immediate supervision, participation, or intervention of the supervising physician is medically prudent in order to assure the health and safety of the client. Physician services that require personal supervision may include invasive procedures and evaluation and management services that require complex medical decision making. Situations that require personal supervision include those in which:

- The clinical condition of the client is unstable or will likely become unstable during, or as a result of, the planned medical intervention.

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- The planned medical intervention, even under optimal conditions will result in a medically reasonable risk for significant morbidity or death following the procedure.
- Deviation from the expected technique at the time the procedure or service is performed presents a medically reasonable, causally-related, foreseeable risk to the patient's life or health.

This criterion applies regardless of the place of service.

The teaching physician must provide medically appropriate, identifiable direct supervision for all other services that do not require personal supervision.

The following prerequisites apply when the teaching physician submits claims for services performed, in whole or in part, by the resident physician in the inpatient hospital setting, the outpatient hospital setting, and surgical services and procedures.

Note: *When requesting services for prior authorization at patient discharge, the signature of the resident on the actual prescription is permitted as long as the Medicaid enrolled attending/supervising physician's signature appears on the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form and on any letters or documentation provided to support medical necessity. The resident's order and the Title XIX Form signed by the attending/supervising physician must be for the same service.*

9.2.2.1 Teaching Physician Prerequisites

Services provided in an outpatient setting.

All requirements for personal or direct supervision in the outpatient setting must be met for the services to qualify for reimbursement. The following tasks must be performed by the teaching physician and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement:

- Review the patient's history and physical examination.
- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Assure that any necessary supervision of interns or residents was provided.
- Confirm that documentation in the medical record supports the level of service provided.

Exception: *Exception for E/M services furnished in certain primary care centers. Teaching physicians that meet the primary care exception under Medicare are allowed to bill for low-level and mid-level E/M services furnished by residents in the absence of a teaching physician. Facilities that meet the primary care exception under Medicare may bill Texas Medicaid, Family Planning, or the Children with Special Health Care Needs (CSHCN) Services Program for new patient services (procedure codes 99202 and 99203) and established patient services (procedure codes 99211, 99212, and 99213).*

Note: *All services provided in an outpatient setting that do not qualify for the exception above require that the teaching physician examine the patient.*

Services provided in an inpatient setting.

For services provided in an inpatient setting, the teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient no later than 36 hours after the patient's admission and before the patient's discharge.

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- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.
- Confirm that documentation in the medical record supports the level of service provided.
- A face-to-face encounter with the client on the same day as any services provided by the resident physician.

Surgical services and procedures.

The teaching surgeon is responsible for the patient's preoperative, operative, and postoperative care. The teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient within a reasonable period of time after the patient's admission and before the patient's discharge.
- Confirm or revise the client's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.

Important: *Reimbursement may be reduced, denied, or recouped if the prerequisites are not documented in the medical record. The documentation must be made in the same manner as required by federal regulations under Medicare.*

9.2.3 Substitute Physician

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

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

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

The substitute physician must be enrolled in Texas Medicaid and must not be on the Texas Medicaid or HHSC Family Planning Program provider exclusion list. The billing provider's name, address, and NPI must appear in Block 33 of the claim form. The name and office or mailing address of the substitute physician must be documented on the claim in Block 19, *not* Block 33.

When a physician bills for a substitute physician, modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a locum tenens arrangement.

When physicians in a group practice bill substitute physician services, the performing NPI of the physician for whom the substitute provided services must be in Block 24J.

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Physicians must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation as detailed above will be subject to recoupment.

9.2.4 Aerosol Treatment

Nebulized aerosol treatments (procedure codes 94640, 94644, and 94645) with short-acting beta-agonists are a benefit of Texas Medicaid and considered medically necessary when breathing is compromised by certain acute medical conditions. Documentation to support an aerosol treatment for the worsening of an acute or chronic condition must be maintained in the client's medical record and is subject to retrospective review.

Procedure code 94645 is only a benefit in the outpatient setting, specifically in a hospital emergency department or an urgent care clinic.

Pulse oximetry and evaluation of the client's use of an aerosol generator, nebulizer, or metered-dose inhaler are considered part of an evaluation and management (E/M) visit and will not be reimbursed separately.

Hypertonic saline used in aerosol therapy will be denied if billed separately.

Refer to: Subsection 4.2.20.1, "Aerosol Treatment" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.4.1 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) is a benefit for Texas Medicaid.

FeNO measurement provided in the physician's office is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a client who has asthma to anti-inflammatory therapy. FeNO measurement may be reimbursed by Texas Medicaid when the test is used as follows:

- To assist in assessing the etiology of respiratory symptoms.
- To help identify the eosinophilic asthma phenotype.
- To assess potential response or failure to respond to anti-inflammatory agents, particularly inhaled corticosteroids (ICS).
- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma.
- To guide changes in dosing of anti-inflammatory medications, i.e., step-down dosing, step-up dosing, or discontinuation of anti-inflammatory medications.
- To assist in the evaluation of adherence to anti-inflammatory medications.
- To assess whether airway inflammation is contributing to respiratory symptoms.

The technical and interpretation components of procedure code 95012 will not be reimbursed separately, as the instrument produces an exhaled nitric oxide (NO) measurement that requires little interpretation. Procedure code 95012 will be limited to once per day and must be submitted with procedure code 94010 or 94060.

If FeNO is measured during an office visit where additional E/M components are fulfilled, a separate E/M procedure code may be reimbursed if it is submitted with modifier 25.

9.2.5 Allergy Services

Texas Medicaid uses the following guidelines for reimbursement of allergy services.

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9.2.5.1 Allergy Immunotherapy

Allergen immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

Preparation of the allergy vial or extracts is a benefit of Texas Medicaid when preparations are made in accordance with the American Academy of Allergy, Asthma, and Immunology. Claims for preparations should be submitted using the following procedure codes:

Procedure Codes for Preparation of Allergy Vial or Extract									
95145	95146	95147	95148	95149	95165	95170			

Administration of the allergy extract may be reimbursed using procedure codes 95115 and 95117.

Rapid desensitization may be reimbursed using procedure code 95180 when submitted with one of the following diagnosis codes:

Diagnosis Codes							
Z516	Z880	Z881	Z882	Z883	Z884	Z885	Z886
Z887	Z888	Z889	Z91010	Z910110	Z910111	Z910112	Z910120
Z910121	Z910122	Z91013	Z91018	Z9102	Z91030	Z91038	Z91040
Z91041	Z91048	Z9109					

Allergen immunotherapy is a benefit for clients who have allergy conditions when the following criteria are met:

- A diagnosed hypersensitivity to an allergen can be indicated by one of the valid diagnosis codes listed below.
- Hypersensitivity cannot be managed by avoidance or pharmacologic therapy to control allergic symptoms, or the client has unacceptable side effects with pharmacologic therapy.
- The pharmacologic treatment is refused by the client or leads to significant side effects.
- The allergen content is based on appropriate skin testing, and the allergens are prepared for the client individually.

The preparation of the allergy vial or extract and the administration of an injection may be reimbursed for the following diagnosis codes:

Diagnosis Codes							
B4481	B552	D690	G43009	G43019	G43109	G43119	G43409
G43419	G43509	G43519	G43609	G43619	G43709	G43719	G43809
G43819	G43829	G43839	G43909	G43919	G43A0	G43A1	G43B0
G43B1	G43C0	G43C1	G43D0	G43D1	G43E01	G43E09	G43E11
G43E19	H01111	H01112	H01113	H01114	H01115	H01116	H01119
H10011	H10012	H10013	H10019	H10021	H10022	H10023	H10029
H1010	H1011	H1012	H1013	H10231	H10232	H10233	H10239
H1030	H1031	H1032	H1033	H10401	H10402	H10403	H10409
H10411	H10412	H10413	H10419	H10421	H10422	H10423	H10429
H10431	H10432	H10433	H1044	H1045	H10501	H10502	H10503
H10509	H10511	H10512	H10513	H10519	H10521	H10522	H10523

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Diagnosis Codes							
H10529	H10531	H10532	H10533	H10539	H1089	H109	H11421
H11422	H11423	H11429	H16261	H16262	H16263	H16269	H6500
H6501	H6502	H6503	H6504	H6505	H6506	H6507	H65111
H65112	H65113	H65114	H65115	H65116	H65117	H65119	H65191
H65192	H65193	H65194	H65195	H65196	H65197	H65199	H6520
H6521	H6522	H6523	H6530	H6531	H6532	H6533	H65411
H65412	H65413	H65419	H65491	H65492	H65493	H65499	H6590
H6591	H6592	H6593	H68001	H68002	H68003	H68009	H68011
H68012	H68013	H68019	H68021	H68022	H68023	H68029	H6981
H6982	H6983	J200	J201	J202	J203	J204	J205
J206	J207	J208	J209	J210	J211	J218	J219
J300	J301	J302	J305	J3081	J3089	J309	J310
J320	J321	J322	J323	J324	J328	J393	J440
J441	J4481	J4489	J449	J4520	J4521	J4522	J4530
J4531	J4532	J4540	J4541	J4542	J4550	J4551	J4552
J45901	J45902	J45909	J45990	J45991	J45998	J670	J671
J672	J673	J674	J675	J676	J677	J678	J679
J8281	J8283	J8289	K0855	L200	L2081	L2082	L2084
L2089	L209	L230	L231	L232	L233	L234	L235
L236	L237	L2381	L2389	L239	L240	L241	L242
L243	L244	L245	L246	L247	L2481	L2489	L249
L250	L251	L252	L253	L254	L255	L258	L259
L272	L279	L2989	L299	L300	L301	L302	L303
L304	L305	L308	L309	L500	L508	L509	L550
L551	L552	L559	L560	L561	L562	L563	L564
L565	L568	L570	L571	L572	L573	L574	L575
L578	L579	L580	L581	L589	L719	M041	M042
M048	M049	R21	T50995A	T531X4A	T531X4D	T531X4S	T532X4A
T532X4D	T532X4S	T533X4A	T533X4D	T533X4S	T534X4A	T534X4D	T534X4S
T536X4A	T536X4D	T536X4S	T59812A	T59812D	T59812S	T63001A	T63001D
T63001S	T63002A	T63002D	T63002S	T63003A	T63003D	T63003S	T63004A
T63004D	T63004S	T63011A	T63011D	T63011S	T63012A	T63012D	T63012S
T63013A	T63013D	T63013S	T63014A	T63014D	T63014S	T63021A	T63021D
T63021S	T63022A	T63022D	T63022S	T63023A	T63023D	T63023S	T63024A
T63024D	T63024S	T63031A	T63031D	T63031S	T63032A	T63032D	T63032S
T63033A	T63033D	T63033S	T63034A	T63034D	T63034S	T63041A	T63041D
T63041S	T63042A	T63042D	T63042S	T63043A	T63043D	T63043S	T63044A
T63044D	T63044S	T63061A	T63061D	T63061S	T63062A	T63062D	T63062S
T63063A	T63063D	T63063S	T63064A	T63064D	T63064S	T63071A	T63071D
T63071S	T63072A	T63072D	T63072S	T63073A	T63073D	T63073S	T63074A

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Diagnosis Codes							
T63074D	T63074S	T63081A	T63081D	T63081S	T63082A	T63082D	T63082S
T63083A	T63083D	T63083S	T63084A	T63084D	T63084S	T63091A	T63091D
T63091S	T63092A	T63092D	T63092S	T63093A	T63093D	T63093S	T63094A
T63094D	T63094S	T63111A	T63111D	T63111S	T63112A	T63112D	T63112S
T63113A	T63113D	T63113S	T63114A	T63114D	T63114S	T63121A	T63121D
T63121S	T63122A	T63122D	T63122S	T63123A	T63123D	T63123S	T63124A
T63124D	T63124S	T63191A	T63191D	T63191S	T63192A	T63192D	T63192S
T63193A	T63193D	T63193S	T63194A	T63194D	T63194S	T632X1A	T632X1D
T632X1S	T632X2A	T632X2D	T632X2S	T632X3A	T632X3D	T632X3S	T632X4A
T632X4D	T632X4S	T63301A	T63301D	T63301S	T63302A	T63302D	T63302S
T63303A	T63303D	T63303S	T63304A	T63304D	T63304S	T63311A	T63311D
T63311S	T63312A	T63312D	T63312S	T63313A	T63313D	T63313S	T63314A
T63314D	T63314S	T63321A	T63321D	T63321S	T63322A	T63322D	T63322S
T63323A	T63323D	T63323S	T63324A	T63324D	T63324S	T63331A	T63331D
T63331S	T63332A	T63332D	T63332S	T63333A	T63333D	T63333S	T63334A
T63334D	T63334S	T63391A	T63391D	T63391S	T63392A	T63392D	T63392S
T63393A	T63393D	T63393S	T63394A	T63394D	T63394S	T63411A	T63411D
T63411S	T63412A	T63412D	T63412S	T63413A	T63413D	T63413S	T63414A
T63414D	T63414S	T63421A	T63421D	T63421S	T63422A	T63422D	T63422S
T63423A	T63423D	T63423S	T63424A	T63424D	T63424S	T63431A	T63431D
T63431S	T63432A	T63432D	T63432S	T63433A	T63433D	T63433S	T63434A
T63434D	T63434S	T63441A	T63441D	T63441S	T63442A	T63442D	T63442S
T63443A	T63443D	T63443S	T63444A	T63444D	T63444S	T63451A	T63451D
T63451S	T63452A	T63452D	T63452S	T63453A	T63453D	T63453S	T63454A
T63454D	T63454S	T63461A	T63461D	T63461S	T63462A	T63462D	T63462S
T63463A	T63463D	T63463S	T63464A	T63464D	T63464S	T63481A	T63481D
T63481S	T63482A	T63482D	T63482S	T63483A	T63483D	T63483S	T63484A
T63484D	T63484S	T63511A	T63511D	T63511S	T63512A	T63512D	T63512S
T63513A	T63513D	T63513S	T63514A	T63514D	T63514S	T63591A	T63591D
T63591S	T63592A	T63592D	T63592S	T63593A	T63593D	T63593S	T63594A
T63594D	T63594S	T63611A	T63611D	T63611S	T63612A	T63612D	T63612S
T63613A	T63613D	T63613S	T63614A	T63614D	T63614S	T63621A	T63621D
T63621S	T63622A	T63622D	T63622S	T63623A	T63623D	T63623S	T63624A
T63624D	T63624S	T63631A	T63631D	T63631S	T63632A	T63632D	T63632S
T63633A	T63633D	T63633S	T63634A	T63634D	T63634S	T63691A	T63691D
T63691S	T63692A	T63692D	T63692S	T63693A	T63693D	T63693S	T63694A
T63694D	T63694S	T63711A	T63711D	T63711S	T63712A	T63712D	T63712S
T63713A	T63713D	T63713S	T63714A	T63714D	T63714S	T63791A	T63791D
T63791S	T63792A	T63792D	T63792S	T63793A	T63793D	T63793S	T63794A
T63794D	T63794S	T63811A	T63811D	T63811S	T63812A	T63812D	T63812S

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Diagnosis Codes							
T63813A	T63813D	T63813S	T63814A	T63814D	T63814S	T63821A	T63821D
T63821S	T63822A	T63822D	T63822S	T63823A	T63823D	T63823S	T63824A
T63824D	T63824S	T63831A	T63831D	T63831S	T63832A	T63832D	T63832S
T63833A	T63833D	T63833S	T63834A	T63834D	T63834S	T63891A	T63891D
T63891S	T63892A	T63892D	T63892S	T63893A	T63893D	T63893S	T63894A
T63894D	T63894S	T6391XA	T6391XD	T6391XS	T6392XA	T6392XD	T6392XS
T6393XA	T6393XD	T6393XS	T6394XA	T6394XD	T6394XS	T65824A	T65824D
T65824S	T7801XA	T7801XD	T7801XS	T78070A	T78070D	T78070S	T78071A
T78071D	T78071S	T78079A	T78079D	T78079S	T78080A	T78080D	T78080S
T78081A	T78081D	T78081S	T78089A	T78089D	T78089S	T78110A	T78110D
T78110S	T78111A	T78111D	T78111S	T78119A	T78119D	T78119S	T78120A
T78120D	T78120S	T78121A	T78121D	T78121S	T78129A	T78129D	T78129S
T7819XA	T7819XD	T7819XS	T782XXA	T782XXD	T782XXS	T783XXA	T783XXD
T783XXS	T7840XA	T7840XD	T7840XS	T7849XA	T7849XD	T7849XS	T8062XD
T8062XS	T8069XD	T8069XS	T886XXA	T886XXD	T886XXS		

9.2.5.1.1 Prior Authorization for Allergy Immunotherapy

Authorization is not required for immunotherapy services; however, requests for services beyond the established limits of 160 doses per one-year period for procedure code 95165 may be considered for prior authorization with documentation of medical necessity. Documentation must be submitted to the Special Medical Prior Authorization Department and include the following information:

- Copy of the allergen testing results
- Severity and periodicity of symptoms
- Physical limitations created by the symptoms
- Concurrent drug treatment
- Explanation of how efficacy has not been achieved with prior treatment and the objectives of the new anticipated treatment program

9.2.5.1.2 Limitations of Allergy Immunotherapy

The quantity billed for the allergy extract preparation procedure must represent the total number of doses to be administered from the vial. If the number of doses is not stated on the claim, a quantity of one is allowed.

> ***Note:*** *A "dose" is defined as the amount of antigen(s) administered in a single injection from a multidose vial.*

Procedure code 95165 is limited to a total of 160 doses per one-year period, which begins the date the immunotherapy is initiated. Additional doses may be considered for reimbursement through prior authorization with documentation of medical necessity. Procedure code 95165 is limited to no more than ten doses per vial.

When an injection is given from a vial, providers should use an administration-only procedure code (95115 or 95117). Reimbursement for the administration is limited to one per day.

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An office visit, clinic visit, or treatment visit is not considered for reimbursement in addition to the fee for the preparation or the administration of the allergy vial or extract unless the additional visit results in a non-allergy-related diagnosis or a re-evaluation of the client's condition. The following E/M procedure codes may be submitted with modifier 25:

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	

Allergen immunotherapy that is considered experimental, investigational, or unproven is not a benefit of Texas Medicaid.

Single dose vials are not a benefit of Texas Medicaid.

Refer to: Subsection 4.5.5, "Outpatient Hospital Revenue Codes" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about outpatient hospital revenue codes for clinic visits, treatment rooms, and observation services.

9.2.5.2 Allergy Testing

Texas Medicaid benefits include allergy testing for clients with clinically significant allergic symptoms. Allergy testing is focused on determining the allergens that cause a particular reaction and the degree of the reaction. Allergy testing also provides justification for recommendations of particular medicines, of immunotherapy, or of specific avoidance measures in the environment.

Evaluation and management (E/M) procedure codes will not be reimbursed in addition to allergy testing on the same day by the same provider, unless they are submitted with modifier 25.

Modifier 25 must be present for both to be reimbursed. Modifier 25 indicates that a significant, separately identifiable E/M service was performed by the same provider on the same date of service as the allergy testing. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

If modifier 25 is not submitted with documentation of a significant, separately identifiable service the allergy testing will be reimbursed, and the E/M procedure code will be denied as part of another procedure on the same day.

The following allergy tests are benefits of Texas Medicaid:

- Percutaneous and intracutaneous skin test. The skin test for IgE-mediated disease with allergenic extracts is used in the assessment of allergy-prone clients. The test involves the introduction of small quantities of test allergens below the epidermis. Procedure codes 95004, 95017, 95018, 95024, 95027, and/or 95028 should be used to submit skin tests for consideration of reimbursement.
- *Patch or application tests*. Patch testing (procedure code 95044) is used for diagnosing contact allergic dermatitis.
- *Photo or photo patch skin test*. Procedure codes 95052 and 95056 may be used for diagnosing contact allergic dermatitis.
- *Ophthalmic mucous membrane or direct nasal mucous membrane tests*. Direct nasal or ophthalmic mucous membrane tests (procedure codes 95060 and 95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.
- *Inhalation bronchial challenge testing (not including necessary pulmonary function tests)*. Bronchial challenge testing with methacholine, histamine, or allergens (procedure code 95070) is used for defining asthma or airway hyperactivity when skin testing results are not consistent with the client's medical history. Results of these tests are evaluated by objective measures of pulmonary function.

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The number of allergy tests performed must be indicated on the claim. When the number of tests is not specified, a quantity of one is allowed.

9.2.5.2.1 Allergy Blood Tests

Allergy blood testing procedure codes 86001, 86003, 86005, and 86008 are a benefit when the test is performed for a reason that includes, but is not limited to, the following:

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

Radioallergosorbent tests (RAST) and multiple allergosorbent tests (MAST) are benefits of Texas Medicaid. RAST testing is used to detect specific allergens. RAST testing is usually performed by an independent lab; however, there are physicians who have the capability of performing these tests in their offices. Physicians who submit RAST/MAST tests performed in the office setting must use modifier SU to be considered for reimbursement. Without the use of the SU modifier, RAST/MAST testing submitted with POS 1 (office) is denied with the message, "Lab performed outside of office must be billed by the performing facility."

RAST/MAST tests must be submitted using procedure codes 86003, 86005, and 86008.

Procedure code 86001 is limited to 20 allergens per rolling year, any provider.

Procedure code 86003 and 86008 are limited to 30 allergens per rolling year, any provider.

Procedure code 86005 is limited to 4 multiallergen tests per rolling year, same provider.

9.2.5.2.2 Collagen Skin Test

Collagen skin tests are a benefit of Texas Medicaid using procedure code Q3031. Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure that utilizes collagen.

Collagen injections that are used for cosmetic surgery are not considered medically necessary and are not a benefit of Texas Medicaid.

9.2.5.2.3 Prior Authorization

Prior authorization is required for collagen skin test procedure code Q3031.

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

Prior authorization is required for procedure codes 86001, 86003, and 86005 only if the limits are exceeded. The following medical documentation must be submitted to the SMPA Department with the prior authorization request for additional procedures:

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

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Procedure code 95199 may be used for an unlisted allergy or clinical immunologic service or procedure if there is not a specific procedure code that describes the service performed. Prior authorization is required for unlisted procedure codes. Every effort must be used to bill with the appropriate CPT code that describes the procedure being performed. If a code does not exist to describe the service performed, prior authorization may be requested using unlisted procedure code 95199 and must be submitted with documentation to assist in determining coverage.

The documentation submitted must include all of the following:

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

9.2.5.2.4 Ingestion Challenge Test

Ingestion challenge tests are a benefit of Texas Medicaid using procedure codes 95076 and 95079.

Procedure code 95076 is limited to one service per day, any provider.

Procedure code 95079 is limited to twice per day, any provider.

Add-on procedure code 95079 must be billed with primary procedure code 95076.

9.2.6 Ambulance Transport Services - Nonemergency

Nonemergency ambulance services require prior authorization in circumstances not involving an emergency. Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services.

Refer to: Non-emergency Ambulance Prior Authorization Request on the TMHP website at www.tmhp.com.

Subsection 2.2.3, "Nonemergency Ambulance Transport Services" in the *Ambulance Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ambulance services.

Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about nonemergency ambulance transport prior authorization.

9.2.7 Anesthesia

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement.

Medicaid may reimburse anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) for administering anesthesia as defined within their individual scope of practice.

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9.2.7.1 Medical Direction by an Anesthesiologist

Medical direction by an anesthesiologist of an anesthesia practitioner (CRNA, AA, or other qualified professional) is a benefit of Texas Medicaid if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.
- The anesthesiologist is physically present in the operating suite.

Exception: *Anesthesiologists may be considered for reimbursement when they medically direct more than four anesthesia services or simultaneously supervise a combination of more than four CRNAs, AAs, or other qualified professionals under emergency circumstances only.*

Medical direction provided by an anesthesiologist is a benefit of Texas Medicaid if the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical portions of the anesthesia plan, including induction and emergence.
- The anesthesiologist ensures that a qualified professional can perform the procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at intervals.
- The anesthesiologist provides direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.
- The anesthesiologist provides postanesthesia care.

The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist who directs the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:

- Address an emergency of short duration in the immediate area
- Administer an epidural or caudal anesthetic to ease labor pain
- Provide periodic, rather than continuous, monitoring of an obstetrical patient
- Receive clients entering the operating suite for the next surgery
- Check or discharge clients in the recovery room
- Handle scheduling matters

As noted above, an anesthesiologist may concurrently medically direct up to four anesthesia procedures. Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicaid client. For example, if three procedures are medically directed but only two involve Medicaid clients, the Medicaid claims must be billed as concurrent medical direction of three procedures.

For medical direction, the anesthesiologist must document in the client's medical record that he or she did the following:

- Performed the pre-anesthetic exam and evaluation.
- Provided indicated post-anesthesia care.
- Was present during the critical and key portions of the anesthesia procedure, including, if applicable, induction and emergence.

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- Was present during the anesthesia procedure to monitor the client's status.

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

- The name of each CRNA, AA, or other qualified professional that was concurrently medically directed or supervised and a description of the procedure that was performed must be documented and maintained.
- Signatures of the anesthesiologist, CRNA, AA, or other qualified professional involved in administering anesthesia services must be documented in the client's medical record.

9.2.7.2 Anesthesia for Sterilization

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 the complete list of family planning diagnosis codes.

Subsection 2.2.8, "Sterilization and Sterilization-Related Procedures" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about FQHCs and billing the annual family planning examination for Title XIX clients.

9.2.7.3 Anesthesia for Labor and Delivery

Providers must bill the most appropriate procedure code for the service provided. Other time-based procedure codes cannot be submitted if either 01960 or 01967 is the most appropriate procedure code.

The following procedure codes must be used for obstetrical anesthesia:

Procedure Codes									
01960	01961	01963	01967	01968	01969				

Procedure codes 01960 and 01967 are limited to once every 210 days when billed by any provider and are reimbursed a flat fee. The time reported must be in minutes. Providers should refer to the definition of time in the CPT manual in the "Anesthesia Guidelines—Time Reporting" section.

Procedure code 01968 or 01969 may be considered for reimbursement when submitted with procedure code 01967. For a Cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a Cesarean delivery must be submitted using procedure code 01968 or 01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

For continuous epidural analgesia procedure codes, Texas Medicaid reimburses providers for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences.

9.2.7.4 Anesthesia Provided by the Surgeon (Other Than Labor and Delivery)

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. The anesthesia service is included in the global surgical fee.

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9.2.7.5 Complicated Anesthesia

The following procedure codes may be reimbursed in addition to an anesthesia procedure or service: 99100, 99116, 99135, and 99140. Documentation supporting the medical necessity for use of the procedure codes may be subject to retrospective review.

Procedure code 99140 is not reimbursed for diagnosis code O80 or O82 when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

9.2.7.6 Multiple Procedures

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items.

When billing for multiple anesthesia services performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.

9.2.7.7 Monitored Anesthesia Care

Monitored anesthesia care may include any of the following:

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

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

The QS modifier is an informational modifier.

9.2.7.8 Reimbursement Methodology

There are two types of reimbursement for anesthesia procedure codes.

- Flat fee
- Time-based fees, which require documentation of the exact amount of face-to-face time with the client

Anesthesiologists directing one or multiple CRNAs and/or AAs during medical procedures will be reimbursed at 50 percent of the established reimbursement rate.

An AA under the supervision of an anesthesiologist is reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

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

Both the flat-fee and time-based-fee procedure codes must be submitted with modifiers and are subject to medical direction/supervision reimbursement adjustments.

Flat Fees

Both OB related anesthesia procedure codes 01960 and 01967 are considered for reimbursement with a flat-fee rate.

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- Flat fees are subject to medically-directed modifier combination adjustments based on the modifier submitted with the anesthesia procedure code.
- The time-based add-on procedure code 01968 must be billed in addition to the flat fee when anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia has occurred.

For flat-fee anesthesiology codes, anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance, that is, when the client may be safely placed under postoperative supervision.

Time-Based Fees

For time-based anesthesiology procedure codes, anesthesia time is the time during which an anesthesia practitioner is present with the client. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

For time-based anesthesiology codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record.

The documented time must be the same in the records or claims of the anesthesiologist and other anesthesia practitioners who were medically directed by the anesthesiologist.

One time unit is equal to 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

Reimbursement of time-based anesthesia services is derived by adding the RVUs (e.g., base units) for the procedures performed (when multiple procedures are performed use the procedure with the highest RVUs) to the total face-to-face anesthesia time in minutes divided by 15 minutes, multiplied by the appropriate conversion factor:

[RVUs + (Minutes / 15] x Conversion Factor = Anesthesia Reimbursement

Provider Type Description - Physician Pricing Example				
Time: 120 minutes	=	120/15	=	8 (quantity billed)
Procedure code: 00851	=	(6 RVUs) 6.00 + 8	=	14.00
Conversion factor: $19.58	=	14.00 x 19.58	=	$274.12 (physician reimbursement)

Conversion Factor

A conversion factor is the multiplier that transforms relative values into payment amounts. There is a standard conversion factor for anesthesia services.

9.2.7.9 Anesthesia Modifiers

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

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

A procedure billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) will be denied if another claim has been paid indicating the service was personally performed by, and reimbursed to, a CRNA (modifier QZ) for the same client, date of service,

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and procedure code. The opposite is also true—a CRNA-administered procedure will be denied if a previous claim was paid to an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

9.2.7.9.1 State-Defined Modifiers

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

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

Anesthesia providers must submit modifier U1 or U2 in combination with an appropriate pricing modifier (AA, GC, QY, QK, AD, QZ, QX) when billing for any payable anesthesia procedure codes.

9.2.7.9.2 Modifier Combinations

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

Anesthesiologists may be reimbursed for medical direction of CRNAs, AAs, or other qualified professional by using one of the following modifier combinations:

Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
Anesthesiologist Directing Other Qualified Professionals		
QY and U1	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one CRNA, AA, or other qualified professional, the QY + U1 modifier combination must be billed together when the CRNA, AA, or qualified professional are a part of a clinic/group.	Only the anesthesiologist
AA, U1, and GC	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one resident physician. ***Note:*** *For procedure code 01967 medical supervision of resident physicians rather than medical direction is required, however, modifiers AA-U1-GC must still be noted on the claim.*	Only the anesthesiologist
QK and U1	When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals.	Only the anesthesiologist

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Modifier Combination Submitted by Anesthesiologist	When is it used?	Who will submit claims?
AD and U1 (Emergency circumstances only)	When a single claim per client is billed by the anesthesiologist for medical supervision of anesthesia services for more than four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.	Only the anesthesiologist
Anesthesiologist Directing CRNAs or AAs		
QY and U2	When two claims per client are billed, one by the medically directing anesthesiologist and one by the CRNA, AA, or other qualified professional.	Both the anesthesiologist and CRNA, AA, or other qualified professional
QK and U2	When two claims per client are billed for medically directed anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals.	Both the anesthesiologist and CRNA, AA, or other qualified professional
AD and U2 (Emergency circumstances only)	When two claims per client are billed for the medical supervision of more than four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures.	Both the anesthesiologist and CRNA, AA, or other qualified professional

9.2.7.9.3 CRNA, AA, and Other Qualified Professional Services

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

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

9.2.7.10 Prior Authorization for Anesthesia

9.2.7.10.1 Anesthesia for Medical Services

Anesthesia services provided in combination with most medical surgical procedures do not require prior authorization. However, some medical surgical procedures may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon will be denied.

9.2.7.11 Claims Filing

Texas Medicaid reimburses anesthesiologists based on the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 paper claim form).
- Person (physician, CRNA, or AA) administering anesthesia (modifiers must be used to designate this provider type).

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- Time in minutes.
- Any other appropriate modifier (refer to subsection 6.3.5, "Modifiers" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for a list of the most common modifiers).

9.2.7.12 Anesthesia (General) for THSteps Dental

Refer to: Section 3, "Texas Health Steps (THSteps) Dental" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information.

9.2.8 Bariatric Surgery

Bariatric surgery is considered medically necessary when used as a means to treat covered medical conditions that are caused or significantly worsened by the client's obesity in cases where those comorbid conditions cannot be adequately treated by standard measures unless significant weight reduction takes place. The pathophysiology of the covered comorbid conditions must be sufficiently severe that the expected benefits of weight loss subsequent to this surgery significantly outweigh the risks associated with bariatric surgery.

The following procedure codes may be reimbursed for medically necessary bariatric surgery services with prior authorization: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, and 43888.

Bariatric surgery is not a benefit when the primary purpose of the surgery is any of the following:

- For weight loss for its own sake
- For cosmetic purposes
- For reasons of psychological dissatisfaction with personal body image
- For the client's or provider's convenience or preference

9.2.8.1 Prior Authorization for Bariatric Surgery

All clients must meet the criteria outlined below.

The same contraindications exist for bariatric surgery as for any other elective abdominal surgery. Documentation provided for prior authorization must attest that none of the following additional contraindications exist:

- Endocrine cause for obesity, inflammatory bowel disease, chronic pancreatitis, cirrhosis, portal hypertension, or abnormalities of the gastrointestinal tract
- Chronic, long-term steroid treatment
- Pregnant, or plans to become pregnant within 18 months
- Noncompliance with medical treatment
- Significant psychological disorders that would be exacerbated or interfere with the long-term management of the client after the operation
- Active malignancy

All clients must undergo preoperative psychological evaluation by a behavioral health provider and have clearance for surgery if any of the following conditions exist:

- They have a history of psychiatric or psychological disorders.
- They are currently under the care of a psychologist or psychiatrist.
- They are on psychotropic medications.

The client's medical record must include documentation of the evaluation.

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Clients without a history of psychiatric or psychological disorder must also undergo a preoperative psychological evaluation by a behavioral health provider and have clearance for surgery. The client's medical record must include documentation that the client is psychologically mature and able to cope with the postsurgical changes of the surgery.

Documentation must be submitted with the prior authorization request that is signed by the surgeon and attests that the services are provided by a facility in Texas that is one of the following:

- Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
- A children's hospital that has a bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and psychosocial needs of the client and family.

Bariatric surgery for clients who are 20 years of age and younger may be prior authorized when the client meets all of the following criteria:

- The client has reached a Tanner Scale stage IV or V plus 95 percent of adult height based on bone age.
- The client has a body mass index (BMI) of greater than or equal to 40 kg/m2.
- The client has one or more comorbid conditions that are exacerbated by or attributable to obesity.
- Female clients must be at least 13 years of age and menstruating.
- Male clients must be at least 15 years of age.

Bariatric surgery for clients who are 21 years of age and older may be prior authorized when the client meets all of the following criteria:

- The client has a BMI of greater than or equal to 35 kg/m2.
- The client has one or more of the following comorbid conditions that are exacerbated by or attributable to obesity:
  - Obesity-associated hypoventilation
  - Moderate to severe sleep apnea (defined as apnea/hypoapnea index of 16 or more events per hour)
  - Congestive heart failure
  - Obesity-induced cardiomyopathy
  - Refractory hypertension resistant to pharmacotherapy (defined as blood pressure greater than 140mmHg systolic or greater than 90mmHg diastolic, despite maximally tolerated doses of at least three different classes of antihypertensive medications)
  - Pseudotumor cerebri (documented idiopathic intracerebral hypertension)
  - Adult onset (Type II) diabetes (with or without complications) with Hgb A1c greater than 9 percent, regardless of therapy, or 7 to 9 percent on maximal medical therapy (defined as taking insulin or maximally tolerated doses of at least two different classes of oral hypoglycemic medications)
  - Cardiovascular or peripheral vascular disease
  - Refractory hyperlipidemia (defined as triglycerides greater than 250 mg/dl, cholesterol greater than 220/mg/dl, HDL less than 35 mg/dl, or LDL greater than 200 mg/dl, despite maximally tolerated doses of at least two different classes of lipid-lowering medications)
  - Recurrent or chronic skin ulcerations with infection

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- Pulmonary hypertension
- Chronic joint disease, deterioration of the joint cartilage, and the formation of new bone (bone spurs) at the margins of the joints, with symptoms that severely affect work or leisure activities, on maximal medical therapy (defined as maximally tolerated dose of a non-steroidal anti-inflammatory drug (NSAID) or COX-II inhibitor or acetaminophen and the completion of at least one physical-therapist-supervised exercise program)
- Hepatic steatosis without evidence of active inflammation

Documentation must include a summary of the treatment provided for the client's comorbid conditions, including descriptions of how the client's response to standard treatment measures are unsatisfactory and why the bariatric surgery is medically necessary in the context of current treatment and medically-reasonable alternatives that are available.

Referral for bariatric surgery to the bariatric surgeon is required from the practitioner who is treating the comorbid condition(s). The bariatric surgeon will determine the client's eligibility for bariatric surgery. Documentation of the referral must be submitted with the prior authorization request.

The client must have had previous unsuccessful medical treatment for obesity, as documented in the medical record. All of the following minimal requirements must be met:

- The client has made a diligent effort to achieve healthy body weight with such efforts described in the medical record and certified by the operating surgeon.
- The client has failed to maintain a healthy weight despite a minimum of 6 months documented regular participation in a structured dietary program overseen by a physician (M.D. or D.O.) within 12 months of the request date.

Documentation that is submitted for prior authorization must also include all of the following:

- The process by which the client will receive postoperative surgical, nutritional, and psychological services.
- Affirmation that the client and the parent/guardian (if applicable) understand and will support the changes in eating habits that must accompany the surgery and the extensive postoperative follow-up.

Repeat bariatric surgery may be considered medically necessary in either of the following circumstances:

- To correct complications from bariatric surgery such as band malfunction, obstruction, or stricture
- To convert to a Roux-en-Y gastroenterostomy or to correct pouch failure in an otherwise compliant client when the initial bariatric surgery met medical necessity criteria

Note: *Conversion to a Roux-en-Y gastroenterostomy may be considered medically necessary for clients who have not had adequate success (defined as a loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure, and the client has been compliant with a prescribed nutrition and exercise program following the procedure.*

All documentation required for prior authorization is to be maintained in the client's medical record and is subject to retrospective review. This includes medical records from both the practitioner treating the comorbid condition(s) and the bariatric surgeon.

Providers may fax or mail prior authorization requests for bariatric surgery services for clients who are 20 years of age and younger to the TMHP Comprehensive Care Program (CCP) Prior Authorization Department. Prior authorization requests for clients who are 21 years of age and older may be faxed or mailed to the TMHP Special Medical Prior Authorization Department.

Clients may be eligible under Texas Medicaid or CCP for separate reimbursement for nutritional and psychological assessment and counseling associated with bariatric surgery.

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Behavioral health services provided as part of the preoperative or postoperative phase of bariatric surgery are subject to behavioral health guidelines, and are not considered part of the bariatric surgery.

Refer to: Subsection 8, "Inpatient Psychiatric Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for information about behavioral health services.

9.2.9 Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer

Live BCG for intravesical (procedure code 90586) or transvesical (procedure code J9030) are benefits of Texas Medicaid for the following diagnosis codes:

Diagnosis Codes							
C670	C671	C672	C673	C674	C675	C676	C677
C678	C679	C7911	D090				

Procedure code 90585 is a benefit of Texas Medicaid and restricted to diagnosis code Z201. Procedure code 90585 is limited to one service per day, same procedure, any provider. Authorization is not required for the BCG vaccine.

Bladder instillation of anticarcinogenic agent (procedure code 51720) may be reimbursed separately when billed with BCG instillation (procedure code 90586 or J9030).

9.2.10 Behavioral Health Services

Refer to: The *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.11 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

9.2.12 Biofeedback Services

Biofeedback services are a benefit of Texas Medicaid for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence
- Fecal incontinence
- Migraine and tension headache

Biofeedback services may be reimbursed using procedure codes 90901, 90912, and 90913.

Biofeedback services are limited to a maximum of 18 sessions rendered by any provider for the lifetime of each client for each condition.

Biofeedback services that are not a benefit of Texas Medicaid are the following:

- Biofeedback performed in the home setting
- Neurofeedback (such as, but not limited to, electroencephalography [EEG])
- Treatment for muscle tension, except tension headache
- Psychological, psychophysiological, and behavioral health therapy and psychosomatic conditions
- Investigational or experimental biofeedback services and procedures

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Procedure codes 90901, 90912, and 90913 are limited to one service per day. The reimbursement for procedure codes 90901, 90912, and 90913 include all modalities of the biofeedback training performed on the same day, regardless of the time increments or the number of modalities performed.

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

9.2.12.1 Biofeedback Certification

A staff member who is certified by Biofeedback Certification International Alliance (BCIA) must perform biofeedback services.

The certification types accepted by Texas Medicaid are the following:

- General biofeedback certification (BCB)
- Pelvic muscle dysfunction biofeedback certification (BCB-PMD)

Providers must maintain documentation in the client's medical record to support the medical necessity of the biofeedback service provided. Documentation must include the name of the staff person who provided the biofeedback and the prescribing physician must maintain in the office a record of the current certification of the staff member(s) who perform biofeedback. Documentation is subject to retrospective review.

9.2.12.2 Prior Authorization for Biofeedback Services

Prior authorization is required for biofeedback services.

- Any combination of procedure codes 90901, 90912, and 90913 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older.
- Procedure code 90901 is a benefit for biofeedback sessions for migraine or tension headache conditions.

The initial request may include up to 12 visits and not exceed a total duration of 12 weeks. Documentation of the following must be submitted for consideration of prior authorization:

- Conventional treatments that were given but were not successful, including, but not limited to, pharmacotherapy, exercise, rest, and heating and cooling modalities.
- Statements from the prescribing physician that the client is capable of understanding the requirements and agrees actively to participate in the biofeedback sessions.
- Name and certification information for the person performing the training.

In addition, documentation must be submitted to support the specific type of biofeedback requested.

Urinary and Fecal Incontinence

- Diagnosis of fecal or urinary stress, urge, overflow, or a mix of stress and urge incontinence in a client who is 4 years of age or older.
- Exclusion by the physician of any underlying medical conditions that could be causing the problem.
- Failed pelvic floor muscle exercise (PME) training for clients who are 21 years of age and older.

Note: *Failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PME exercises.*

Migraine and tension headache

- A diagnosis of migraine, tension headache, or mixed migraine and tension headache.
- Symptoms that occur with a duration of at least 4 hours for at least 15 days a month over at least 3 months.

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- Failure of first-line approaches, including avoidance of precipitating stimuli and pharmacological prophylaxis.

Prior authorization requests must be submitted by the physician to the Special Medical Prior Authorization (SMPA) Department. The request must be submitted with documentation that supports medical necessity. Providers may submit prior authorization requests online through the TMHP website at www.tmhp.com, by fax to 1-512-514-4213, or by mail to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418

After the client completes the initial biofeedback treatment course, prior authorization may be considered for a total of six follow-up sessions not to exceed three sessions per week and total duration not to exceed eight weeks. Providers must submit prior authorization documentation for the same condition as the original request, and must include each original symptom and how it has objectively improved. Documentation may include, but is not limited to, the following:

- For treatment of urinary incontinence, improvement in continence scores, vitality, health, a decrease in high-grade stress incontinence, nocturnal enuresis, and urine loss with activity. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For treatment of fecal incontinence, improvement in continence scores, squeeze and anal pressures, squeeze duration, vitality, and health. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For migraine and tension headaches, diminished intensity, frequency, and duration of the headache activity.

9.2.13 Blepharoplasty Procedures

Procedure codes 15820, 15821, 67911, 67961, 67966, 67971, 67973, 67974, and 67975 are not diagnosis-restricted.

Procedure codes 67901, 67902, 67903, 67904, 67906, 67908, and 67909 may be reimbursed for clients who are 20 years of age and younger without prior authorization when performed for one of the following diagnosis codes:

Diagnosis Codes							
Q100	Q101	Q102	Q103				

Procedure codes 67901, 67902, 67903, 67904, 67906, and 67908 do not require prior authorization for clients who are 21 years of age and older when billed for the following diagnosis codes:

Diagnosis Codes							
H0231	H0232	H0234	H0235	H02411	H02412	H02413	H02421
H02422	H02423	H02431	H02432	H02433			

Blepharoplasty for clients who are 21 years of age and older requires mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty for procedure codes 15820, 15821, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911:

- A brief history and physical evaluation
- Photographs of the eyelid problem

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- Visual field measurements
- Diagnosis code

The following blepharoplasty and eyelid repair procedures do not require prior authorization:

Procedure Codes									
67916	67917	67923	67924	67961	67966	67971	67973	67974	67975

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Retroactive authorization may be granted on an appeal basis when submitted with the appropriate documentation.

9.2.14 Bone Growth Stimulation

Professional services for bone growth stimulation (procedure codes 20974, 20975, and 20979) are a benefit of Texas Medicaid.

Prior authorization is required for a bone growth stimulator device (procedure codes E0747, E0748, E0749, and E0760).

Refer to: Subsection 2.2.8, "Bone Growth Stimulators" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for prior authorization criteria.

9.2.14.1 Invasive Bone Growth Stimulation

Invasive bone growth stimulation (procedure code 20975) is indicated for the following conditions:

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

9.2.14.2 Non-invasive Bone Growth Stimulation

Non-invasive bone growth stimulation (procedure code 20974) is indicated for the following conditions:

- Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care.
- Delayed unions of fractures of failed arthrodesis at high-risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

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Documentation must also indicate all of the following:

- Serial radiographs have confirmed that no progressive signs of healing have occurred.
- The fractured gap is 1 cm or less.
- The individual can be adequately immobilized and is likely to comply with non-weight-bearing restrictions.

Non-invasive bone growth stimulation for spinal application is indicated for the following conditions:

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

9.2.14.3 Ultrasound Bone Growth Stimulation

Ultrasound bone growth stimulation (procedure code 20979) is indicated for nonunion of a fracture, other than the skull or vertebrae, in a skeletally mature person, which is documented by a minimum of two sets of radiographs that were:

- Obtained prior to starting treatment with the osteogenesis stimulator.
- Separated by a minimum of 90 days.
- Taken with multiple views of the fracture site.
- Accompanied by a written interpretation by a physician who states that there has been no clinically significant evidence of fracture healing between the two set of radiographs.

Documentation must also indicate evidence of all of the following:

- The fracture is not tumor related.
- The fracture is not fresh (less than 7 days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture).

9.2.14.4 Reimbursement

Professional claims that are submitted for bone growth stimulation (procedure codes 20974, 20975, and 20979) may be reimbursed if the claim includes documentation of one of the following:

- Documentation of medical necessity as outlined for each type of bone growth stimulation.
- The corresponding bone growth stimulator device was submitted within 95 days of the date the bone growth stimulation procedure was performed.

The appropriate evaluation and management (E/M) procedure code must be billed for monitoring the effectiveness of bone growth stimulation treatment.

Procedure codes 20974, 20975, and 20979 are limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the criteria for a bone growth stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

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9.2.15 Cancer Screening and Testing

9.2.15.1 BRCA Testing

Refer to: Subsection 3.5, "Breast Cancer Gene 1 and 2 (BRCA) Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.15.1.1 Colorectal Cancer Screening

Colorectal cancer screening is a benefit of Texas Medicaid. Fecal occult blood tests, multi-targeted stool DNA (mt-sDNA) tests, screening colonoscopies, and sigmoidoscopies are evidenced based methods of colorectal cancer screening. Screening refers to the testing of asymptomatic persons to assess their risk for the development of colorectal cancer. Screening has been shown to decrease mortality due to this cancer by detecting cancers at earlier stages and allowing the removal of adenomas, thus preventing the subsequent development of cancer.

The American Cancer Society (ACS) recommends screening people at average risk for colorectal cancer beginning at 45 years of age by any of the following methods:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year, or
- A multi-targeted stool DNA test (mt-sDNA) every three years, or
- Flexible sigmoidoscopy every five years, or
- A Flexible sigmoidoscopy every ten years, in addition to annual FIT screening, or
- Colonoscopy every ten years

Note: *For FOBT, the take-home multiple sample method with three samples should be used.*

The U.S. Preventative Services Task Force (USPSTF) guidelines indicate that the net benefit of colorectal cancer screening in adults who are 76 years of age and older who have been previously screened is small. The risks should be considered on an individual basis, as screening in this age group is most appropriate for those healthy enough to undergo treatment.

The ACS and USPSTF recommends screening for people at high-risk for colorectal cancer once every two years.

Indications/characteristics of a high-risk individual may include one or more of the following:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- There is a family history of familial adenomatous polyposis.
- There is a family history of hereditary nonpolyposis colorectal cancer.
- There is a personal history of adenomatous polyps.
- There is a personal history of colorectal cancer.
- There is a personal history of colonic polyps.
- There is a personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

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

Colorectal screening services are considered for reimbursement when submitted using procedure codes G0328 (with modifier QW), G0104, G0105, and G0121, by associated risk category based on the ACS and USPSTF frequency recommendations. Reimbursement for these procedure codes is considered when medical necessity is documented in the client's record.

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Fecal Occult Blood Tests

Procedure code G0328 (with modifier QW) and 82270 may be reimbursed once per rolling year for clients who are 45 years of age and older.

MT-sDNA Test

Procedure code 81528 is considered for reimbursement once every three years for clients who are 45 years of age and older.

Sigmoidoscopies

Procedure code G0104 is considered for reimbursement once every five years for clients who are 45 years of age or older when submitted with one of the following diagnosis codes, as recommended by the ACS and USPSTF:

Diagnosis Codes							
Z0000	Z0001	Z1210	Z1211	Z1213	Z859	Z86002	Z86003
Z86004	Z86006	Z86007	Z860100	Z860102	Z860109		

Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

If a lesion or growth is detected that results in a biopsy or removal of the growth during a screening flexible sigmoidoscopy, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal must be reported.

Colonoscopies: Average Risk

Procedure code G0121 is considered for reimbursement once every ten rolling years for clients who are 45 years of age and older when submitted with diagnosis code Z0000, Z0001, Z1210, Z1211, or Z1213. Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

Colonoscopies: High-Risk

Procedure code G0105 is considered for reimbursement once every two years for clients who meet the definition of high-risk. Procedure code G0105 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K5010	K50111
K50112	K50113	K50114	K50118	K5080	K50811	K50812	K50813
K50814	K50818	K5090	K50911	K50912	K50913	K50914	K50918
K50919	K5120	K51211	K51212	K51213	K51214	K51218	K5130
K51311	K51312	K51313	K51314	K51318	K5180	K51811	K51812
K51813	K51814	K51818	K5190	K51911	K51912	K51913	K51914
K51918	K51919	K523	K5281	K5282	K52831	K52832	K52838
K52839	K5289	K529	Z800	Z83710	Z83711	Z83718	Z83719
Z8372	Z85038	Z85048	Z859	Z86002	Z86003	Z86004	Z86006
Z86007	Z860101						

9.2.15.1.2 Prior Authorization for Colorectal Cancer Screening

Prior authorization is not required for colorectal screening.

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9.2.15.1.3 Exclusions

Barium enemas for colorectal cancer screening are not a benefit of Texas Medicaid.

9.2.15.2 Genetic Testing for Colorectal Cancer

Genetic testing for colorectal cancer may be considered for reimbursement to independent laboratories with prior authorization.

Genetic testing may be provided to clients who have a known predisposition (i.e., having a first- or second-degree relative) for colorectal cancer. Results of the testing may indicate whether the client has an increased risk of developing colorectal cancer. A first-degree relative is defined as a sibling, parent, or offspring. A second-degree relative is defined as an uncle, aunt, grandparent, nephew, niece, or half-sibling.

Genetic test results, when informative, may influence clinical management decisions. Documentation in the medical record must reflect that the client or family members have been given information on the nature, inheritance, and implications of genetic disorders to help them make informed medical and personal decisions before the genetic testing.

Genetic testing for colorectal cancer may be considered for reimbursement with the following procedure codes:

Procedure Codes									
81201	81202	81203	81210	81233	81237	81275	81288	81292	81293
81294	81295	81296	81297	81298	81299	81300	81301	81317	81318
81319	81327								

Diagnosis code Z800 is acceptable as a diagnosis for the procedure codes in the table above. Prior authorization is still required and must be obtained for these services. Interpretation of gene mutation analysis results is not reimbursed separately. Interpretation is part of the physician E/M service.

The genetic testing for colorectal testing procedure codes in the table above are limited to once per lifetime for any procedure code by any provider. Testing is limited to once per lifetime for any procedure code by any provider, regardless of whether additional services are authorized.

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

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

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results.

The medical record is subject to retrospective review.

9.2.15.2.1 Testing for Familial Adenomatous Polyposis

Testing for familial adenomatous polyposis (procedure codes 81201, 81202, and 81203) may be offered to clients who have well-defined hereditary cancer syndromes and for whom a positive or negative result will change medical care. Testing for familial adenomatous polyposis may be considered for reimbursement with documentation of at least one of the following:

- The client has more than 20 polyps.
- The client has a first-degree relative with familial adenomatous polyposis and a documented mutation.

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- For clients who are 7 years of age and younger, 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.

9.2.15.2.2 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

Testing for HNPCC (procedure codes 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, and 81319) is used to determine whether a client has an increased risk of colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome. Results of the test may influence clinical management decisions. Testing for HNPCC may be considered for reimbursement with documentation of at least one of the following:

- The client has three or more family members, one of whom is a first-degree relative, with colorectal cancer; two successive generations are affected; one or more of the colorectal cancers was diagnosed before the family member was 50 years of age; and familial adenomatous polyposis has been ruled out for the client.
- The client has had two previous HNPCCs.
- The client has colorectal cancer and a first-degree relative who has one of the following:
  - Colorectal cancer or HNPCC extracolonic cancer at 50 years of age and younger
  - Colorectal adenoma at 40 years of age and younger
- The client has had colorectal cancer or endometrial cancer at 50 years of age and younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern of histology at 50 years of age and younger.
- The client has had signet-cell type colorectal cancer at 50 years of age and younger.
- The client has had a colorectal adenoma at 40 years of age and younger.
- The client is asymptomatic and has a first- or second-degree relative who has a documented HPNCC mutation.
- The client has a family history of malignant neoplasm in the gastrointestinal tract.
- For clients who are 20 years of age and younger, 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.

9.2.15.2.3 Prior Authorization for Genetic Testing for Colorectal Cancer

Prior authorization is required for genetic testing for colorectal cancer. A completed Special Medical Authorization Request Form must be signed, dated, and submitted by the ordering provider rendering direct care. Requests from laboratories will not be processed. The provider should then share the authorization number with the laboratory submitting the claim.

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

Medical documentation that is submitted by the physician must verify the client's diagnosis or family history. Requisition forms from the laboratory are not sufficient for verification of the personal and family history.

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To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity. The form may be faxed to 1-512-514-4213 or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12365-A Riata Trace Parkway
Austin, TX 78727-6418

A request for retroactive authorization must be submitted no later than 7 calendar days after the lab draw is performed. To facilitate a determination of medical necessity and avoid unnecessary denials, the ordering physician rendering care must provide correct and complete information, including the accurate medical necessity of the services requested.

9.2.15.3 Mammography (Screening and Diagnostic Studies of the Breast)

The following breast imaging studies are benefits of Texas Medicaid:

- Screening mammogram
- Diagnostic mammogram
- Diagnostic breast ultrasound

The American Cancer Society recommends that women discuss when to start breast cancer screening mammography with their provider beginning at 40 years of age.

By the age of 45 all women should begin annual breast cancer mammography screening.

By the age of 55 women may transition to screening with mammography every other year, or in some cases may continue annual screenings in consultation with their healthcare provider.

Digital breast tomosynthesis (DBT), also known as three-dimensional (3D) mammography, provides 3D images and is a modification of conventional mammography. Screening DBT is used, along with conventional screening mammography, to detect breast changes in women who have no signs or symptoms of breast cancer.

Diagnostic DBT is used, along with conventional diagnostic mammography, to diagnose breast disease in women or men who have breast symptoms or findings on physical examination or screening mammogram.

A screening mammogram may be billed using procedure code 77067.

Procedure code 77063 must be billed with primary procedure code 77067. Reimbursement may be considered for procedure code 77063 when performed on the same date of service, by any provider, as procedure code 77067.

Procedure codes 77063 and 77067 are limited to one per rolling year, any provider.

A diagnostic mammogram may be billed using procedure code 77065 or 77066.

Procedure code 77065 will be denied if it is submitted for the same date of service as procedure code 77066 by any provider.

Procedure code G0279 must be billed with primary procedure code 77065 or 77066. Reimbursement may be considered for procedure code G0279 when performed on the same date of service, by any provider, as procedure code 77065 or 77066.

Reimbursement may be considered for a screening mammogram (procedure code 77063 or 77067) performed on the same patient on the same date of service as a diagnostic mammogram (procedure code 77065, 77066, or G0279), by submitting the diagnostic mammography with the modifier GG.

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A mammogram may be indicated for a male client based on medical necessity due to existing signs and symptoms. In such rare circumstances, procedure codes 77065, 77066, and G0279 may be considered for reimbursement.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement using procedure code 76098, 77053, or 77054. Procedure code 77053 will be denied if it is submitted for the same date of service as procedure code 77054 by any provider. Procedure code 76098 may be reimbursed for both male and female clients.

Breast ultrasound may be considered for reimbursement using procedure code 76641 or 76642.

Authorization is not required for these services.

The prescribing physician must maintain documentation of medical necessity in the client's medical record.

The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician.

9.2.15.4 Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of Texas Medicaid when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.

Prognostic breast and gynecological cancer studies are divided into three categories: Receptor assays, Her-2/neu, and gene expression profiling.

- Receptor Assays (procedure codes 84233 and 84234) - The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and endometrial cancer.
- Her-2/neu (procedure codes 83950, 88237, 88239, 88271, 88274, 88291, 88341, 88342, 88344, 88360, 88361, 88364, 88365, 88366, 88367, 88368, 88369, 88373, 88374, and 88377) - Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The overexpression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.
- Gene expression profiling (procedure code 81518, 81519, and 81520) - Gene expression profiling analyzes the expression of a panel of genes to predict the likelihood of breast cancer recurrence in clients with newly diagnosed early-stage invasive breast cancer.

Reimbursement for procedure codes 88360 and 88361 is limited to claims with a diagnosis of breast or uterine cancer as listed in the following table:

Diagnosis Codes							
C50011	C50012	C50021	C50022	C50111	C50112	C50121	C50122
C50211	C50212	C50221	C50222	C50311	C50312	C50321	C50322
C50411	C50412	C50421	C50422	C50511	C50512	C50521	C50522
C50611	C50612	C50621	C50622	C50811	C50812	C50821	C50822
C50921	C50922	C50A0	C50A1	C50A2	C540	C541	C542
C543	C548	C792	C7981	D0501	D0502	D0511	D0512

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Diagnosis Codes							
D0581	D0582						

Testing for other diagnoses will be denied.

Interpretation of receptor assays, and Her-2/neu results is not considered separately for reimbursement. Interpretation is part of the physician's E/M service.

Gene expression profiling (procedure code 81518, 81519, and 81520) is a benefit when all of the following criteria are met:

- The test is ordered by an oncologist.
- The client has newly diagnosed breast cancer. ("Newly diagnosed" means that not more than six months have elapsed since the initial diagnosis.)
- There is no evidence of metastatic breast cancer.

Procedure code 81519 is a benefit when all the following additional criteria are met:

- The clinical stage of the breast cancer is I, II, or IIIa, and the cancer has not spread to more than three lymph nodes.
- The primary tumor is estrogen receptor positive and Her-2/neu receptor negative, or the primary tumor is Her-2/neu receptor positive and less than 1 cm in diameter.
- The client is a candidate for adjuvant chemotherapy.
- The outcome of the test will guide decision-making regarding adjuvant chemotherapy.

Procedure code 81520 is a benefit when all the following additional criteria are met:

- The clinical stage of the breast cancer is I or II, and the cancer has not spread to more than three lymph nodes.
- The primary tumor is hormone receptor positive.
- The client is female and post-menopausal.

Procedure code 81518 is a benefit when all the following additional criteria are met:

- The clinical stage of breast cancer is I, II, or IIIa in cases where the cancer has not spread to more than three lymph nodes.
- The primary tumor is estrogen receptor or progesterone receptor positive.
- The cancer cells are Her-2/neu receptor negative.
- Adjuvant therapy is not precluded due to any other factor (e.g., advanced age or significant comorbidities).
- Before Breast Cancer Index (BCI) testing, the client and provider have discussed the potential results of the test and agree to use the results to guide therapy.

Procedure code 81518 may be reimbursed once per lifetime, any procedure, any provider, when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50111	C50112	C50211	C50212	C50311	C50312
C50411	C50412	C50511	C50512	C50611	C50612	C50811	C50812
C50911	C50912	C50A0	C50A1	C50A2	D0501	D0502	D0511
D0512	D0581	D0582	Z170	Z1721	Z1731	Z1732	Z17410

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Diagnosis Codes							
Z17411							

Procedure code 81519 may be reimbursed once per lifetime, any procedure, any provider, when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50021	C50022	C50111	C50112	C50121	C50122
C50211	C50212	C50221	C50222	C50311	C50312	C50321	C50322
C50411	C50412	C50421	C50422	C50511	C50512	C50521	C50522
C50611	C50612	C50621	C50622	C50811	C50812	C50821	C50822
C50911	C50912	C50921	C50922	D0501	D0502	D0511	D0512
D0581	D0582	Z170	Z1721	Z1731	Z1732	Z17410	Z17411

Procedure code 81520 may be reimbursed once per lifetime, any procedure, any provider, when submitted with one of the following diagnosis codes:

Diagnosis Codes							
C50011	C50012	C50111	C50112	C50211	C50212	C50311	C50312
C50411	C50412	C50511	C50512	C50611	C50612	C50811	C50812
C50911	C50912	D0501	D0502	D0511	D0512	D0581	D0582
Z170							

Gene expression profiling is limited to once per lifetime, but may be considered for reimbursement more than once per lifetime for the same client on appeal. The provider must submit documentation that demonstrates that the client has a new, second, primary breast cancer diagnosis that meets the criteria described above.

The provider must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service.

Gene expression profiling is not covered for repeat testing or testing of multiple tumor sites in the same client.

9.2.16 Capsulotomy

A capsulotomy is a benefit when not performed with a joint surgery.

9.2.17 Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. Cardiac rehabilitation programs must include all of the following:

- Physician-prescribed exercise for each day on which cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to a client's individual needs
- Psychosocial assessment
- Outcomes assessment

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- An individual treatment plan that specifies how components are used for a client and that is reviewed and signed by the prescribing physician every 30 days

Cardiac rehabilitation procedure codes 93797 and 93798 are benefits of Texas Medicaid.

The appropriate procedure code must be billed with one of the following diagnosis codes:

Diagnosis Codes							
I110	I160	I161	I169	I201	I202	I2081	I2089
I209	I2101	I2102	I2109	I2111	I2119	I2121	I2129
I213	I214	I219	I21A1	I21A9	I21B	I220	I221
I222	I228	I229	I2720	I2721	I2722	I2723	I2724
I2729	I2783	I501	I5020	I5021	I5022	I5023	I5030
I5031	I5032	I5033	I5040	I5041	I5042	I5043	I50810
I50811	I50812	I50813	I50814	I5082	I5083	I5084	I5089
I509	I5A	Z941	Z943	Z951	Z952	Z953	Z954
Z955	Z9861	Z98890					

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients for whom there is documentation of any of the following conditions within the 12 months immediately preceding the beginning of the program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: *A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms (ECGs) to a remote site is not a benefit of Texas Medicaid.*

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use.

Cardiac rehabilitation is limited to 2 one-hour sessions per day for 18 weeks per rolling year and can not exceed 36 sessions.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the client has another documented cardiac event or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. To confirm that a continuation of cardiac rehabilitation is at the request of or is coordinated with the prescribing physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and the prescribing physician. If the physician responsible for such follow-up is the medical director, then the physician's notes must be evident in each client's chart.

Additional cardiac rehabilitation sessions must be prior authorized and must not exceed a total of 36 sessions for 52 weeks from the date of authorization of additional sessions.

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If no clinically-significant arrhythmia is documented during the first three weeks of the program, the physician may give the order for the client to complete the remaining portion of the cardiac rehabilitation without telemetry monitoring.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program that is conducted by personnel who are not physicians but are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease and who provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs.

9.2.17.1 Prior Authorization for Cardiac Rehabilitation

Prior authorization is not required for the initial 36 sessions of cardiac rehabilitation.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions in the following circumstances:

- The medical record must support the client has had another cardiac event; or
- The prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Documentation must include the following:
  - Progress made from the beginning of cardiac rehabilitation period to the current service request date, including progress towards previous goals.
  - Information that supports the client's capability of continued measurable progress.
  - A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs.

Requests for prior authorization for additional sessions that exceed a total of 36 sessions in 52 weeks will not be granted. Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department.

9.2.17.2 Reimbursement

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be billed with modifier 25 appended to the E/M code when a separately identifiable E/M service was provided on the same day by the provider that rendered cardiac rehabilitation. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Physical and occupational therapy will not be reimbursed when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition that requires such therapy, e.g., a client who is recuperating from an acute phase of heart disease and may have had a stroke that requires physical and/or occupational therapy.

Client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity, that help a client adjust living habits because of the cardiac condition; will not be separately reimbursed when the services are provided as part of the cardiac rehabilitation program.

9.2.18 Casting, Splinting, and Strapping

Casting, splinting, and strapping are subject to global surgery fee guidelines. The following procedure codes for casting, splinting, and strapping are a benefit of Texas Medicaid:

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Procedure Codes									
29000	29010	29015	29035	29040	29044	29046	29049	29055	29058
29065	29075	29085	29086	29105	29125	29126	29130	29131	29200
29240	29260	29280	29305	29325	29345	29355	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29520	29530	29540
29550	29580	29799							

The following procedure codes for cast removal, windowing, wedging, or repair may be reimbursed to a provider other than the provider who applied the initial cast, splint, or strap:

Procedure Codes									
29700	29705	29710	29720	29730	29740	29750	29799		

Authorization is not required for casting, splinting, or strapping services.

9.2.19 Cardiopulmonary Resuscitation (CPR)

CPR (procedure code 92950) is a benefit of Texas Medicaid and may be reimbursed when medical necessity is documented in the client's medical record. Only the primary provider performing CPR may be reimbursed for procedure code 92950. CPR billed as an ambulance service by an ambulance provider will be denied.

CPR may be billed with the same date of service as critical care when reported as a separately identifiable procedure. The time spent performing CPR must not be included in the time reported as critical care.

9.2.20 Circumcisions

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54161. Circumcisions performed on clients who are 1 year of age and older must be documented with medical necessity.

Refer to: Subsection 9.2.47.1, "Circumcisions for Newborns" in this handbook for additional benefit information.

9.2.21 Closure of Wounds

The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures.

Wound closures may use sutures, staples, or tissue adhesives. Wounds closed with adhesive strips must not be reported using wound closure procedure codes. When adhesive strips are the only wound closure material used, providers must report the most appropriate E/M visit procedure code on their claim.

Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is considered inclusive to the wound closure and will not be reimbursed separately.

The lengths of multiple closures of wounds must be added together and billed as one procedure code if they meet at least one of the following criteria:

- The closures have the same CPT classification (see "Repair [Closure]" in the CPT manual).
- The closures are in anatomic sites that are grouped together in the same procedure code descriptor.

Providers must submit the procedure code that represents the total length of the repairs. Lengths of repairs from different CPT classifications or groupings of anatomic sites must be billed as separate procedure codes.

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Wound closures must be billed using the following procedure codes:

Procedure Codes									
Repair Simple									
12001	12002	12004	12005	12006	12007	12011	12013	12014	12015
12016	12017	12018	12020	12021					
Repair Intermediate									
12031	12032	12034	12035	12036	12037	12041	12042	12044	12045
12046	12047	12051	12052	12053	12054	12055	12056	12057	
Repair Complex									
13100	13101	13102	13120	13121	13122	13131	13132	13133	13151
13152	13153	13160							

Multiple wounds on the same day will be paid the full allowed amount for the major (largest total length of the repair at the same anatomic site) wound and one-half the allowed amount for each additional laceration (total length of the repair at the same anatomic site).

No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

When the debridement is carried out separately without immediate primary closure, when gross contamination requires prolonged cleansing, or when large amounts of devitalized or contaminated tissue are removed, debridement may be reimbursed separately. Debridement rendered during the same surgical session as wound closure is considered inclusive to the closure and is not reimbursed separately.

Refer to: Subsection 9.2.74.11, "Supplies, Trays, and Drugs" in this handbook for the hospital-based emergency department.

Wound suture and wound closure are considered part of any surgical procedure performed on the same area, except for excision of benign or malignant lesion procedure codes that require more than simple closure. Providers may be reimbursed for the appropriate intermediate or complex closure procedure code. Multiple surgery guidelines apply.

The exceptions listed above apply to the following excision and closure procedure codes:

Excision of Benign Lesion Procedure Code									
11400	11401	11402	11403	11404	11406	11420	11421	11422	11423
11424	11426	11440	11441	11442	11443	11444	11446		

Excision of Malignant Lesion Procedure Codes									
11600	11601	11602	11603	11604	11606	11620	11621	11622	11623
11624	11626	11640	11641	11642	11643	11644	11646		

Intermediate Closure Procedure Codes									
12031	12032	12034	12035	12036	12037	12041	12042	12044	12045
12046	12047	12051	12052	12053	12054	12055	12056	12057	

Complex Closure Procedure Codes									
13100	13101	13102	13120	13121	13122	13131	13132	13133	13151

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Complex Closure Procedure Codes									
13152	13153	13160							

9.2.22 Cochlear Implants

Cochlear implants, when medically indicated, are benefits of Texas Medicaid with prior authorization. A cochlear implant device (procedure code 69930) is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multichannel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

Refer to: Subsection 3.2.1, "Cochlear Implants" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on benefit and authorization requirements for cochlear implants.

9.2.23 Colon Capsule Endoscopy

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

Diagnosis Codes					
K635	K921	K922	R195	Z5309	Z538

9.2.24 Continuous Glucose Monitoring (CGM)

CGM (procedure codes 95250 and 95251) is a benefit of Texas Medicaid with prior authorization.

Procedure codes 95250 and 95251 are limited to once per 12 calendar months by any provider.

The rental or purchase of a continuous glucose monitoring system (CGMS) is considered part of the CGM and is not reimbursed separately.

9.2.24.1 Prior Authorization for Continuous Glucose Monitoring

CGM requires prior authorization and must be prescribed by the client's treating practitioner performing the glucose monitoring.

Prior authorization will be considered for clients who have diabetes mellitus. The client must be compliant with his or her current medical regimen, use multiple daily insulin administrations or be on an insulin pump, have documentation of medical necessity, and have a provider statement in the medical record that they have a history of performing daily self blood glucose monitoring. For all diabetic clients who are not using insulin, at least one or more of the following conditions must be present:

- Frequent problematic hypoglycemic episodes
- Unexplained large fluctuations in daily, preprandial blood glucose
- Episodes of ketoacidosis or hospitalization for uncontrolled glucose

Additional CGM services may be considered with documentation of medical necessity that indicates the client meets the criteria above and has a change in condition that would warrant a second procedure within 12 calendar months.

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

Note: *The submission of daily blood glucose logs is not required for prior authorization.*

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9.2.25 Developmental Screening and Testing and Aphasia Assessment

The following types of developmental screening and testing and aphasia assessment are benefits of Texas Medicaid when medically necessary:

- Developmental screening when performed outside of a Texas Health Steps (THSteps) medical checkup (procedure code 96110)
- Developmental testing (procedure codes 96112 and 96113 [add-on procedure code must be submitted with primary procedure code 96112])
- Assessment of aphasia (procedure code 96105)

Re-evaluations are a benefit of Texas Medicaid only to address a clinical need, to provide the documentation needed to measure a client's status over time, and to direct the plan of care.

Procedure codes 96105, 96110, 96112, and 96113 are used to report medically necessary aphasia assessment, developmental screening, and testing.

Prior authorization is not required for developmental screening, developmental testing, and aphasia assessment.

9.2.25.1 Developmental Screening

Developmental screening requiring the use of a standardized, validated screening tool (procedure code 96110) is a benefit of Texas Medicaid for clients who are birth through 6 years of age.

Developmental screening is limited to once per rolling year, any provider, outside of a THSteps medical checkup when medically necessary. This screening should only be completed for a diagnosis of suspected developmental delay or to evaluate a change in the client's developmental status outside of a THSteps medical checkup.

Developmental screening should be used to identify clients who are birth through 6 years of age and who may need a more comprehensive evaluation. Results of developmental screening may guide or identify the need for further testing. Clients with abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age who have suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) within 7 days after the child has been identified.

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on the Texas ECI program.

Subsection 4.3.12.1.2, "Developmental Surveillance or Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information on developmental screening for THSteps checkups.

9.2.25.2 Developmental Testing

Developmental testing (procedure codes 96112 and 96113) is a benefit of Texas Medicaid for clients who are birth through 20 years of age.

Developmental testing consists of an extended evaluation and requires the use of a standardized norm-referenced tool. Developmental testing is medically necessary when there is suspected developmental delay supported by clinical evidence. Developmental testing is only medically indicated when clinical evidence suggests the following:

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

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Procedure codes 96112 and 96113 are limited to two services per rolling year, any provider.

Developmental testing performed when a development delay or a change in the client's developmental status is not suspected is not a benefit of Texas Medicaid.

Developmental testing is not a benefit when completed for the purposes of entering day care, Head Start, or a school setting.

Providers cannot bill the client for developmental testing that better fits the description of developmental screening.

The physician must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service. The following information is required at least every six months to establish medical necessity:

- The physician's prescription that includes a description of the specific service being prescribed
- The treatment plan that includes a copy of the current evaluation and documented age of the child at the time of the evaluation

9.2.25.3 Assessment of Aphasia

Aphasia assessment (procedure code 96105) is a benefit of Texas Medicaid when medically necessary and is limited to the following diagnosis codes:

Diagnosis codes				
R4701	R4702	R471	R4781	R4789

Procedure code 96105 is limited to two services per rolling year, any provider.

9.2.25.4 12-Hour Limitation for Procedure Codes 96110, 96112, and 96113

APRNs, PAs, and psychologists are limited to a maximum, combined total of 12 hours per day for developmental screening and testing, and inpatient and outpatient mental health services.

Because physicians (M.D. and D.O.) can delegate and may submit claims for services in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Developmental screening and testing are included in the 12-hour per day, per provider, system limitation. The following table lists the procedure codes that are included in the 12-hour per day system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

Procedure Code	Time Applied by System
96110	30 Minutes
96112	60 Minutes
96113	30 minutes

Refer to: Subsection 4.5, "Twelve Hour System Limitation" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about procedure codes included in the 12-hour system limitation.

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All providers, including physicians and all providers to whom they delegate services, are subject to retrospective review. HHSC and TMHP routinely perform retrospective reviews of all providers. All providers are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day. Retrospective review may include:

- All E/M procedure codes, including those listed in the Evaluation and Management Section of the *CPT Manual,* billed with a diagnosis listed in the diagnosis table above under Neurobehavioral Testing
- All developmental screening and testing procedure codes included in the 12-hour system limitation

Note: *Developmental screening and testing procedure codes and mental health procedure codes are included in the review. If a provider provides developmental and neurological assessment and testing at more than one location, any of these services may be retrospectively reviewed.*

9.2.26 Diagnostic Tests

9.2.26.1 Blood Pressure Monitoring

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

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring may also be used for the following:

- Clients who are under treatment for established hypertension
- Evaluating refractory or treatment-resistant blood pressure
- Evaluating symptoms such as light-headedness corresponding with blood pressure changes
- Evaluating nighttime blood pressure
- Examining diurnal patterns of blood pressure

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for the evaluation of one of the following conditions:

- White coat hypertension, which is defined as the following:
  - Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
  - At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
  - There is no evidence of end-organ damage.
- Resistant hypertension
- Hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Syncope

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for initial diagnosis of hypertension and should not be used for maintenance monitoring.

Self-measured blood pressure monitoring may also be indicated for re-evaluation of clients previously diagnosed with hypertension.

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

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

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

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

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

Use procedure codes 93784, 93786, 93788, and/or 93790 to bill in 24-hour increments for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is limited to two services per lifetime, any provider. Ambulatory blood pressure monitoring performed more than twice per lifetime may be considered when documentation of medical necessity is submitted with the claim.

9.2.26.2 Ambulatory and Long-Term Electroencephalogram (Ambulatory EEG)

Ambulatory EEG monitoring is a covered benefit for clients in whom a seizure diathesis is suspected but not defined by history, physical, and resting EEG.

The EEG technical component procedure codes are limited to 3 studies for each physician for the same client per 6 months when medically necessary.

The following procedure codes should be submitted when billing for the EEG technical component:

Procedure Codes									
95705	95706	95707	95708	95709	95710	95711	95712	95713	95714
95715	95716								

Procedure code 95700 will be limited to three units per six months for each physician for the same client.

Professional component procedure codes are limited to three studies per six months for each physician for the same client, when medically necessary.

Technical component procedure codes are limited to three studies per six months for each physician for the same client, when medically necessary.

Note: A study includes one unit of procedure code 95700 (set-up, education, and takedown) and any appropriate combination of the corresponding technical and professional procedure codes.

The following procedure codes should be submitted when billing for the EEG professional component:

Procedure Codes									
95717	95718	95719	95720	95721	95722	95723	95724	95725	95726

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The procedure codes in the tables above may be reimbursed when they are submitted with the following diagnosis codes:

Diagnosis Codes							
F05	F060	F068	G253	G3101	G3109	G3183	G40001
G40009	G40011	G40019	G40101	G40109	G40111	G40119	G40201
G40209	G40211	G40219	G40301	G40309	G40311	G40319	G40401
G40409	G40411	G40419	G40501	G40509	G40801	G40802	G40803
G40804	G40811	G40812	G40813	G40814	G40841	G40842	G40843
G40844	G4089	G40901	G40909	G40911	G40919	G40A11	G40A19
G40B01	G40B09	G40B11	G40B19	G40C01	G40C09	G40C11	G40C19
G912	O99351	O99352	O99353	O99354	O99355	P90	P912
R410	R4182	R5601	R561	R569	S060X1A	S060X1D	S060X1S
S060XAA	S060XAD	S060XAS	Z052				

Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

9.2.26.3 Bone Marrow Aspiration, Biopsy

Physicians may bill procedure code 85097 if interpretation is for smear interpretation, or procedure code 88305 if interpretation is for preparation and interpretation of cell block. If both procedure codes 85097 and 88305 are billed, procedure code 88305 is paid and procedure code 85097 is denied.

Physicians may bill procedure code 85097 or 88305 for preparation and interpretation of the specimen.

9.2.26.4 Cytopathology Studies—Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client's E/M and will not be reimbursed separately.

Procedure codes 88160, 88161, and 88162 are reimbursed according to the POS where the cytopathology smear is interpreted.

Procedure code 88177 is limited to three services per day by the same provider.

9.2.26.5 Echoencephalography

Echoencephalography (procedure code 76506) is medically indicated for the following conditions or diagnosis codes:

Diagnosis Codes							
A066	A170	A171	A1781	A1782	A1789	C410	C6961
C6962	C700	C710	C711	C712	C713	C714	C715
C716	C717	C718	C719	C7221	C7222	C7231	C7232
C7241	C7242	C7259	C729	C751	C752	C768	C7931
C7932	C7940	C7949	C7951	C7952	C7989	D075	D098
D164	D3161	D3162	D320	D329	D330	D331	D332
D333	D3500	D3501	D3502	D420	D421	D429	D432
D433	D434	D438	D439	D47Z1	D47Z2	D480	D487
D492	D496	D497	F0390	F03911	F03918	F0392	F0393
F0394	G060	G062	G07	G08	G132	G138	G232

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Diagnosis Codes							
G233	G300	G301	G308	G309	G3101	G3109	G311
G312	G3180	G3183	G3184	G3185	G3186	G3187	G3189
G319	G910	G911	G912	G930	G932	G9340	G9341
G9342	G9343	G9344	G9345	G9349	G935	G936	G937
G9381	G9389	G939	G94	G988	G998	H35361	H4600
H4601	H4602	H4603	H4610	H4611	H4612	H4613	H462
H463	H468	H469	H47011	H47012	H47013	H47019	H47021
H47022	H47023	H47029	H47031	H47032	H47033	H47039	H47091
H47092	H47093	H47099	H4710	H4711	H4712	H4713	H47141
H47142	H47143	H47149	H4720	H47211	H47212	H47213	H47219
H4722	H47231	H47232	H47233	H47239	H47291	H47292	H47293
H47299	H47311	H47312	H47313	H47319	H47321	H47322	H47323
H47329	H47331	H47332	H47333	H47339	H47391	H47392	H47393
H47399	H4741	H4742	H4743	H4749	H47511	H47512	H47519
H47521	H47522	H47529	H47531	H47532	H47539	H47611	H47612
H47619	H47621	H47622	H47629	H47631	H47632	H47639	H47641
H47642	H47649	I6000	I6001	I6002	I6010	I6011	I6012
I602	I6030	I6031	I6032	I604	I6050	I6051	I6052
I606	I607	I608	I609	I610	I611	I612	I613
I614	I615	I616	I618	I619	I6200	I6201	I6202
I6203	I621	I629	I6330	I63311	I63312	I63319	I63321
I63322	I63323	I63333	I63329	I63331	I63332	I63339	I6339
I6340	I63411	I63412	I63419	I63421	I63422	I63429	I63431
I63432	I63439	I6349	I6350	I63511	I63512	I63513	I63519
I63521	I63522	I63523	I63529	I63531	I63532	I63533	I63539
I63543	I6381	I6389	I6601	I6602	I6603	I6609	I6611
I6612	I6613	I6619	I6621	I6622	I6623	I6629	I668
I669	I671	I6781	I6782	I6783	I67850	I67858	I6789
I680	I69098	I6921	I69210	I69211	I69212	I69213	I69214
I69215	I69218	I69219	I69220	I69221	I69222	I69223	I69269
I69290	I69291	I69292	I69293	I69298	O99411	O99412	O99413
O99419	O9942	O9943	P0082	P0700	P0701	P0702	P0703
P0710	P0714	P0715	P0716	P0717	P100	P101	P102
P103	P104	P108	P109	P112	P119	P120	P121
P122	P123	P124	P1281	P1289	P129	P150	P151
P152	P153	P154	P155	P156	P158	P352	P370
P371	P372	P373	P374	P378	P520	P521	P5221
P5222	P523	P524	P525	P526	P528	P529	P90
P912	P91811	P91819	P91821	P91822	P91823	P91829	P9188
Q010	Q011	Q012	Q018	Q02	Q030	Q031	Q038

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Diagnosis Codes							
Q040	Q041	Q042	Q045	Q046	Q048	Q050	Q051
Q052	Q054	Q0701	Q0702	Q0703	Q282	Q283	R220
R221	R5600	R569	S0190XA	S0190XD	S0190XS	S060X0A	S060X0D
S060X0S	S060X1A	S060X1D	S060X1S	S060X9A	S060X9D	S060X9S	S060XAA
S060XAD	S060XAS	S061X0A	S061X0D	S061X0S	S061X1A	S061X1D	S061X1S
S061X2A	S061X2D	S061X2S	S061X3A	S061X3D	S061X3S	S061X4A	S061X4D
S061X4S	S061X5A	S061X5D	S061X5S	S061X6A	S061X6D	S061X6S	S061X7A
S061X8A	S061X9A	S061X9D	S061X9S	S061XAA	S061XAD	S061XAS	S06305A
S06305D	S06305S	S06306A	S06306D	S06306S	S06307A	S06308A	S0630AA
S0630AD	S0630AS	S06310A	S06310D	S06310S	S06311A	S06311D	S06311S
S06312A	S06312D	S06312S	S06313A	S06313D	S06313S	S06314A	S06314D
S06314S	S06315A	S06315D	S06315S	S06316A	S06316D	S06316S	S06317A
S06318A	S06319A	S06319D	S06319S	S0631AA	S0631AD	S0631AS	S06320A
S06320D	S06320S	S06321A	S06321D	S06321S	S06322A	S06322D	S06322S
S06323A	S06323D	S06323S	S06324A	S06324D	S06324S	S06325A	S06325D
S06325S	S06326A	S06326D	S06326S	S06327A	S06328A	S06329A	S06329D
S06329S	S0632AA	S0632AD	S0632AS	S06330A	S06330D	S06330S	S06331A
S06331D	S06331S	S06332A	S06332D	S06332S	S06333A	S06333D	S06333S
S06334A	S06334D	S06334S	S06335A	S06335D	S06335S	S06336A	S06336D
S06336S	S06337A	S06338A	S06339A	S06339D	S06339S	S0633AA	S0633AD
S0633AS	S06340A	S06340D	S06340S	S06341A	S06341D	S06341S	S06342A
S06342D	S06342S	S06343A	S06343D	S06343S	S06344A	S06344D	S06344S
S06345A	S06345D	S06345S	S06346A	S06346D	S06346S	S06347A	S06348A
S06349A	S06349D	S06349S	S0634AA	S0634AD	S0634AS	S06350A	S06350D
S06350S	S06351A	S06351D	S06351S	S06352A	S06352D	S06352S	S06353A
S06353D	S06353S	S06354A	S06354D	S06354S	S06355A	S06355D	S06355S
S06356A	S06356D	S06356S	S06357A	S06358A	S06359A	S06359D	S06359S
S0635AA	S0635AD	S0635AS	S06360A	S06360D	S06360S	S06361A	S06361D
S06361S	S06362A	S06362D	S06362S	S06363A	S06363D	S06363S	S06364A
S06364D	S06364S	S06365A	S06365D	S06365S	S06366A	S06366D	S06366S
S06367A	S06368A	S06369A	S06369D	S06369S	S0636AA	S0636AD	S0636AS
S06370A	S06370D	S06370S	S06371A	S06371D	S06371S	S06372A	S06372D
S06372S	S06373A	S06373D	S06373S	S06374A	S06374D	S06374S	S06375A
S06375D	S06375S	S06376A	S06376D	S06376S	S06377A	S06378A	S06379A
S06379D	S06379S	S0637AA	S0637AD	S0637AS	S06380A	S06380D	S06380S
S06381A	S06381D	S06381S	S06382A	S06382D	S06382S	S06383A	S06383D
S06383S	S06384A	S06384D	S06384S	S06385A	S06385D	S06385S	S06386A
S06386D	S06386S	S06387A	S06388A	S06389A	S06389D	S06389S	S0638AA
S0638AD	S0638AS	S064X0A	S064X0D	S064X0S	S064X1A	S064X1D	S064X1S
S064X2A	S064X2D	S064X2S	S064X3A	S064X3D	S064X3S	S064X4A	S064X4D

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

9.2.26.6 Electrocardiogram (ECG)

Electrocardiograms (ECG) are a benefit of Texas Medicaid when used for the evaluation and management (E/M) of a confirmed or suspected primary disease of the heart, pericardium, and coronary arteries or when necessary for management of diseases that are not primarily cardiac, but can affect the heart directly or indirectly.

ECGs are limited to six treatments for each client, by any provider per benefit period.

For ECGs, a benefit period is defined as 12 consecutive months, beginning with the month the client receives the first ECG.

The following procedure codes may be reimbursed for ECGs: 93000, 93005, 93010, 93040, 93041, and 93042.

Claims that are denied for exceeding the six-ECG limitation may be appealed with documentation supporting medical necessity. The documentation must include the following:

- Diagnosis
- Treatment history
- Documentation of why additional ECGs are needed

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The report of the professional component (the interpretation) for the ECG must be a complete written report that includes relevant findings and appropriate comparisons.

The interpretation may appear on the actual tracing.

When the ECG is performed in conjunction with the performance of an evaluation and management (E/M) service, the interpretation may appear with a progress note or other report of the E/M service; however, if the ECG is billed as a separate service from the E/M service, the interpretation should contain the same information as a report made upon the tracing itself.

A simple notation of "ECG/EKG normal" without an accompanying tracing will not suffice as documentation of a separately payable interpretation.

Appropriate documentation, which includes a copy of the ECG tracing, must be kept in the client's medical record. Documentation must support the medical necessity of the ECG. Documentation may appear on the actual tracing or with a progress note or report. Documentation is subject to retrospective review.

Only an ECG interpretation that directly contributes to the diagnosis and treatment of a client may be considered for reimbursement. Services, such as routine admission ECGs performed without medical indications, that do not directly contribute to the diagnosis and treatment of an individual client are not considered medically necessary.

9.2.26.6.1 Prior Authorization for ECG

Prior authorization is not required for ECGs performed in the emergency room or inpatient hospital setting.

Prior authorization is required for more than six ECGs in a rolling 12-month period.

Requests for additional ECGs must be submitted on the Special Medical Prior Authorization (SMPA) Request Form along with documentation of medical necessity.

Providers may request a prior authorization up to 12 months in advance. When requesting retroactive authorization, a provider must submit the request no later than 14 calendar days after the ECG is completed.

Before submitting a prior authorization request for an ECG, a provider must have a completed SMPA Request Form that has been signed and dated by a physician who is familiar with the client. The completed SMPA Request Form must include the procedure codes and numerical quantities for the services requested. The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

The SMPA Request Form must include all of the following information, which is related to medical necessity:

- Procedure requested (CPT)
- Diagnosis
- Treatment history
- Treatment plan

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Prior authorization requests submitted by paper, must be faxed or mailed with the completed SMPA Request Form to the SMPA department and a copy of the signed and dated form must be retained in the client's medical record at the provider's place of business. Requests may be faxed or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

9.2.26.7 Esophageal pH Probe Monitoring

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

Esophageal pH probe monitoring should be coded with procedure codes 91034, 91035, and 78262.

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) are limited to two services per rolling year, same procedure, any provider.

Claims that are denied for exceeding two services per rolling year may be considered on appeal with documentation of one of the following:

- The client is new and the provider has been unsuccessful in obtaining the client's previous records from a different provider.
- The provider is not aware that the client received previous esophageal testing.

Only one appeal will be considered per client, for the same provider. Providers must request prior authorization for any additional esophageal testing performed after the appealed service.

9.2.26.7.1 Prior Authorization

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) require prior authorization for services that exceed two per rolling year.

Requests for additional testing may be considered when submitted with documentation of medical necessity that supports, but is not limited to, the following:

- Adult's unintentional weight loss is more than 5 percent of their normal body weight in a span of 12 months or less
- Child's weight loss is 3 to 5 percent of their body mass in less than 30 days
- Symptoms of gastroesophageal reflux disease (GERD) that include heartburn and regurgitation that do not respond to treatment with medication
- Atypical symptoms of GERD, such as chest pain, coughing, wheezing, hoarseness, and sore throat

Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The completed prior authorization request form must be maintained by the requesting provider and the prescribing physician. The original, signed copy must be kept by the physician in the client's medical record.

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9.2.26.8 Helicobacter Pylori (H. pylori)

Initial testing for H. pylori may be performed using the following tests:

- Serology testing (procedure codes 83009 and 86677)
- Stool testing (procedure code 87338 with modifier QW)
- Breath testing (procedure codes 78267, 78268, 83013, and 83014)
- Amplified probe technique (procedure code 87513)

Serology testing for H. pylori is a noninvasive diagnostic procedure that is preferred for initial diagnosis but is not indicated after a diagnosis has been made. Serology testing is not indicated or covered for monitoring a response to therapy.

Procedure codes 83009 and 86677 are allowed once per lifetime when submitted by any provider. A second test may be considered on appeal with documentation that indicates the original test result was negative for H. pylori.

Procedure code 87513 is limited to two services per 28 days, any provider.

Urea breath tests (UBTs) and fecal antigen tests provide reliable means of identifying active H. pylori infection before antibiotic therapy. UBTs are the most reliable non-endoscopic test to document eradication of H. pylori infection.

H. pylori is accepted as an etiologic factor in duodenal ulcers, peptic ulcer disease, gastric carcinoma, and primary B cell gastric lymphoma. H. pylori testing may be indicated for symptomatic clients who have a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. The history must delineate the failed conservative treatment for the condition.

H. pylori testing is not indicated or covered for any of the following:

- New onset uncomplicated dyspepsia.
- New onset dyspepsia responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAID] and/or use of antisecretory agents). If the treatment does not prove successful in eliminating the symptoms, further testing may be indicated to determine the presence of H. pylori.
- Screening for H. pylori in asymptomatic clients.
- Dyspeptic clients requiring endoscopy and biopsy.

H. pylori testing is not indicated under the following circumstances:

- There has been a negative endoscopy in the previous 90 days.
- An endoscopy is planned.
- H. pylori is of new onset and still being treated.

H. pylori testing will be denied if it is performed within 90 days of an upper gastrointestinal endoscopy. Procedure codes 87338 (with modifier QW), 78267, 78268, 83013, and 83014 may be reimbursed within the 90 days if the provider submits documentation that indicates the client was tested for eradication after treatment.

If a follow-up breath or stool test is used to document eradication of H. pylori, the medical record documentation must verify the history of the following previous complication(s):

- The client remains symptomatic after a treatment regimen for H. pylori.
- The client is asymptomatic after H. pylori eradication therapy but has a history of hemorrhage, perforation, or outlet obstruction from peptic ulcer disease.
- The client has a history of ulcer on chronic NSAID or anticoagulant therapy.

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Testing for H. pylori eradication after the completion of antibiotic therapy (procedure codes 87338 [with modifier QW], 78267, 78268, 83013, and 83014) will be denied if billed less than 35 days after the initial test.

Procedure code 87339 is not a benefit of Texas Medicaid.

9.2.26.9 Myocardial Perfusion Imaging

Refer to: Subsection 4.2.1, "Cardiac Nuclear Imaging" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.26.10 Pediatric Pneumogram

A pediatric pneumogram (procedure code 94772) is a 12-hour to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

The following diagnosis codes may be reimbursed for a pediatric pneumogram in infants from birth through 11 months of age:

Diagnosis Codes							
K200	K2080	K2081	K2090	K2091	K2100	K2101	K219
K220	P0082	P220	P228	P270	P271	P278	P282
P2830	P2831	P2832	P2833	P2839	P2840	P2841	P2842
P2843	P2849	P285	P2881	P2889	P84	R0600	R0609
R0681	R0682	R0683	R0689	R6813			

A pediatric pneumogram is limited to two services per lifetime without prior authorization when submitted with one of the diagnosis codes listed above. Additional studies may be considered under CCP with documentation of medical necessity, and will require prior authorization.

Refer to: Section 2, "Medicaid Children's Services Comprehensive Care Program (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms are reimbursed on the same day as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component and are denied if billed separately.

9.2.27 Diagnostic Doppler Sonography

Diagnostic Doppler sonography is a benefit of Texas Medicaid when treatment decisions depend on the results. Authorization is not required for diagnostic Doppler services.

Doppler sonography uses a transducer that transmits and receives the returned sound waves as vibrations. The transducer turns the vibrations into electrical pulses that travel to the ultrasonic scanner where they are processed and transformed into a digital image. It is used to study blood flow throughout the body.

A vascular diagnostic study may be personally performed by a physician or by a technologist. The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and physician performing and interpreting the study. Consequently, the physician who performs and/or interprets the study must be able to document training through recent residency training or post-graduate continuing medical education and experience and must maintain that documentation for post-payment review.

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If noninvasive vascular diagnostic studies are performed by a technologist, the technologist must have demonstrated competency in ultrasound by receiving one of the following credentials in vascular ultrasound technology:

- Registered Vascular Specialist (RVS) provided by Cardiovascular Credentialing International (CCI)
- Registered Vascular Technologist (RVT) provided by the American Registry of Diagnostic Medical Sonographers (ARDMS)
- Vascular Sonographer (VS) provided by the American Registry of Radiologic Technologists (ARRT), Sonography

Alternately, such studies must be performed in a facility or vascular laboratory accredited by one of the following nationally recognized accreditation organizations. If a vascular laboratory or facility is accredited, the technologists performing noninvasive cerebrovascular arterial studies in that laboratory are considered to have demonstrated competency in cerebrovascular ultrasound:

- American College of Radiology (ACR) Vascular Ultrasound Accreditation Program
- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)

9.2.27.1 Cerebrovascular Doppler Studies

Cerebrovascular Doppler sonography includes both extracranial and transcranial (intracranial) studies. This group of Doppler studies is used to investigate cerebral hemodynamics (e.g., blood flow, vasculitis, cerebral fluid collection/hydrocephalus, cerebral vascular disorders,). Cerebrovascular Doppler sonography should not be used when treatment decisions will not be affected by the findings.

Cerebrovascular Doppler studies for the diagnosis of migraine are considered experimental and are not a benefit of Texas Medicaid.

Extracranial arterial Doppler (procedure codes 93880 and 93882) are limited to the following diagnosis codes:

Diagnosis Codes							
D446	D447	D7821	D7822	G450	G451	G452	G453
G454	G458	G459	G460	G461	G462	G463	G464
G465	G466	G467	G468	G8101	G8102	G8103	G8104
G8111	G8112	G8113	G8114	G8191	G8192	G8193	G8194
G830	G8311	G8312	G8313	G8314	G8321	G8322	G8323
G8324	G8331	G8332	G8333	G8334	G9751	G9752	G9761
G9762	H3401	H3402	H3403	H3411	H3412	H3413	H34211
H34212	H34213	H34231	H34232	H34233	H3582	H5311	H53121
H53122	H53123	H53131	H53132	H53133	H59311	H59312	H59313
H59319	H59321	H59322	H59323	H59329	H59331	H59332	H59333
H59339	H59341	H59342	H59343	H59349	H9541	H9542	H9551
H9552	I2510	I340	I341	I342	I350	I351	I352
I610	I611	I612	I613	I614	I615	I616	I618
I619	I6300	I63011	I63012	I63013	I6302	I63031	I63032
I63033	I6309	I6310	I63111	I63112	I63113	I6312	I63131
I63132	I63133	I6319	I6320	I63211	I63212	I63213	I63219

*** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
**** Use R221 to report pulsatile neck mass**
***** Use R0989 to report carotid bruit**

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Diagnosis Codes							
I6322	I63231	I63232	I63233	I6329	I63311	I63312	I63313
I63321	I63322	I63323	I63331	I63332	I63333	I63341	I63342
I63343	I6339	I63411	I63412	I63413	I63421	I63422	I63423
I63431	I63432	I63433	I63441	I63442	I63443	I6349	I63511
I63512	I63513	I63521	I63522	I63523	I63531	I63532	I63533
I63541	I63542	I63543	I6359	I636	I6501	I6502	I6503
I651	I6521	I6522	I6523	I658	I6601	I6602	I6603
I6611	I6612	I6613	I6621	I6622	I6623	I663	I668
I671	I672	I676	I6781	I6782	I67841	I67848	I67850
I67858	I6789	I680	I69031	I69032	I69033	I69034	I69041
I69042	I69043	I69044	I69051	I69052	I69053	I69054	I69131
I69132	I69133	I69134	I69141	I69142	I69143	I69144	I69151
I69152	I69153	I69154	I69231	I69232	I69233	I69234	I69241
I69242	I69243	I69244	I69251	I69252	I69253	I69254	I69331
I69332	I69333	I69334	I69341	I69342	I69343	I69344	I69351
I69352	I69353	I69354	I69831	I69832	I69833	I69834	I69841
I69842	I69843	I69844	I69851	I69852	I69853	I69854	I69931
I69932	I69933	I69934	I69941	I69942	I69943	I69944	I69951
I69952	I69953	I69954	I720	I749	I76	I771	I772
I773	I776	I7771	I7789	I97610	I97611	I97618	I97620
I97621	I97630	I97631	I97638	J95830	J95831	J95860	J95861
K9161	K91840	K91841	K91870	K91871	L7621	L7622	L7631
L7632	M96830	M96831	M96840	M96841	N99820	N99821	N99840
N99841	R0989***	R221**	R260	R261	R295	R29810	R4701
R4702	R471	R4781	R4789	R55*	S15011A	S15011D	S15011S
S15012A	S15012D	S15012S	S15021A	S15021D	S15021S	S15022A	S15022D
S15022S	S15091A	S15091D	S15091S	S15092A	S15092D	S15092S	S15111A
S15111D	S15111S	S15112A	S15112D	S15112S	S15121A	S15121D	S15121S
S15122A	S15122D	S15122S	S15191A	S15191D	S15191S	S15192A	S15192D
S15192S	S25111A	S25111D	S25111S	S25112A	S25112D	S25112S	S25121A
S25121D	S25121S	S25122A	S25122D	S25122S	S25191A	S25191D	S25191S
S25192A	S25192D	S25192S	T82817A	T82817D	T82817S	T82818A	T82818D
T82818S	T82827A	T82827D	T82827S	T82828A	T82828D	T82828S	T82837A
T82837D	T82837S	T82838A	T82838D	T82838S	T82847A	T82847D	T82847S
T82848A	T82848D	T82848S	T82857A	T82857D	T82857S	T82858A	T82858D
T82858S	T82867A	T82867D	T82867S	T82868A	T82868D	T82868S	T8381XA
T8381XD	T8381XS	T8382XA	T8382XD	T8382XS	T8383XA	T8383XD	T8383XS
T8384XA	T8384XD	T8384XS	T8385XA	T8385XD	T8385XS	T8386XA	T8386XD

*** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
**** Use R221 to report pulsatile neck mass**
***** Use R0989 to report carotid bruit**

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Diagnosis Codes							
T8386XS	T85818A	T85818D	T85818S	T85828A	T85828D	T85828S	T85838A
T85838D	T85838S	T85848A	T85848D	T85848S	T85858A	T85858D	T85858S
T85868A	T85868D	T85868S	T85898A	T85898D	T85898S	Z09	Z98890

*** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**
**** Use R221 to report pulsatile neck mass**
***** Use R0989 to report carotid bruit**

Transcranial Doppler (procedure codes 93886, 93888, 93892, 93893, 93896, 93897, and 93898) are limited to the following diagnosis codes:

Diagnosis Codes							
D7821	D7822	G450	G452	G453	G454	G458	G459
G460	G461	G462	G9382	G9389*	G9731	G9732	G9748
G9749	G9751	G9752	G9761	G9762	H59311	H59312	H59313
H59319	H59321	H59322	H59323	H59329	H59331	H59332	H59333
H59339	H59341	H59342	H59343	H59349	H9541	H9542	H9551
H9552	I6011	I6012	I602	I6031	I6032	I604	I6051
I6052	I606	I608	I610	I611	I613	I614	I615
I616	I618	I63011	I63012	I63013	I6302	I63031	I63032
I63033	I6309	I63111	I63112	I63113	I6312	I63131	I63132
I63133	I6319	I63211	I63212	I63213	I6322	I63231	I63232
I63233	I6329	I63311	I63312	I63313	I63321	I63322	I63323
I63331	I63332	I63333	I63341	I63342	I63343	I6339	I63411
I63412	I63413	I63421	I63422	I63423	I63431	I63432	I63433
I63441	I63442	I63443	I6349	I63511	I63512	I63513	I63521
I63522	I63523	I63531	I63532	I63533	I63541	I63542	I63543
I6359	I636	I6381	I6389	I639	I6501	I6502	I6503
I651	I6521	I6522	I6523	I658	I6601	I6602	I6603
I6611	I6612	I6613	I6621	I6622	I6623	I663	I668
I671	I672	I677	I6781	I6782	I67841	I67848	I67850
I67858	I6789	I679	I726	I749**	I76	I97610	I97611
I97618	I97620	I97621	I97630	I97631	I97638	J95830	J95831
J95860	J95861	K9161	K91840	K91841	K91870	K91871	L7621
L7622	L7631	L7632	M96830	M96831	M96840	M96841	N99820
N99821	N99840	N99841	Q282	Q283	R260	R261	R2681
R2689	R295	R29810	R4701	R4702	R471	R4781	R4789
R55***	S090XXA	S090XXD	S090XXS	S15111A	S15111D	S15111S	S15112A
S15112D	S15112S	S15121A	S15121D	S15121S	S15122A	S15122D	S15122S
S15191A	S15191D	S15191S	S15192A	S15192D	S15192S	T82818A	T82818D
T82818S	T82828A	T82828D	T82828S	T82838A	T82838D	T82838S	T82848A

*** Use G9389 to identify assessment of suspected brain death**
**** Use I749 to report paradoxical cerebral embolism**
***** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**

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Diagnosis Codes							
T82848D	T82848S	T82858A	T82858D	T82858S	T82868A	T82868D	T82868S
Z09							
*** Use G9389 to identify assessment of suspected brain death** **** Use I749 to report paradoxical cerebral embolism** ***** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency**							

In addition to the diagnosis codes listed in the table above, procedure codes 93886, 93888, 93896, 93897, and 93898 are benefits for clients who are 2 through 16 years of age with sickle cell disease to evaluate the risk of stroke when submitted with the following diagnosis codes:

Diagnosis Codes							
D5700	D5702	D571	D5720	D57212	D57219	D5780	D57812
D57819							

9.2.27.2 Peripheral Doppler Studies

Peripheral Doppler sonography is used to determine vascular impedance and evaluate peripheral masses and peripheral nerve continuity.

9.2.27.3 Peripheral Arterial Doppler Studies

Noninvasive peripheral arterial examinations that are performed to establish the level and degree of arterial occlusive disease are reasonable and necessary if significant signs or symptoms of possible limbischemia are present, and the client is a candidate for invasive therapeutic procedures.

Peripheral arterial Doppler (procedure codes 93922, 93923, 93924, 93925, 93926, 93930, and 93931) are limited to the following diagnosis codes (unless otherwise indicated):

Diagnosis Codes							
E0851	E0852	E0859	E0951	E0952	E0959	E1051	E1052
E1059	E1151	E1152	E1159	E1351	E1352	E1359	G9751
G9752	I2583	I670	I700	I70218	I70228	I7025	I70268
I70298	I70418	I70428	I7045	I70468	I70498	I70518	I70528
I7055	I70568	I70598	I70618	I70628	I7065	I70668	I70698
I70718	I70728	I7075	I70768	I70798	I7092	I7102	I7103
I723	I728	I7300	I7301	I731	I7389	I739	I7401
I7409	I7411	I7419	I745	I748	I770	I771	I772
I773	I775	I7771	I7772	I7773	I7774	I7779	I77810
I77811	I77812	I7789	I790	I791	I798	I96	I97410
I97411	I97418	I9742	I9751	I9752	I97610	I97611	I97618
J9561	J9562	J9571	J9572	J95830	J95831	K9161	K9162
K9171	K9172	K91840	K91841	L7601	L7602	L7611	L7612
L7621	L7622	L89112	L89113	L89114	L89116	L89122	L89123
L89124	L89126	L89132	L89133	L89134	L89136	L89142	L89143
L89144	L89146	L89152	L89153	L89154	L89156	L89216	L89226
L89316	L89326	L8946	L89812	L89813	L89814	L89892	L89893
L89894	L89896	L98421	L98422	L98423	L98424	L98425	L98426
L98428	L98429	M314	M315	M316	M318	M79609	M96810

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Diagnosis Codes							
M96811	M96820	M96821	M96830	M96831	N184	N185	N186
N9961	N9962	N9971	N9972	N99820	N99821	R0989	R1901
R1902	R1903	R1904	R1905	R1906	R1907	R1909	R200
R201	R202	R203	T801XXA	T801XXD	T801XXS	T8131XA	T8131XD
T8131XS	T81320A	T81320D	T81320S	T81321A	T81321D	T81321S	T81328A
T81328D	T81328S	T81329A	T81329D	T81329S	T81718A	T81718D	T81718S
T8172XA	T8172XD	T8172XS	T8189XA	T8189XD	T8189XS	T82310A	T82310D
T82310S	T82311A	T82311D	T82311S	T82312A	T82312D	T82312S	T82318A
T82318D	T82318S	T82320A	T82320D	T82320S	T82321A	T82321D	T82321S
T82322A	T82322D	T82322S	T82328A	T82328D	T82328S	T82330A	T82330D
T82330S	T82331A	T82331D	T82331S	T82332A	T82332D	T82332S	T82338A
T82338D	T82338S	T82390A	T82390D	T82390S	T82391A	T82391D	T82391S
T82392A	T82392D	T82392S	T82398A	T82398D	T82398S	T8241XA	T8241XD
T8241XS	T8242XA	T8242XD	T8242XS	T8243XA	T8243XD	T8243XS	T8249XA
T8249XD	T8249XS	T82510A	T82510D	T82510S	T82511A	T82511D	T82511S
T82513A	T82513D	T82513S	T82514A	T82514D	T82514S	T82515A	T82515D
T82515S	T82518A	T82518D	T82518S	T82520A	T82520D	T82520S	T82521A
T82521D	T82521S	T82523A	T82523D	T82523S	T82524A	T82524D	T82524S
T82525A	T82525D	T82525S	T82528A	T82528D	T82528S	T82530A	T82530D
T82530S	T82531A	T82531D	T82531S	T82533A	T82533D	T82533S	T82534A
T82534D	T82534S	T82535A	T82535D	T82535S	T82538A	T82538D	T82538S
T82590A	T82590D	T82590S	T82591A	T82591D	T82591S	T82593A	T82593D
T82593S	T82594A	T82594D	T82594S	T82595A	T82595D	T82595S	T82598A
T82598D	T82598S	T827XXA	T827XXD	T827XXS	T82817A	T82817D	T82817S
T82818A	T82818D	T82818S	T82827A	T82827D	T82827S	T82828A	T82828D
T82828S	T82837A	T82837D	T82837S	T82838A	T82838D	T82838S	T82847A
T82847D	T82847S	T82848A	T82848D	T82848S	T82856A	T82856D	T82856S
T82857A	T82857D	T82857S	T82858A	T82858D	T82858S	T82867A	T82867D
T82867S	T82868A	T82868D	T82868S	T82897A	T82897D	T82897S	T82898A
T82898D	T82898S	T8381XA	T8381XD	T8381XS	T8382XA	T8382XD	T8382XS
T8383XA	T8383XD	T8383XS	T8384XA	T8384XD	T8384XS	T8385XA	T8385XD
T8385XS	T8386XA	T8386XD	T8386XS	T8389XA	T8389XD	T8389XS	T8481XA
T8481XD	T8481XS	T8482XA	T8482XD	T8482XS	T8483XA	T8483XD	T8483XS
T8484XA	T8484XD	T8484XS	T8485XA	T8485XD	T8485XS	T8486XA	T8486XD
T8486XS	T8489XA	T8489XD	T8489XS	T85810A	T85810D	T85810S	T85818A
T85818D	T85818S	T85860A	T85860D	T85860S	T85868A	T85868D	T85868S
T8601	T8602	T8603	T8609	T8611	T8612	T8613	T8619
T8621	T8622	T8623	T86290	T86298	T8631	T8632	T8633
T8639	T8641	T8642	T8643	T8649	T86810	T86811	T86812
T86818	T86830	T86831	T86832	T86838	T86850	T86851	T86852

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Diagnosis Codes							
T86858	T86890	T86891	T86892	T86898	T872	T888XXA	Z09
Z4803	Z48812	Z4889	Z951	Z955	Z95820	Z95828	Z9861

Diagnosis Codes for Upper Extremity Conditions							
I721	I742	I75011	I75012	I75013	I7776	L89012	L89013
L89014	L89016	L89022	L89023	L89024	L89026	M79A11	M79A12
Q2731	S45011A	S45011D	S45011S	S45012A	S45012D	S45012S	S45091A
S45091D	S45091S	S45092A	S45092D	S45092S	S45111A	S45111D	S45111S
S45112A	S45112D	S45112S	S45191A	S45191D	S45191S	S45192A	S45192D
S45192S	S45211A	S45211D	S45211S	S45212A	S45212D	S45212S	S45219A
S45219D	S45219S	S45291A	S45291D	S45291S	S45292A	S45292D	S45292S
S45311A	S45311D	S45311S	S45312A	S45312D	S45312S	S45391A	S45391D
S45391S	S45392A	S45392D	S45392S	S45811A	S45811D	S45811S	S45812A
S45812D	S45812S	S45891A	S45891D	S45891S	S45892A	S45892D	S45892S
S55011A	S55011D	S55011S	S55012A	S55012D	S55012S	S55091A	S55091D
S55091S	S55092A	S55092D	S55092S	S55111A	S55111D	S55111S	S55112A
S55112D	S55112S	S55191A	S55191D	S55191S	S55192A	S55192D	S55192S
S55211A	S55211D	S55211S	S55212A	S55212D	S55212S	S55291A	S55291D
S55291S	S55292A	S55292D	S55292S	S55811A	S55811D	S55811S	S55812A
S55812D	S55812S	S55891A	S55891D	S55891S	S55892A	S55892D	S55892S
S65011A	S65011D	S65011S	S65012A	S65012D	S65012S	S65091A	S65091D
S65091S	S65092A	S65092D	S65092S	S65111A	S65111D	S65111S	S65112A
S65112D	S65112S	S65191A	S65191D	S65191S	S65192A	S65192D	S65192S
S65211A	S65211D	S65211S	S65212A	S65212D	S65212S	S65291A	S65291D
S65291S	S65292A	S65292D	S65292S	S65311A	S65311D	S65311S	S65312A
S65312D	S65312S	S65391A	S65391D	S65391S	S65392A	S65392D	S65392S
S65411A	S65411D	S65411S	S65412A	S65412D	S65412S	S65491A	S65491D
S65491S	S65492A	S65492D	S65492S	S65510A	S65510D	S65510S	S65511A
S65511D	S65511S	S65512A	S65512D	S65512S	S65513A	S65513D	S65513S
S65514A	S65514D	S65514S	S65515A	S65515D	S65515S	S65516A	S65516D
S65516S	S65517A	S65517D	S65517S	S65518A	S65518D	S65518S	S65590A
S65590D	S65590S	S65591A	S65591D	S65591S	S65592A	S65592D	S65592S
S65593A	S65593D	S65593S	S65594A	S65594D	S65594S	S65595A	S65595D
S65595S	S65596A	S65596D	S65596S	S65597A	S65597D	S65597S	S65598A
S65598D	S65598S	S65811A	S65811D	S65811S	S65812A	S65812D	S65812S
S65891A	S65891D	S65891S	S65892A	S65892D	S65892S	T870X1	T870X2

Diagnosis Codes for Lower Extremity Conditions							
I70211	I70212	I70213	I70221	I70222	I70223	I70231	I70232
I70233	I70234	I70235	I70238	I70241	I70242	I70243	I70244

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Diagnosis Codes for Lower Extremity Conditions							
I70245	I70248	I70261	I70262	I70263	I70291	I70292	I70293
I70411	I70412	I70413	I70421	I70422	I70423	I70431	I70432
I70433	I70434	I70435	I70438	I70441	I70442	I70443	I70444
I70445	I70448	I70461	I70462	I70463	I70491	I70492	I70493
I70511	I70512	I70513	I70521	I70522	I70523	I70531	I70532
I70533	I70534	I70535	I70538	I70541	I70542	I70543	I70544
I70545	I70548	I70561	I70562	I70563	I70591	I70592	I70593
I70611	I70612	I70613	I70621	I70622	I70623	I70631	I70632
I70633	I70634	I70635	I70638	I70641	I70642	I70643	I70644
I70645	I70648	I70661	I70662	I70663	I70691	I70692	I70693
I70711	I70712	I70713	I70721	I70722	I70723	I70731	I70732
I70733	I70734	I70735	I70738	I70741	I70742	I70743	I70744
I70745	I70748	I70761	I70762	I70763	I70791	I70792	I70793
I724	I743	I75021	I75022	I75023	I7777	I83011	I83012
I83013	I83014	I83015	I83018	I83021	I83022	I83023	I83024
I83025	I83028	L89212	L89213	L89214	L89222	L89223	L89224
L89312	L89313	L89314	L89322	L89323	L89324	L8942	L8943
L8944	L89512	L89513	L89514	L89516	L89522	L89523	L89524
L89526	L89612	L89613	L89614	L89616	L89622	L89623	L89624
L89626	L97111	L97112	L97113	L97114	L97115	L97116	L97118
L97119	L97121	L97122	L97123	L97124	L97125	L97126	L97128
L97129	L97205	L97206	L97208	L97209	L97211	L97212	L97213
L97214	L97215	L97216	L97218	L97219	L97221	L97222	L97223
L97224	L97305	L97306	L97308	L97309	L97311	L97312	L97313
L97314	L97315	L97316	L97318	L97319	L97321	L97322	L97323
L97324	L97325	L97326	L97328	L97329	L97411	L97412	L97413
L97414	L97415	L97416	L97418	L97419	L97421	L97422	L97423
L97424	L97425	L97426	L97428	L97429	L97511	L97512	L97513
L97514	L97521	L97522	L97523	L97524	L97811	L97812	L97813
L97814	L97816	L97818	L97819	L97821	L97822	L97823	L97824
L98411	L98412	L98413	L98414	L98415	L98416	L98418	L98419
M79A21	M79A22	Q2732	S75011A	S75011D	S75011S	S75012A	S75012D
S75012S	S75021A	S75021D	S75021S	S75022A	S75022D	S75022S	S75091A
S75091D	S75091S	S75092A	S75092D	S75092S	S75111A	S75111D	S75111S
S75112A	S75112D	S75112S	S75121A	S75121D	S75121S	S75122A	S75122D
S75122S	S75191A	S75191D	S75191S	S75192A	S75192D	S75192S	S75211A
S75211D	S75211S	S75212A	S75212D	S75212S	S75221A	S75221D	S75221S
S75222A	S75222D	S75222S	S75291A	S75291D	S75291S	S75292A	S75292D
S75292S	S75811A	S75811D	S75811S	S75812A	S75812D	S75812S	S75891A
S75891D	S75891S	S75892A	S75892D	S75892S	S85011A	S85011D	S85011S

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Diagnosis Codes for Lower Extremity Conditions							
S85012A	S85012D	S85012S	S85091A	S85091D	S85091S	S85092A	S85092D
S85092S	S85141A	S85141D	S85141S	S85142A	S85142D	S85142S	S85151A
S85151D	S85151S	S85152A	S85152D	S85152S	S85171A	S85171D	S85171S
S85172A	S85172D	S85172S	S85181A	S85181D	S85181S	S85182A	S85182D
S85182S	S85211A	S85211D	S85211S	S85212A	S85212D	S85212S	S85291A
S85291D	S85291S	S85292A	S85292D	S85292S	S85311A	S85311D	S85311S
S85312A	S85312D	S85312S	S85391A	S85391D	S85391S	S85392A	S85392D
S85392S	S85411A	S85411D	S85411S	S85412A	S85412D	S85412S	S85491A
S85491D	S85491S	S85492A	S85492D	S85492S	S85511A	S85511D	S85511S
S85512A	S85512D	S85512S	S85591A	S85591D	S85591S	S85592A	S85592D
S85592S	S85811A	S85811D	S85811S	S85812A	S85812D	S85812S	S85891A
S85891D	S85891S	S85892A	S85892D	S85892S	S95011A	S95011D	S95011S
S95012A	S95012D	S95012S	S95091A	S95091D	S95091S	S95092A	S95092D
S95092S	S95111A	S95111D	S95111S	S95112A	S95112D	S95112S	S95191A
S95191D	S95191S	S95192A	S95192D	S95192S	S95211A	S95211D	S95211S
S95212A	S95212D	S95212S	S95291A	S95291D	S95291S	S95292A	S95292D
S95292S	S95811A	S95811D	S95811S	S95812A	S95812D	S95812S	S95891A
S95891D	S95891S	S95892A	S95892D	S95892S	T871X1	T871X2	

9.2.27.4 Peripheral Venous Doppler Studies

Non-invasive vascular diagnostic studies utilize ultrasonic Doppler and physiologic principles to assess irregularities in blood flow in the venous system.

Peripheral venous Doppler (procedure codes 93970 and 93971) are limited to the following diagnosis codes:

Diagnosis Codes							
I2601	I2602	I2603	I2604	I2609	I2690	I2692	I2693
I2694	I2695	I2696	I2699	I749	I8001	I8002	I8003
I8011	I8012	I8013	I80211	I80212	I80213	I80221	I80222
I80223	I80231	I80232	I80233	I80241	I80242	I80243	I80251
I80252	I80253	I80291	I80292	I80293	I808	I821	I82220
I82411	I82412	I82413	I82421	I82422	I82423	I82431	I82432
I82433	I82441	I82442	I82443	I82451	I82452	I82453	I82461
I82462	I82463	I82491	I82492	I82493	I82511	I82512	I82513
I82521	I82522	I82523	I82531	I82532	I82533	I82541	I82542
I82543	I82551	I82552	I82553	I82561	I82562	I82563	I82591
I82592	I82593	I82611	I82612	I82613	I82621	I82622	I82623
I82711	I82712	I82713	I82721	I82722	I82723	I82A11	I82A12
I82A13	I82A21	I82A22	I82A23	I82C11	I82C12	I82C13	I82C21
I82C22	I82C23	I82811	I82812	I82813	I82890	I82891	I83011
I83012	I83013	I83014	I83015	I83018	I83021	I83022	I83023

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Diagnosis Codes							
I83024	I83025	I83028	I8311	I8312	I83211	I83212	I83213
I83214	I83215	I83218	I83221	I83222	I83223	I83224	I83225
I83228	I83811	I83812	I83813	I83891	I83892	I83893	I87001
I87002	I87003	I87011	I87012	I87013	I87021	I87022	I87023
I87031	I87032	I87033	I87091	I87092	I87093	I871	I872
I87311	I87312	I87313	I87321	I87322	I87323	I87331	I87332
I87333	I87391	I87392	I87393	I96	J80	J9600	J9601
J9602	J9690	L89016	L89026	L89116	L89126	L89136	L89146
L89156	L89216	L89226	L89316	L89326	L8946	L97111	L97112
L97113	L97114	L97115	L97116	L97118	L97119	L97121	L97122
L97123	L97124	L97125	L97126	L97128	L97129	L97211	L97212
L97213	L97214	L97215	L97216	L97218	L97219	L97221	L97222
L97223	L97224	L97225	L97226	L97228	L97229	L97311	L97312
L97313	L97314	L97315	L97316	L97318	L97319	L97321	L97322
L97323	L97324	L97325	L97326	L97328	L97329	L97411	L97412
L97413	L97414	L97415	L97416	L97418	L97419	L97421	L97422
L97423	L97424	L97425	L97426	L97428	L97429	L97511	L97512
L97513	L97514	L97515	L97516	L97518	L97519	L97521	L97522
L97523	L97524	L97525	L97526	L97528	L97529	L97811	L97812
L97813	L97814	L97815	L97816	L97818	L97819	L97821	L97822
L97823	L97824	L97825	L97826	L97828	L97829	M7121	M7122
M79601	M79602	M79604	M79605	M79621	M79622	M79631	M79632
M79641	M79642	M79644	M79645	M79651	M79652	M79661	M79662
M79671	M79672	M79674	M79675	O2221	O2222	O2223	O2231
O2232	O2233	O870	O871	O88211	O88212	O88213	O8822
O8823	Q2731	Q2732	Q278	R042	R0600	R0602	R0609
R0682	R071	R0781	R0782	R0789	R079	R2231	R2232
R2233	R2241	R2242	R2243	R600	R601	R609	T800XXA
T801XXA	T8172XA	T82817A	T82818A	T82827A	T82828A	T82837A	T82838A
T82847A	T82848A	T82857A	T82858A	T82867A	T82868A	T8381XA	T8382XA
T8383XA	T8384XA	T8385XA	T8386XA	T85818A	T85828A	T85838A	T85848A
T85858A	T85868A	T85898A					

In addition to the diagnosis codes listed in the table above, procedure code 93971 is also a benefit when submitted with diagnosis code Z01810, Z01818, or Z09.

Doppler echocardiography color flow velocity mapping (procedure code 93325) must be billed with one of the corresponding procedure codes in column B to be considered for reimbursement:

Column A Procedure Code	Column B Procedure Codes
93325	76825, 76826, 76827, 76828, 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, or 93351

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9.2.27.5 Limitations for Diagnostic Doppler Sonography

Documentation of medical necessity for the diagnostic Doppler study must be maintained by the ordering provider in the client's medical record.

Procedure codes described as complete bilateral studies are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Diagnostic Doppler procedure codes are limited to one study per day, same provider.

When medically necessary, multiple Doppler procedures (e.g., studies of extracranial arteries and intracranial arteries) billed on the same day by the same provider will be reimbursed at full fee for the first study and one-half fee for each additional study, regardless of the number of services billed.

The use of transcranial Doppler studies performed for the assessment of stroke risk in clients who are 2 through 16 years of age who have sickle cell anemia should be limited to once every 6 months.

The use of a simple hand-held or other Doppler device that does not produce hard copy output or that does not permit analysis of bidirectional vascular flow is considered part of the physical examination of the vascular system and is not separately reported.

9.2.28 Evoked Response Tests and Neuromuscular Procedures

The following services are a benefit of Texas Medicaid:

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

9.2.28.1 Autonomic Function Tests

AFTs are a benefit of Texas Medicaid when submitted with procedure codes 95921, 95922, 95923, and 95924.

Prior authorization is not required for AFTs.

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

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

- Amyloid neuropathy
- Diabetic autonomic neuropathy
- Distal small fiber neuropathy
- Excessive sweating
- Gastrointestinal dysfunction
- Idiopathic neuropathy
- Irregular heart rate
- Multiple system atrophy
- Orthostatic symptoms
- Pure autonomic failure

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- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)
- Sjögren's syndrome

9.2.28.1.1 Documentation Requirements for Autonomic Function Testing

The reason for the referral, the specific autonomic function being tested, and a clear diagnostic impression must be documented in the client's medical record for each AFT performed.

The client's medical records must clearly document the medical necessity for the AFT. The medical record documentation must reflect the actual results of specific tests.

Medical necessity for reevaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- Clinical benefit of additional studies.

The client's medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.28.2 Electromyography and Nerve Conduction Studies

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as electrodiagnostic (EDX) testing, must be medically indicated and may be reimbursed with the diagnosis codes listed below. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

Diagnosis Codes							
C701	C720	C721	D510	D511	D513	D518	D519
D538	E0842	E0942	E1041	E1042	E10610	E1141	E1142
E1144	E11610	E1342	E5111	E5112	E512	E518	E519
E52	E530	E531	E538	E550	E559	E560	E568
E610	E7281	E7289	E7841	E7849	E786	E851	E852
E853	E8581	E8582	E8589	E859	G120	G121	G1221
G1222	G1223	G1224	G1225	G1229	G128	G129	G130
G243	G2589	G26	G320	G360	G370	G375	G501
G510	G511	G512	G5131	G5132	G5133	G5139	G514
G518	G519	G522	G523	G527	G528	G540	G541
G542	G543	G544	G545	G548	G549	G5601	G5602
G5603	G5611	G5612	G5613	G5621	G5622	G5623	G5631
G5632	G5633	G5641	G5642	G5643	G5681	G5682	G5683
G5691	G5692	G5693	G5701	G5702	G5703	G5711	G5712

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Diagnosis Codes							
G5713	G5721	G5722	G5723	G5731	G5732	G5733	G5741
G5742	G5743	G5751	G5752	G5753	G5761	G5762	G5763
G5771	G5772	G5773	G5781	G5782	G5783	G5791	G5792
G5793	G587	G588	G589	G59	G600	G601	G602
G603	G608	G609	G610	G6181	G6182	G6189	G619
G620	G621	G622	G6281	G6282	G629	G63	G650
G651	G652	G7000	G7001	G701	G702	G7081	G7089
G709	G7100	G7101	G7102	G7109	G7111	G7112	G7113
G7114	G7119	G7120	G7121	G71220	G71228	G7129	G713
G718	G719	G721	G722	G723	G7241	G7249	G7281
G7289	G729	G731	G733	G737	G800	G801	G802
G803	G804	G808	G809	G8311	G8312	G8313	G8314
G8321	G8322	G8323	G8324	G834	G8381	G8382	G8383
G8384	G8389	G839	G9009	G902	G904	G9050	G90511
G90512	G90513	G90519	G90521	G90522	G90523	G90529	G9059
G909	G950	G9511	G9519	G9520	G9529	G9581	G9589
G959	G990	G992	I776	I951	J3800	J3801	J3802
K5902	K5903	K5904	K5909	K592	K594	K624	K6289
M05411	M05412	M05421	M05422	M05431	M05432	M05441	M05442
M05451	M05452	M05461	M05462	M05471	M05472	M0549	M05511
M05512	M05521	M05522	M05531	M05532	M05541	M05542	M05551
M05552	M05561	M05562	M05571	M05572	M0559	M05711	M05712
M05721	M05722	M05731	M05732	M05741	M05742	M05751	M05752
M05761	M05762	M05769	M05771	M05772	M05779	M0579	M057A
M05811	M05812	M05821	M05822	M05831	M05832	M05841	M05842
M05851	M05852	M05861	M05862	M05871	M05872	M0589	M058A
M05A	M06011	M06012	M06021	M06022	M06031	M06032	M06041
M06042	M06051	M06052	M06061	M06062	M06071	M06072	M0608
M0609	M060A	M06811	M06812	M06821	M06822	M06831	M06832
M06841	M06842	M06852	M06861	M06862	M06871	M06872	M0688
M0689	M068A	M069	M21271	M21272	M21331	M21332	M21511
M21512	M216X1	M216X2	M21831	M21832	M21931	M21932	M320
M3210	M3211	M3212	M3213	M3214	M3215	M3219	M328
M329	M3300	M3301	M3302	M3309	M3310	M3311	M3312
M3319	M3320	M3321	M3322	M3329	M3390	M3391	M3392
M3399	M340	M341	M342	M3481	M3482	M3483	M3489
M3500	M3501	M3502	M3503	M3504	M3505	M3506	M3507
M3508	M3509	M3581	M3589	M350A	M350B	M350C	M3581
M3589	M360	M4321	M4322	M4323	M4324	M4325	M4326
M4327	M4328	M436	M438X9	M4644	M4645	M4646	M4647

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Diagnosis Codes							
M4711	M4712	M4713	M4714	M4715	M4716	M4721	M4722
M4723	M4724	M4725	M4726	M4727	M4728	M47811	M47812
M47813	M47814	M47815	M47816	M47817	M47818	M47891	M47892
M47893	M47894	M47895	M47896	M47897	M47898	M4801	M4802
M4803	M4804	M4805	M48062	M4807	M4808	M5000	M5001
M50020	M50021	M50022	M50023	M5003	M5011	M50120	M50121
M50122	M50123	M5013	M5020	M5021	M50220	M50221	M50222
M50223	M5023	M5030	M5031	M50320	M50321	M50322	M50323
M5033	M5080	M5081	M50820	M50821	M50822	M50823	M5083
M5091	M50920	M50921	M50922	M50923	M5093	M5104	M5105
M5106	M5124	M5125	M5126	M5127	M5134	M5135	M51360
M51361	M51362	M51369	M51370	M51371	M51372	M51379	M5184
M5185	M5186	M5187	M5410	M5411	M5412	M5413	M5414
M5415	M5416	M5417	M5431	M5432	M5450	M5451	M5459
M546	M5489	M60011	M60012	M60021	M60022	M60031	M60032
M60041	M60042	M60044	M60051	M60052	M60061	M60062	M60070
M60071	M60073	M60074	M60076	M60077	M6008	M6009	M60111
M60112	M60121	M60122	M60131	M60132	M60141	M60142	M60151
M60152	M60161	M60162	M60171	M60172	M6018	M6019	M609
M6250	M62511	M62512	M62519	M62521	M62522	M62529	M62531
M62532	M62539	M62541	M62542	M62549	M62551	M62552	M62559
M62561	M62562	M62569	M62571	M62572	M62579	M6258	M6259
M625A0	M625A1	M625A2	M625A9	M6281	M6284	M6285	M629
M7910	M7911	M7912	M7918	M792	M79601	M79602	M79604
M79605	M79621	M79622	M79631	M79632	M79641	M79642	M79651
M79652	M79661	M79662	M79671	M79672	M797	M961	N393
N3941	N3942	N3943	N3944	N3945	N3946	N39490	N39491
N39492	N39498	N94819	R150	R151	R152	R159	R200
R201	R202	R203	R208	R209	R260	R261	R2681
R2689	R269	R290	R295	R29701	R29702	R29703	R29704
R29705	R29706	R29707	R29708	R29709	R29710	R29711	R29712
R29713	R29714	R29715	R29716	R29717	R29718	R29719	R29720
R29721	R29722	R29723	R29724	R29725	R29726	R29727	R29728
R29729	R29730	R29731	R29732	R29733	R29734	R29735	R29736
R29737	R29738	R29739	R29740	R29741	R29742	R32	R3914
R39191	R39192	R39198	R4702	R471	R4781	R4789	R498
R6884	R7681	S14101A	S14101D	S14101S	S14102A	S14102D	S14102S
S14103A	S14103D	S14103S	S14104A	S14104D	S14104S	S14105A	S14105D
S14105S	S14106A	S14106D	S14106S	S14107A	S14107D	S14107S	S14108A
S14108D	S14108S	S14109A	S14109D	S14109S	S14111A	S14111D	S14111S

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Diagnosis Codes							
S14112A	S14112D	S14112S	S14113A	S14113D	S14113S	S14114A	S14114D
S14114S	S14115A	S14115D	S14115S	S14116A	S14116D	S14116S	S14117A
S14117D	S14117S	S14118A	S14118D	S14118S	S14121A	S14121D	S14121S
S14122A	S14122D	S14122S	S14123A	S14123D	S14123S	S14124A	S14124D
S14124S	S14125A	S14125D	S14125S	S14126A	S14126D	S14126S	S14127A
S14127D	S14127S	S14128A	S14128D	S14128S	S14131A	S14131D	S14131S
S14132A	S14132D	S14132S	S14133A	S14133D	S14133S	S14134A	S14134D
S14134S	S14135A	S14135D	S14135S	S14136A	S14136D	S14136S	S14137A
S14137D	S14137S	S14138A	S14138D	S14138S	S14141A	S14141D	S14141S
S14142A	S14142D	S14142S	S14143A	S14143D	S14143S	S14144A	S14144D
S14144S	S14145A	S14145D	S14145S	S14146A	S14146D	S14146S	S14147A
S14147D	S14147S	S14148A	S14148D	S14148S	S14151A	S14151D	S14151S
S14152A	S14152D	S14152S	S14153A	S14153D	S14153S	S14154A	S14154D
S14154S	S14155A	S14155D	S14155S	S14156A	S14156D	S14156S	S14157A
S14157D	S14157S	S14158A	S14158D	S14158S	S142XXA	S142XXD	S142XXS
S143XXA	S143XXD	S143XXS	S144XXA	S144XXD	S144XXS	S145XXA	S145XXD
S145XXS	S148XXA	S148XXD	S148XXS	S149XXA	S149XXD	S149XXS	S24101A
S24101D	S24101S	S24102A	S24102D	S24102S	S24103A	S24103D	S24103S
S24104A	S24104D	S24104S	S24109A	S24109D	S24109S	S24111A	S24111D
S24111S	S24112A	S24112D	S24112S	S24113A	S24113D	S24113S	S24114A
S24114D	S24114S	S24131A	S24131D	S24131S	S24132A	S24132D	S24132S
S24133A	S24133D	S24133S	S24134A	S24134D	S24134S	S24141A	S24141D
S24141S	S24142A	S24142D	S24142S	S24143A	S24143D	S24143S	S24144A
S24144D	S24144S	S24151A	S24151D	S24151S	S24152A	S24152D	S24152S
S24153A	S24153D	S24153S	S24154A	S24154D	S24154S	S242XXA	S242XXD
S242XXS	S243XXA	S243XXD	S243XXS	S244XXA	S244XXD	S244XXS	S248XXA
S248XXD	S248XXS	S249XXA	S249XXD	S249XXS	S34109A	S34109D	S34109S
S34111A	S34111D	S34111S	S34112A	S34112D	S34112S	S34113A	S34113D
S34113S	S34114A	S34114D	S34114S	S34115A	S34115D	S34115S	S34121A
S34121D	S34121S	S34122A	S34122D	S34122S	S34123A	S34123D	S34123S
S34124A	S34124D	S34124S	S34125A	S34125D	S34125S	S34131A	S34131D
S34131S	S34132A	S34132D	S34132S	S34139A	S34139D	S34139S	S3421XA
S3421XD	S3421XS	S3422XA	S3422XD	S3422XS	S343XXA	S343XXD	S343XXS
S344XXA	S344XXD	S344XXS	S345XXA	S345XXD	S345XXS	S4400XA	S4400XD
S4400XS	S4401XA	S4401XD	S4401XS	S4402XA	S4402XD	S4402XS	S4410XA
S4410XD	S4410XS	S4411XA	S4411XD	S4411XS	S4412XA	S4412XD	S4412XS
S4420XA	S4420XD	S4420XS	S4421XA	S4421XD	S4421XS	S4422XA	S4422XD
S4422XS	S4430XA	S4430XD	S4430XS	S4431XA	S4431XD	S4431XS	S4432XA
S4432XD	S4432XS	S4440XA	S4440XD	S4440XS	S4441XA	S4441XD	S4441XS
S4442XA	S4442XD	S4442XS	S4450XA	S4450XD	S4450XS	S4451XA	S4451XD

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

Any EDX testing procedures may be reimbursed up to four different dates of service per calendar year, same provider. Any E/M service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

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

9.2.28.2.1 Documentation Requirements for EMG and NCS

The reason for the referral, the specific site(s) tested, and a clear diagnostic impression must be documented in the client's medical record for each NCS or EMG study performed.

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The client's medical records must clearly document the medical necessity for the NCS and EMG testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis. Examples may include suspected:
  - Peripheral nerve entrapment syndromes
  - Other neuropathies (traumatic, metabolic, or demyelinating)
  - Neuromuscular junction disorders (myasthenia gravis, botulism)
  - Myopathies (dermatomyositis, congenital myopathies)
  - Unexplained symptoms suggestive of peripheral nerve, muscle or neuromuscular junction pathology, manifested by:
    - Muscle weakness
    - Muscle atrophy
    - Loss of dexterity
    - Spasticity
    - Sensory deficits
    - Swallowing dysfunction
    - Diplopia
    - Dysarthria
- The client's diagnosis could not be confirmed on previous studies, although suspected.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional electrodiagnostic studies.

The client's medical records are subject to retrospective review. NCS hard copies of the wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.28.2.2 EMG

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

Procedure Codes									
51784	51785	95860	95861	95863	95864	95865	95866	95867	95868
95869	95999								

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Procedure codes 95872 and 95875 may be reimbursed up to two services per day, same provider. Procedure code 95870 may be reimbursed in multiple quantities if specific muscles are documented.

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.

Prior authorization is not required for EMG.

9.2.28.2.3 NCS

NCS are reimbursed by Texas Medicaid with documentation of medical necessity using the following procedure codes:

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

NCS must be performed by either one of the following:

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

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

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

Prior authorization is required when the anticipated number of nerve conduction studies planned for an evaluation exceeds the following maximum number of studies:

Procedure Code	Limitation
95885, 95886	Reimbursed once per extremity up to 2 units, using any combination of procedure codes, per day, any provider.
95885, 95886, 95887	Must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913.
95937	Up to 3 studies per day, per procedure, same provider without prior authorization.

9.2.28.2.4 Prior Authorization for NCS

Requests for prior authorization with documentation supporting the medical necessity for the number of studies requested must be received on or within 90 days before the requested date(s) of service.

The Special Medical Prior Authorization (SMPA) Request Form must be signed by the requesting provider on or within 90 days prior to the requested start of service. All dates of service prior to the prescribing providers signature date will be denied.

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

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

- Other diagnosis in the differential that require consideration should include provider notes about both of the following:
  - The additional diagnoses considered.
  - The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
- If multiple diagnoses have been established by nerve conduction studies and the recommendations in the table above for a single diagnostic category do not apply, then the provider should document all diagnoses established as a result of EDX testing.
- Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol [ETOH] usage).
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms, for example:
  - Underlying metabolic disease (such as thyroid condition or diabetes mellitus)
  - Nutritional deficiency (alcoholism)
  - Malignant disease
  - Inflammatory disorder (including but not limited to lupus, sarcoidosis or Sjögren's syndrome)

9.2.28.3 Evoked Potential Testing

Evoked potential (EP) testing is a benefit of Texas Medicaid when medically necessary. Prior authorization is not required for EP testing. The most common EP tests are:

- Brainstem auditory evoked potentials (BAEPs)
- Intraoperative neurophysiology monitoring (IONM)
- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Vestibular evoked myogenic potentials (VEMP)
- Visual evoked potentials (VEPs)

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

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

Intraoperative neurophysiology monitoring (procedure codes 95940 and 95941) is a benefit when performed in addition to each evoked potential test on the same day.

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

Procedure codes 95940 and 95941 must be billed in conjunction with one of the following procedure codes or the service will be denied:

Procedure Codes									
92653	95822	95860	95861	95863	95864	95865	95866	95867	95868

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Procedure Codes									
95869	95870	95907	95908	95909	95910	95911	95912	95913	95925
95926	95927	95928	95929	95930	95933	95937	95938	95939	

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

9.2.28.3.1 Documentation Requirements for Evoked Potential Testing

The reason for the referral, the specific nerve evoked potential being tested, and a clear diagnostic impression must be documented in the client's medical record for each EP study performed.

The client's medical records must clearly document the medical necessity for the EP testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

The documentation for the IONM (procedure codes 95940 and 95941) must include the time during which each test is performed.

9.2.28.3.2 Intraoperative Neurophysiology Monitoring (IONM)

IONM is a benefit of Texas Medicaid when performed in addition to each evoked potential test on the same day.

Prior authorization is not required for IONM.

9.2.28.3.3 Visual Evoked Potentials

Some of the conditions under which VEP testing (procedure code 95930) may be appropriate include, but are not limited to, the following:

- Identification of persons at increased risk for developing clinically definite multiple sclerosis.
- Diagnosing, monitoring, and assessing treatment response in multiple sclerosis.
- Localizing the cause of a visual field defect not explained by lesions seen on CT or MRI, or by metabolic disorders or infectious disease.
- Evaluating the signs and symptoms of visual loss in persons who are unable to communicate (e.g., unresponsive persons, non-verbal persons).
- Evaluating clients who experience double vision, blurred vision, loss of vision, eye injuries, head injuries, or weakness of the eyes, arms, or legs.

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9.2.28.4 Vestibular Evoked Myogenic Potentials (VEMP)

Vestibular Evoked Myogenic Potential (VEMP) is a benefit of Texas Medicaid when submitted with procedure codes 92517, 92518, and 92519.

VEMP testing must be medically indicated and may be reimbursed when submitted with one of the following diagnosis codes:

Diagnosis Codes							
H81311	H81312	H81313	H81319	H81391	H81392	H81393	H81399
H814	H818X1	H818X2	H818X3	H818X9	H8190	H8191	H8192
H8193	H821	H822	H823	H829	H8301	H8302	H8303
H8309	H8311	H8312	H8313	H8319	H832X1	H832X2	H832X3
H832X9	H833X1	H833X2	H833X3	H833X9	H838X1	H838X2	H838X3
H838X9	H8390	H8391	H8392	H8393	H9311	H9312	H9313
H9319	R110	R1110	R1111	R112	R42		

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

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

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

Documentation must include other differential diagnoses under consideration, and must include the following:

- The additional diagnoses considered.
- The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.

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

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

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

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9.2.28.5 Motion Analysis Studies

Motion analysis studies (procedure codes 96000, 96001, and 96002) are a benefit of Texas Medicaid for clients who are 3 through 20 years of age.

The neuromuscular disorders evaluated include, but are not limited to, cerebral palsy, traumatic brain injury, myelomeningocele, or stroke.

Prior authorization is not required for motion analysis studies.

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

In the following table, the procedure codes in Column A will be denied when they are submitted on the same date of service by the same provider as the procedure codes in Column B:

Column A (Denied)	Column B
96000	96001
95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, 95872	96002

9.2.28.5.1 Documentation Requirements for Motion Analysis Studies

Documentation must include the following information that indicates the client meets all the requirements for motion analysis studies. The client must be:

- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices.
- At least 3 through 20 years of age.
- Physically able to tolerate up to three hours of testing.

The reason for the referral and a clear diagnostic impression must be documented in the client's medical record for each motion analysis study performed.

The client's medical records must clearly document the medical necessity for the motion analysis study. The medical record documentation must reflect the actual results of specific tests.

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
  - Diagnosis
  - Current clinical signs and symptoms
  - Prior clinical condition
  - Expected clinical disease course
- There is clinical benefit of additional studies.

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

9.2.29 Extracorporeal Membrane Oxygenation (ECMO)

ECMO may be effective on a short-term basis for clients with life-threatening respiratory and/or cardiac insufficiency.

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ECMO may be reimbursed for clients who have the following clinical indications (this is not an all-inclusive list):

- Persistent pulmonary hypertension
- Meconium aspiration syndrome
- Respiratory distress syndrome
- Adult respiratory distress syndrome
- Congenital diaphragmatic hernia
- Sepsis
- Pneumonia
- Preoperative and postoperative congenital heart disease or heart transplantation
- Reversible causes of cardiac failure
- Cardiomyopathy
- Myocarditis
- Aspiration pneumonia
- Pulmonary contusion
- Pulmonary embolism

The following procedure codes may be used when billing ECMO:

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

Terminal disease with expectation of short survival, advanced multiple organ failure syndrome, irreversible central nervous system injury and severe immunosuppression are contraindications to ECMO. Claims for ECMO services may be recouped if the services are provided in the presence of these conditions.

The initial 24 hours of veno-venous (VV) ECMO should be submitted using procedure code 33946. Procedure code 33948 should be used for each additional 24 hours. Procedure code 33946 is denied as part of procedure code 33948 if submitted with the same date of service. Procedure codes 33946 and 33948 are limited to one per day when billed by any provider.

The initial 24 hours of veno-arterial (VA) ECMO should be submitted using procedure code 33947. Procedure code 33949 should be used for each additional 24 hours. Procedure codes 33947 and 33949 are limited to one per day when billed by any provider.

If insertion of VV cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33946 or 33948, the insertion of the cannula is denied, and the ECMO (procedure code 33946 or 33948) is considered for reimbursement.

If insertion of VA cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33947 or 33949, the insertion of the cannula is denied, and the ECMO (procedure code 33947 and 33949) is considered for reimbursement.

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9.2.30 Family Planning

Physicians, PAs, NPs, CNSs, and CNMs are encouraged to provide family planning services to Texas Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through Texas Medicaid (Title XIX) or through the DSHS Family Planning Program.

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

Section 2, "Healthy Texas Women (HTW) Program Overview" in the *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

The *Health and Human Services Commission Family Planning Program Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.31 Gynecological Health Services

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

Refer to: Section 6, "Gynecological Health Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for information about contraception, sterilizations, and family planning annual examinations.

9.2.32 Hospital Visits

Refer to: Subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in this handbook.

9.2.33 Hyperbaric Oxygen Therapy (HBOT)

Physicians who bill for the professional component of HBOT must use procedure code 99183. Hospital providers who bill for the chamber time must use procedure code G0277 with revenue code 413.

Note: *Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.*

Texas Medicaid recognizes the following indications for HBOT, as approved by the Undersea and Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps
- Crush injuries, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Delayed radiation injury (soft tissue and bony necrosis)
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Intracranial abscess
- Necrotizing soft tissue infections
- Refractory osteomyelitis

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- Acute thermal burn injuries

HBOT is not a replacement for other standard successful therapeutic measures.

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

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

The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber and may not delegate the rendering of the service. Both the facility's medical record and the client's medical record must contain documentation to support that there was a physician in attendance who provided direct supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

9.2.33.1 Prior Authorization for HBOT

HBOT procedure codes 99183 and G0277 require prior authorization. Prior authorization requests submitted for procedure code G0277 must also include revenue code 413. When requesting prior authorization, providers should use the Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for detailed information about prior authorization requirements.

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

Covered Indication	Total 30-Minute Intervals Allowed for Procedure Code G0277	Total Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Air or gas embolism	6	2	Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics
Carbon monoxide poisoning - initial authorization	15	5	Persistent neurological dysfunction secondary to carbon monoxide inhalation
Carbon monoxide poisoning - one subsequent authorization	9	3	Evidence of continuing improvement in cognitive functioning
Central retinal artery occlusion	36	6	Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion
Compromised skin grafts and flaps - initial authorization	80	10	Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia
Compromised skin grafts and flaps - one subsequent authorization	40	5	Evidence of stabilization of graft or flap

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Covered Indication	Total 30-Minute Intervals Allowed for Procedure Code G0277	Total Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Crush injury, compartment syndrome and other acute traumatic ischemias	36	12	Adjunct to standard medical and surgical interventions
Decompression sickness	28	1	Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure
Diabetic foot ulcer - initial authorization	60	30	After at least 30 days of standard medical wound therapy, with a wound pO2 less than 40 mmHg AND wound classified as Wagner grade 3 or higher. *
Diabetic foot ulcer - two subsequent authorizations	60	20	Evidence of continuing healing and wound pO2 less than 40 mmHg
Severe anemia	50	10	Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs
Clostridial myositis and myonecrosis (gas gangrene)	39	13	Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid
Necrotizing soft tissue infections - initial authorization	36	12	Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue
Necrotizing soft tissue infections - two subsequent authorizations	15	5	Evidence that advancement of dying tissue has slowed
Delayed radiation injury (soft tissue and bony necrosis) -initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional treatment
Delayed radiation injury - one subsequent authorization	40	10	Evidence of improvement demonstrated by clinical response
Refractory osteomyelitis - initial authorization	40	10	Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment
Refractory osteomyelitis - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response
Acute thermal burn injury - initial authorization	45	15	Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum

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Covered Indication	Total 30-Minute Intervals Allowed for Procedure Code G0277	Total Professional Sessions Allowed for Procedure Code 99183	Medical Necessity Documentation of the Following is Required
Acute thermal burn injury - three subsequent authorizations	30	10	Evidence of continuing improvement demonstrated by clinical response
Intracranial abscess - initial authorization	15	5	Adjunct to standard medical and surgical interventions when one or more of the following conditions exist: Multiple abscesses Abscesses in a deep or dominant location Compromised host Surgery contraindicated or client is a poor surgical risk
Intracranial abscess - one subsequent authorization	15	5	Evidence of improvement demonstrated by clinical response and radiological findings

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

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

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

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

In emergency situations, the prior authorization request must be submitted no later than three business days after the date the service is rendered. Providers must not submit a claim until the prior authorization request has been approved. If the request has not been approved, the claim will be denied.

9.2.34 Ilizarov Device and Procedure

Providers must use procedure codes 20692, 20693, 20694, and 20999 when submitting claims for the Ilizarov procedure. A global fee payment methodology is applied to the Ilizarov device procedure codes. Procedure codes 20692, 20693, 20694, and 20999 include the preconstruction, surgical application, adjustments to the device for up to 6 months, and the removal of the device.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 20690 or 20692, where applicable, when billing for the surgical applications.

9.2.35 Immunization Guidelines and Administration

Texas Medicaid reimburses immunizations (vaccines and toxoids) that the Advisory Committee on Immunization Practices (ACIP) recommends as routine.

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Providers must follow the most current ACIP recommendations unless they conflict with guidelines from the Texas Vaccines for Children (TVFC) Program, in which case providers must follow TVFC guidelines. Providers must also provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC). VISs explain the benefits and risks of the vaccines and toxoids administered.

Note: *Administered vaccines and toxoids must be reported to DSHS. After obtaining consent, DSHS submits all reported vaccines and toxoids to a centralized repository of immunization histories. This lifespan registry is known in Texas as ImmTrac2.*

9.2.35.1 Administration Fee

An administration fee may be reimbursed for all covered vaccines and toxoids that are administered according to the ACIP. The following procedure codes may be reimbursed when billed for vaccine and toxoid administration:

Procedure Code									
90460	90461	90471	90472	90473	90474				

Procedure code 90461 is used to report the administration of additional components of a vaccine and is not reimbursable for providers when administering TVFC-eligible vaccines under the TVFC program.

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473, and 90474 are benefits when counseling is not provided for the immunization administered. Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed for services rendered to clients of any age.

The administration fee may be reimbursed when the procedure code for the vaccine or toxoid administered (regardless of the source of the vaccine or toxoid) and the administration fee procedure code are billed on the same claim with the same date of service. Only one administration fee may be reimbursed to any provider for each vaccine or toxoid administered per day.

The following vaccine procedure codes are a benefit of Texas Medicaid and distributed by TVFC (does not include COVID-19, influenza, and RSV vaccines):

Procedure Codes	Age Range	Number of Recognized Components
90619	2 years of age or older	1
90620	10 years of age or older	1
90621	10 years of age or older	1
90623	10 years through 23 years of age	1
90624	10 through 23 years of age	1
90632	18 years of age or older	1
90633	Birth through 18 years of age	2
90647	6 weeks through 18 years of age	1
90648	6 weeks of age or older	1
90651	9 years through 45 years of age	1
90670	2 months of age or older	1
90671	6 weeks of age or older	1
90677	2 months of age or older	1
90680	Birth through 8 months of age	1

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Procedure Codes	Age Range	Number of Recognized Components
90681	Birth through 8 months of age	1
90696	4 years through 6 years of age	4
90697	Birth through 4 years of age	6
90698	Birth through 5 years of age	5
90700	Birth through 6 years of age	3
90702	Birth through 6 years of age	2
90707	1 year of age or older	3
90710	1 year through 12 years of age	4
90713	2 months of age or older	1
90714	7 years of age or older	2
90715	7 years of age or older	3
90716	1 year of age or older	1
90723	6 weeks through 6 years of age	5
90732	2 years of age or older	1
90734	2 months of age through 55 years of age	1
90743	11 years through 17 years of age	1
90744	Birth through 17 years of age	1
90746	18 years of age or older	1
90750	50 years of age or older	1

Note: *A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.*

COVID-19 Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for COVID-19:

Procedure Codes	Age Range
91320	12 years of age or older
91322	12 years of age or older
91323	12 years of age or older

Because the ACIP frequently reviews the composition of COVID-19 vaccines and makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of COVID-19 vaccines that TVFC is distributing for clients who are birth through 18 years of age.

Procedure code 90480 must be used in conjunction with one of the vaccine procedure codes listed above for reimbursement of COVID-19 vaccine administration.

COVID-19 vaccine counseling (procedure code G0315) may be reimbursed for clients who are birth through 20 years of age.

Procedure code G0315 will be denied if billed on the same day by the same provider as procedure code 90480.

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Procedure code G0315 is limited to once per day, by the same provider, and three per rolling year by any provider.

Influenza Vaccines

The following vaccine procedure codes are a benefit of Texas Medicaid for influenza:

Procedure Codes	Age Range
90653	65 years of age or older
90655	6 months through 35 months of age
90656	6 months of age or older
90657	6 months through 35 months of age
90658	6 months of age or older
90660	2 years through 49 years of age
90661	6 months of age or older
90662	65 years of age or older
90672	2 years through 49 years of age
90673	18 years of age or older
90674	6 months of age or older
90682	18 years of age or older
90685	6 months through 35 months of age
90686	6 months of age or older
90687	6 months through 35 months of age
90688	6 months of age or older
90694	65 years of age or older
90756	6 months of age or older

Because the ACIP reviews the composition of influenza vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the influenza vaccines that TVFC is distributing for clients who are birth through 18 years of age for the current flu season.

Peak influenza activity generally occurs from October of one year through February of the next year, although activity can last through May. This time period is commonly referred to as "flu season."

The first time a client who is 6 months through 8 years of age receives the influenza vaccine, he/she should receive a second dose of the vaccine during the same flu season at least 4 weeks after the first dose. If the client turns 9 years old between the first and second doses, he/she should still receive the second dose.

Excepting the scenario described in the previous line, clients who are 9 years of age or older should only receive one dose of the influenza vaccine per flu season, even if it is their first time receiving the influenza vaccine.

The following vaccine procedure codes are a benefit of Texas Medicaid and are not distributed by TVFC:

Procedure Codes	Age Range	Number of Recognized Components
90476	19 years through 50 years of age	1
90477	19 years through 50 years of age	1

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Procedure Codes	Age Range	Number of Recognized Components
90581	19 years through 65 years of age	1
90585	All ages	1
90586	All ages	1
90589	19 years of age or older	1
90593	12 years of age or older	1
90611	18 years of age or older	1
90625	19 years through 64 years of age	1
90626	19 years of age or older	1
90627	19 years of age or older	1
90636	19 years of age or older	2
90675	All ages	1
90679	50 years of age or older	1
90683	50 years of age or older	1
90684	19 years of age or older	1
90690	19 years of age or older	1
90691	19 years of age or older	1
90717	19 years of age or older	1
90736	60 years of age or older	1
90738	19 years of age or older	1
90739	18 years of age or older	1
90740	20 years of age or older	1
90747	20 years of age or older	1
90758	18 years of age or older	2
90759	18 years of age or older	1
J9030	All ages	1

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

Each vaccine procedure code must be submitted with the appropriate "administration with counseling" procedure code(s) (procedure codes 90460 and 90461) or the most appropriate "administration without counseling" procedure code (procedure code 90471, 90472, 90473, or 90474). If an "administration with counseling" procedure code is submitted with an "administration without counseling" procedure code for the same vaccine, the second administration of the vaccine will be denied.

Procedure code 90480 is a benefit for clients who are 6 months of age or older. Procedure code 90480 includes counseling and may only be reported with a COVID-19 vaccine procedure code.

Procedure code M0201 is a benefit for clients of any age. Procedure code M0201 may be reported, in addition to the vaccine and vaccine administration procedure codes when a pneumococcal, influenza, hepatitis B, and/or COVID-19 vaccine is administered inside a client's home.

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Administration with Counseling

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

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

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client's medical record.

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

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

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

Administration without Counseling

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

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

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

9.2.35.2 Documentation

Providers must document the following information in the client's medical record, which is subject to retrospective review to determine appropriate utilization and reimbursement of this service:

- The vaccine or toxoid given
- The date of the vaccine or toxoid administration (day, month, year)
- The name of the vaccine or toxoid manufacturer and the vaccine or toxoid lot number
- The signature and title of the person administering the vaccine or toxoid
- The organization's name and address

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- The publication date of the VIS issued to the client, parent, or guardian
- The site at which the vaccine was given (recommended)

9.2.35.3 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after the administration of any vaccine in the United States, even if it's unclear whether a vaccine caused it. The *National Childhood Vaccine Injury Act* (NCVIA) requires health-care providers to report:

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

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Documentation of the injection site is recommended but not required.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/docs/VAERS_Table_of_Reportable_Events_Following_Vaccination.pdf.

9.2.36 Immunizations for Clients Birth through 20 Years of Age

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of THSteps when provided as part of a THSteps medical checkup. A THSteps provider who bills vaccines and toxoids with diagnosis or age restrictions is subject to those restrictions. In addition to the age appropriate diagnosis for the THSteps preventive care medical checkup, providers must bill the claim with the diagnosis code that indicates the condition that necessitates the vaccine or toxoid.

If an immunization is administered as part of the preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

If an immunization is the only service provided during an office visit, providers may submit only diagnosis code Z23 on the claim.

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of CCP when the vaccine or toxoid is provided as part of an acute medical visit outside of a THSteps medical checkup.

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on THSteps age related diagnosis codes.

9.2.36.1 Vaccine Coverage Through the TVFC Program

Providers may refer to the TVFC web site at www.dshs.texas.gov/immunizations/health-departments/overview for information about the program and for a list of vaccines available through the program.

Note: *All vaccines and toxoids recommended by Advisory Committee on Immunization Practices (ACIP) are available from the TVFC Program to enrolled clinic sites. Clinics participating in the TVFC Program have agreed to administer all ACIP-recommended vaccines to the eligible populations that are served.*

When a single antigen vaccine or toxoid or a comparable antigen vaccine or toxoid is available through TVFC, but the provider chooses to use a different ACIP-recommended product, the administration fee will be reimbursed but the vaccine or toxoid will not be reimbursed.

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Although Texas Medicaid does not mandate that providers enroll in TVFC, Texas Medicaid will not reimburse providers when the vaccine is available through TVFC. Only the administration fee will be reimbursed through Texas Medicaid when the vaccine or toxoid procedure code is identified on the claim. Clients may not be billed for vaccines and toxoids that are available through TVFC.

If a vaccine or toxoid meets the definition of "not available" through TVFC, it may be separately reimbursed through CCP when billed with modifier U1. Modifier U1 may be used in the following situations:

- The TVFC, based on their federal resolution (distribution/guidelines), does not distribute an HHSC-approved vaccine or toxoid following the ACIP recommendation, and the provider purchases vaccine to administer to all ACIP-recommended ages or risk groups.
- A new vaccine or toxoid approved by the ACIP with established guidelines, but has not been negotiated or added to a TVFC contract
- Funding for new vaccine or toxoid has not been established by TVFC
- Insufficient vaccine and toxoid supply due to national supply or distribution issues, as reported to HHSC by TVFC

HHSC will notify providers if a vaccine or toxoid meets the definition of "not available" from TVFC and when the provider's privately purchased vaccine or toxoid may be billed with modifier U1. Modifier U1 must not be used due to a provider's failure to enroll in TVFC or to maintain sufficient TVFC vaccine or toxoid inventory.

Refer to: Subsection 4.5.1, "Texas Vaccines for Children (TVFC) Program" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about TVFC and immunizations for infants and children.

9.2.36.2 Vaccine and Toxoid Procedure Codes

The following vaccine and toxoid procedure codes may be reimbursed for Texas Medicaid clients who are birth through 20 years of age:

Procedure Codes									
Bacillus Calmette-Guérin (BCG)									
Refer to: Subsection 9.2.9, "Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer" in this handbook.									
Adenovirus									
90476	90477								
Anthrax									
90581									
Chikungunya Virus									
90589	90593								
Cholera									
90625									
COVID-19									
91320	91322								
Ebola Virus									
90758									
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**									

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Procedure Codes									
Hepatitis A and B									
90632	90633*	90636	90723*	90740	90743	90744*	90746	90747	90759
Providers must document in the client's medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Providers are expected to follow the ACIP recommendations for administration.									
Hepatitis B Immune Globulin									
90371	96372	96374	J1571	J1573					
Providers must document in the client's medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Intramuscular hepatitis B immune globulin (HBIg) may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC. Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205. Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code. Procedure codes 96372 and 96374 may be reimbursed for HBIg administration. Providers are expected to follow the ACIP recommendations for administrations.									
Hib									
90647*	90648*								
Human Papilloma (HPV)									
90651*									
Influenza									
90655*	90656*	90657*	90658*	90660*	90661	90672*	90673	90674	90682
90685*	90686*	90687*	90688*	90756*					
Influenza vaccine is a benefit of Texas Medicaid for high-risk clients who are not covered by THSteps or TVFC or when the vaccine is not declared available through the TVFC. Texas Medicaid considers the influenza season in the United States to be October through the end of May.									
Japanese Encephalitis (JE)									
90738									
Measles, Mumps, Rubella Vaccine (MMR)									
90707*									
Measles, Mumps, Rubella, and Varicella Vaccine (MMRV)									
90710*									
Pneumococcal and Meningococcal									
90620*	90621*	90623†	90624*	90670*	90671*	90677*	90684	90732*	90734*
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**									

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Procedure Codes									
The pneumococcal polysaccharide vaccine (procedure code 90732) is a benefit for Texas Medicaid clients who are not covered by the THSteps or TVFC programs. The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. For high-risk clients, revaccination is recommended once in a lifetime five years after the initial dose. Revaccination after a second dose is not a benefit of Texas Medicaid. Pneumococcal polysaccharide vaccine is not recommended for children who are birth through 23 months of age. Providers are expected to follow the ACIP recommendations for administrations.									
Poliovirus (IPV)									
90713*									
Respiratory Syncytial Virus (RSV)									
90380*	90381*	90382*	90678*						
Rotavirus									
90680*	90681*								
Tetanus and Diphtheria									
90696*	90698*	90700*	90702*	90714*	90715*	90723*			
Tick-borne Encephalitis (TBE)									
90626	90627								
Typhoid Vaccine									
90690	90691								
Varicella Virus									
90716*									
Yellow Fever									
90717									
*** Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational.**									

9.2.37 Immunizations for Clients Who Are 21 Years of Age or Older

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary. Providers are expected to follow the ACIP recommendations for administration.

The following immunizations are identified and recommended by the ACIP for clients who are 21 years of age or older (this list is not all-inclusive):

Immunization Procedure Codes									
BCG									
Refer to: Subsection 9.2.9, "Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer" in this handbook.									
Adenovirus									
90476	90477								
Anthrax									
90581									
Chikungunya Virus									

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Immunization Procedure Codes									
90589	90593								
Cholera									
90625									
COVID-19									
91320	91322								
Ebola Virus									
90758									
Hepatitis A and B									
90632	90740	90746	90747	90759					
Providers must document in the client's medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747.									
Hepatitis B Immune Globulin									
90371	96372	96374	J1571	J1573					
Providers must document in the client's medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. Intramuscular HBIg may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIg is not provided through TVFC. Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205. Only one HBIg procedure code will be paid if billed with the same date of service by any provider as any other HBIg procedure code. Procedure codes 96372 and 96374 may be reimbursed for HBIg administration.									
Hepatitis A and B									
90636									
Haemophilus Influenza Type B (Hib)									
90648									
Human Papilloma (HPV)									
90651									
Influenza									
90653	90656	90658	90660	90661	90662	90672	90673	90674	90682
90686	90688	90694	90756						
Influenza vaccine is a benefit of Texas Medicaid for all clients. Texas Medicaid considers the influenza season in the United States to be October through the end of May. The optimal time to receive influenza vaccine is as early in the season as it is available. However, clients should continue to receive influenza vaccine through March. The vaccine may be administered one time per influenza season.									
Japanese Encephalitis (JE)									
90738									
MMR									
90707									
Pneumococcal and Meningococcal									

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Immunization Procedure Codes									
90619	90620	90621	90623	90670	90671	90677	90684	90732	90734
The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. Revaccination is recommended five years (not interpreted to mean every five years) after the initial dose for high-risk individuals. Revaccination after a second dose is not reimbursed.									
Poliovirus (IPV)									
90713									
Respiratory Syncytial Virus (RSV)									
90678	90679	90683							
Shingles									
90736	90750								
Tetanus									
90714									
Tetanus, Diphtheria, and Acellular Pertussis Vaccine (Tdap)									
90715									
Tick-borne Encephalitis (TBE)									
90626	90627								
Typhoid Vaccine									
90690	90691								
Varicella Virus									
90716									
Yellow Fever									
90717									

The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code. Diagnosis code Z23 may also be included. The type of immunization given will be identified by the procedure code.

9.2.38 Rabies Prophylaxis

The rabies vaccine (procedure code 90675) and rabies immune globulin (procedure codes 90375, 90376, and 90377) are benefits of Texas Medicaid as part of rabies prophylaxis.

Rabies immune globulin is limited to clients with diagnosis code Z203.

9.2.38.1 Rabies Vaccine Availability and Animal Bite Reporting

Providers that determine a client requires the rabies vaccination series may obtain the biologicals directly from the manufacturer or through one of the Texas Department of State Health Services (DSHS) depots around the state.

Animal bites to people must be reported as soon as possible to the designated Local Rabies Control Authority (LRCA).

9.2.38.2 Prior Authorization for Postexposure Rabies Vaccine

Prior authorization is not required for postexposure rabies vaccine. The physician must maintain documentation of the exposure in the client's medical record.

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9.2.38.3 Limitations for Postexposure Rabies Vaccine

Reimbursement for postexposure rabies vaccine is limited to one per client per day, by any provider.

Reimbursement for postexposure rabies vaccine is limited to 5 occurrences per 90 rolling days. Claims billed for any vaccine given beyond 90 rolling days will be denied.

9.2.38.3.1 Obtaining Rabies Vaccine and HRIG from DSHS for PEP Use

Providers may obtain the vaccine and HRIG directly from the manufacturer. If a provider is not able to obtain the vaccine and/or HRIG directly, providers may contact DSHS local or state public health professionals.

For each potential rabies exposure, providers must consult with their local health department or the DSHS regional ZC program office that serves their area. Requests for consultations made to DSHS after-hours or on holidays should be directed to the DSHS On-Call Physician at 1-888-963-7111.

Local public health professionals or regional ZC staff will help providers determine whether or not the exposure situation warrants PEP. If the exposure situation is determined to be valid, providers will be given detailed information about how to obtain rabies vaccine and HRIG for the patient.

Providers can refer to the following DSHS web pages for the contact information of local public health professionals:

- Full Service Local Health Departments and Districts of Texas at www.dshs.texas.gov/regions/lhds.shtm
- Zoonosis Control Branch at www.dshs.texas.gov/idcu/health/zoonosis/contact/
- Use of a Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies, Recommendations of the Advisory Committee on Immunization Practices March 19, 2010 www.cdc.gov/mmwr/pdf/rr/rr5902.pdf
- DSHS rabies website at www.dshs.texas.gov/idcu/disease/Rabies/
- Regional DSHS ZC offices
- "Human Rabies Prevention—United States, 2008 Recommendations of the Advisory Committee on Immunization Practices"
- CDC rabies website at www.cdc.gov/rabies/

9.2.38.4 Smallpox and Mpox (Monkeypox) Vaccine

Procedure code 90611 may be reimbursed for clients who are 18 years of age or older.

Procedure code 90622 is informational only.

9.2.39 Respiratory Syncytial Virus (RSV)

The following procedure codes may be reimbursed for RSV monoclonal antibodies and RSV vaccines:

Procedure Code	Age Range	Number of Recognized Components
90380	Birth through 19 months of age	1
90381	Birth through 19 months of age	1
90382	Birth through 7 months of age	1
90678	10 years of age or older	1
90679	50 years of age or older	1
90683	50 years of age or older	1

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Because the ACIP reviews the composition of certain seasonal vaccines annually and frequently makes updates to their recommendations, providers should refer to the CDC website for current recommendations.

Providers should refer to the TVFC website for the most up-to-date list of the RSV vaccines and RSV monoclonal antibodies that TVFC is distributing for clients who are birth through 18 years of age for the current RSV season.

RSV vaccine (procedure code 90678) may be reimbursed for clients who are:

- Pregnant and are 32 through 36 weeks gestation.
- 60 years of age or older.

RSV vaccine (procedure code 90679 and 90683) may be reimbursed for clients who are 50 years of age or older.

Vaccine administration (procedure code 90460 or 90471) must be used in conjunction with one of the RSV vaccine procedure codes (90678, 90679 or 90683) for reimbursement of RSV vaccine administration.

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

RSV monoclonal antibodies (clesrovimab, procedure code 90382) may be administered to clients who are birth through 7 months of age and are limited to one per lifetime.

RSV monoclonal antibody administration (procedure code 96380 or 96381) must be used in conjunction with one of the monoclonal antibody procedure codes (90380, 90381, or 90382) for reimbursement of RSV monoclonal antibody administration.

9.2.40 Implantable Infusion Pumps

Implantable infusion pump (IIPs) are intended to provide long-term, continuous, or intermittent drug infusion. They may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of Intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver
- Administration of intra-arterial chemotherapy in head and neck cancers

An implantable infusion pump is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

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Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786. If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

9.2.40.0.1 Prior Authorization for Implantable Infusion Pumps

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

Providers must request prior authorization through the Special Medical Prior Authorization (SMPA) department. The ASC or DME provider may submit a request for prior authorization using the Special Medical Prior Authorization (SMPA) Form, which must be completed and signed by a physician.

The completed, signed and dated SMPA form must be maintained by the provider and the prescribing physician in the client's medical record.

The completed SMPA Form must include the procedure code and quantity for the services that are requested. Documentation that is submitted with the prior authorization request must indicate whether the IIP will be provided by the ASC or the DME provider.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested IIP. The requesting provider may be asked for additional information to clarify or complete a request for the IIP.

Documentation submitted with the prior authorization request must indicate the client or caregiver has:

- The ability to provide a return demonstration performance.
- The attention, desire, interest, flexibility, and independence.
- An understanding of cause and effect and object permanence.

As indicated in the following sections, supporting documentation that is based on the type of IIP requested must be included with the request for prior authorization. All of the documentation listed under the specific type of IIP must be included with the request for prior authorization.

9.2.40.0.2 IIP for Administration of Anti-spasmodic Drug to Treat Severe Refractory Spasticity

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
- Degree of spasticity
- Affected muscle groups
- Functional impact
- Duration of symptoms
- Any recent hospitalizations (within past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- Treatment history of self-administration with evidence of:

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- A minimum of six weeks of non-invasive methods of spasticity control, including, but not limited to, oral antispasmodics, that either:
- Failed to adequately control the spasticity, or
- Produced intolerable side effects
- The role, participation, and compliance of the family or client that demonstrate the following:
- The ability to provide a return demonstration performance
- Attentiveness, desire, interest, flexibility, and independence
- An understanding of cause and effect and object permanence
- Favorable response to a trial intrathecal dose of the antispasmodic
- No contraindications to implantation exist, including, but not limited to, the following:
- Coagulopathy
- Infection
- Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
- Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
- Antispasmodic to be infused
- Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
- Expected outcome
- Treatment goals

9.2.40.1 IIP for Administration of Analgesic (Opioid or Nonopioid) Drug for Treatment of Severe Intractable Pain

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
- Severity of pain
- Functional impact
- Source of pain or location, including whether pain is malignant or non-malignant
- Duration of symptoms
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- A life expectancy of at least three months

Note: *The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*

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For malignant pain, the following documentation is required for prior authorization:

- Treatment history with evidence of a favorable response to a trial intrathecal dose of the analgesic drug, defined as a minimum of 50 percent reduction in pain
- Failure of more conservative methods of pain control, including, but not limited to, oral analgesics, surgery, or therapy, that were ineffective due to one of the following:
- Failed to adequately control the pain, or
- Produced intolerable side effects

Note: *The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*

For nonmalignant pain, the following documentation is required for prior authorization:

- A minimum of six months of more conservative methods of pain control, including but not limited to oral analgesics, surgery, attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated pain reaction, that were ineffective due to one of the following:
  - Failed to adequately control the pain, or
  - Produced intolerable side effects

Examples of non-malignant severe intractable pain include, but are not limited to, the following:

- Complex regional pain syndrome I & II (causalgia/RSD) refractory to other treatments.
- Post herpetic neuralgia
- Failed back syndrome
- Phantom limb pain
- Arachnoiditis (proven with MRI/increased CSF protein levels)
- Spinal cord myelopathy (refractory to conservative measurements)
- The role, participation, and compliance of the family or client that demonstrate the following:
- The ability to provide a return demonstration performance
- Attentiveness, desire, interest, flexibility, and independence
- An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
- Coagulopathy
- Infection
- Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
- Tumor encroachment on the thecal sac
- Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
- Analgesic to be infused
- Follow-up including pump refilling, maintenance, and monitoring of changes in infusion rate
- Expected outcome
- Treatment goals

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9.2.40.2 IIP for Administration of Intrahepatic Chemotherapy in Primary Liver Cancer or Colorectal Cancer with Liver Metastases

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis of one of the following:
- Primary liver cancer
- Metastatic cancer with metastases limited to the liver
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family and/or client demonstrating:
  - The ability to provide a return demonstration performance
  - Attentiveness, desire, interest, flexibility, and independence
  - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Chemotherapeutic agent to be infused. The prescribed drug must be approved by the U.S. Food and Drug Administration (FDA) for the intended use and must be compatible with the implantable device (such as floxuridine or methotrexate)
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

9.2.40.3 IIP for Administration of Intra-Arterial Chemotherapy in Head and Neck Cancers

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis and site(s) of any metastases
- Any hospitalizations (within the past 12 months) and all other diagnoses
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family or client that demonstrates the following:
  - The ability to provide a return demonstrate performance

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- Attentiveness, desire, interest, flexibility, and independence
- An understanding of cause and effect and object permanence

- No contraindications to implantation exist, including, but not limited to, the following:
  - Coagulopathy
  - Infection
  - Other implanted devices where the "crosstalk" between devices may inadvertently change the prescription
  - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
  - Chemotherapeutic agent to be infused
  - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
  - Expected outcome
  - Treatment goals

9.2.40.4 Replacement of an IIP

An IIP is expected to last a minimum of five years. Prior authorization for replacement of an IIP is considered within five years when one of the following occurs:

- There has been a significant change in the client's condition and the current equipment no longer meets the client's needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.
- Loss or irreparable damage to the IIP has occurred. The following must be submitted with the prior authorization request:
- A copy of the police or fire report, when appropriate
- A statement about the measures to be taken in order to prevent reoccurrence

Replacement of an IIP for a client who is birth through 20 years of age that does not meet the criteria above may be considered for prior authorization through CCP.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The DME provider must maintain the signed and dated form in the client's medical record.

Refer to: Subsection 2.8.3.5, "DME Certification and Receipt Form" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about this form.

9.2.40.5 Implantation of Catheters, Reservoirs, and Pumps

The following procedure codes may be used to bill the implantation of catheters and infusion pumps or devices for long term medication administration:

Procedure Codes				
62350	62351	62360	62361	62362

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Procedure code 62350 or 63251 may be reimbursed when billed for the same date of service as procedure code 62360, 62361, or 62362.

Procedure codes 62355 and 62365 do not require prior authorization.

The following procedure codes are denied as included in the total anesthesia time when billed with the same date of service as an anesthesia procedure by the same physician:

Procedure Codes						
62350	62351	62355	62360	62361	62362	62365

These procedure codes are considered for reimbursement according to multiple surgery guidelines when billed with the same date of service as another surgical procedure performed by the same physician.

Procedure codes 95990, 96521, and 96522 are considered for reimbursement when used for refilling an implantable pump.

Procedure codes 62367, 62368, 62369, and 62370 may be used to bill for electronic analysis of an implantable infusion pump.

Procedure codes 62369 and 62370 will be denied when billed for the same date of service by the same provider as procedure code 62362.

The following procedure codes may be used to bill the insertion, revision, removal, or repair associated with implantable infusion pumps:

Procedure Codes						
36260	36261	36262	36563	36576	62355	62365

9.2.40.6 Drug Monitoring Services

Providers must use the most appropriate procedure codes when submitting claims for drug monitoring services that monitor prescribed medications that can be abused when used for the treatment of chronic pain. These claims are subject to retrospective review. Claims may be reprocessed and recouped if they are submitted for these drug monitoring services in the office setting using a procedure code for a quantitative test rather than a qualitative or semiquantitative test.

An enzyme immunoassay (EIA) device can be used to provide preliminary qualitative or semiquantitative test results for point-of-care monitoring purposes. EIA devices and the reagents used to perform in-office drug testing are cleared by the FDA only to obtain qualitative or semiquantitative initial screen or preliminary results.

Immunoassay and enzyme assay are tests that produce qualitative and semiquantitative results, so these tests must not be reported with procedure codes for quantitative tests. A qualitative or semiquantitative test is not a quantitative test and must not be billed as such.

The initial drug screen or preliminary result testing yields qualitative and semiquantitative results, which must be reported with an appropriate drug testing procedure code, as categorized in the CPT manual as "Drug Testing." Only those procedure codes that are a benefit of Texas Medicaid may be reimbursed.

CPT-categorized "Chemistry" and "Therapeutic Drug Assay" procedure codes are for quantitative tests and must not be reported for an initial screen or preliminary result that was performed in the point-of-care setting.

Refer to: The CPT manual for drug testing, chemistry, and therapeutic drug assay procedure codes, and to the Texas Medicaid fee schedule for procedure codes that may be reimbursed by Texas Medicaid.

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Using procedure codes for quantitative tests to report preliminary qualitative or semiquantitative test results is considered systematic upcoding and may lead to administrative sanctions, civil monetary penalties, and criminal prosecution.

Providers may refer to the CMS website for more information about laboratory tests that may be rendered in the office setting. For tests that require a CLIA certificate of waiver, CMS publishes a list of all waived tests. The list is updated quarterly and includes the procedure code to use when billing a test.

9.2.41 Joint Injections and Trigger Point Injections

Injectable medication and the administration of medications through the intramuscular (IM), subcutaneous (SQ), or intravenous (IV) route are a benefit of Texas Medicaid.

Viscosupplementation agents include hyaluronic acid, which is injected into the knee joint to relieve pain associated with osteoarthritis.

The following viscosupplement procedure codes must be used to submit claims for osteoarthritis of the knee:

Procedure Codes									
J3470	J3471	J3472	J3473	J7318	J7320	J7321	J7322	J7323	J7324
J7325	J7326	J7328	J7329						

If an administration procedure code is billed with one of the following viscosupplement procedure codes without a qualifying diagnosis code, the claim will be denied.

Texas Medicaid may reimburse claims for viscosupplement procedure codes that are submitted with the following approved diagnosis codes:

Diagnosis Codes							
M170	M1710	M1711	M1712	M172	M1730	M1731	M1732
M174	M175	M179					

The following procedure codes must be used to submit claims for injections into joints:

Procedure Codes						
20600	20604	20605	20606	20610	20611	20612

The following procedure codes must be used to submit claims for trigger point injections:

Procedure Codes					
20526	20527	20550	20551	20552	20553

Joint injections and trigger point injections are valid only in the treatment of acute problems or the exacerbation of a chronic condition. The provider must use the AT modifier to indicate an acute condition and use modifiers LT (left) and/or RT (right) as appropriate.

The cost of the injection does not include the drugs used. The drug can be reimbursed separately. Multiple joint injections may be reimbursed when billed with the same date of service if the claim indicates the specific site of each injection. The first injection or aspiration is reimbursed at the full profile allowance and any subsequent injections are reimbursed at half allowance.

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9.2.42 * Laboratory Services

Texas Medicaid benefits are provided for professional and technical services ordered by a physician and provided under the supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the client's medical record as medically necessary and referenced to an appropriate diagnosis. Texas Medicaid does not reimburse baseline or screening laboratory studies.

Providers may bill only for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory must not be billed on the provider's claim. Laboratories bill Texas Medicaid directly for the tests they perform.

Unless otherwise noted, interpretation of laboratory tests is considered part of the provider's professional services (hospital, office, or emergency room visits) and must not be billed separately. Modifier Q4 is required for laboratory, radiology, and ultrasound interpretations by any provider other than the attending physician.

Laboratory tests that are generally considered part of a laboratory panel (e.g., chemistries, CBCs, urinalyses [UAs]) and that are performed on the same day must be billed as a panel regardless of the method used to perform the tests (automated or manual).

Physician interpretations that are requested of a consulting pathologist and require professional reading and reporting of results may be billed to Texas Medicaid separately as a professional charge.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA cannot be reimbursed for laboratory services.

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

Refer to: ***[Revised]*** The TMHP website Required CLIA Lab Certifications web page at www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for claims processing instructions.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.4.2, "Reimbursement" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for claims processing instructions.

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.

9.2.42.1 THSteps Laboratory Services

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

9.2.42.2 Laboratory Handling Charge

The laboratory handling charge covers the expense of obtaining and packaging the specimen and sending it to a reference laboratory.

A laboratory handling charge (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The reference laboratory name and address or NPI must be listed in Block 32 of the CMS-1500 claim form, and Block 20 must be completed.

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The provider is required to forward the client's name, address, Medicaid ID number, and diagnosis, if appropriate, with the specimen to the reference laboratory so the laboratory may bill Texas Medicaid for its services.

A provider may bill only one laboratory handling charge per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This laboratory handling benefit does not apply to THSteps medical checkup providers who must submit specimens to the DSHS Laboratory.

9.2.42.3 Blood Counts

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

Refer to: Subsection 2.2.6, "Complete Blood Count (CBC)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about blood counts.

9.2.42.4 Clinical Lab Panel Implementation

Refer to: Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about laboratory panels.

9.2.42.5 Clinical Pathology Consultations

Clinical pathology consultations (procedure code 80503, 80504, 80505, or 80506) are a benefit of Texas Medicaid for services rendered by a consultant who is either a clinical pathologist or a geneticist. In a clinical pathology consultation, the consultant may also help the ordering physician determine whether further study is appropriate, based on test results.

Providers may be reimbursed for clinical pathology consultations when the claim indicates the following information:

- The name, address, and NPI of the physician who requested the consultation.
- A written narrative report describing the findings of the consultation, which will also be included in the client's medical record.

Note: *To submit claims for interpretation, the provider must document an interaction that clearly shows that the consultant interpreted the test results and made specific recommendations to the attending physicians.*

If the claim does not include all of this information, the clinical pathology consultation will be denied.

Note: *Geneticists who provide a pathology consultation must submit claims using their acute care NPI.*

Routine conversations held between a consultant and attending physicians about test orders or results are not consultations. Information that can be furnished by a non-physician laboratory specialist does not qualify as a consultation service.

9.2.42.6 Cytogenetics Testing

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes.

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

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Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

Diagnosis Codes							
C8280	C8281	C8282	C8283	C8284	C8285	C8286	C8287
C8288	C8289	C828A	C8291	C8292	C8293	C8294	C8295
C8296	C8297	C8298	C8299	C829A	C8310	C8311	C8312
C8313	C8314	C8315	C8316	C8317	C8318	C8319	C831A
C8380	C8381	C8382	C8383	C8384	C8385	C8386	C8387
C8388	C8389	C838A	C8440	C8441	C8442	C8443	C8444
C8445	C8446	C8447	C8448	C8449	C844A	C8461	C8462
C8463	C8464	C8465	C8466	C8467	C8468	C8469	C846A
C8471	C8472	C8473	C8474	C8475	C8476	C8477	C8478
C8479	C847A	C847B	C8581	C8582	C8584	C8585	C8586
C8587	C8588	C8589	C858A	C8840	C8841	C8880	C8881
C9012	C9100	C9101	C9102	C9110	C9111	C9112	C9190
C9191	C9192	C91Z0	C91Z1	C91Z2	C9200	C9201	C9202
C9210	C9211	C9212	C9220	C9221	C9222	C9230	C9231
C9232	C9240	C9241	C9242	C9250	C9251	C9252	C9260
C9261	C9262	C9290	C9291	C9292	C92A0	C92A1	C92A2
C92Z0	C92Z1	C92Z2	C9300	C9301	C9302	C9310	C9311
C9312	C9330	C9331	C9390	C9391	C9392	C93Z0	C93Z1
C93Z2	C9400	C9401	C9402	C9420	C9421	C9422	C9430
C9431	C9432	C9480	C9481	C9482	C9500	C9501	C9502
C9510	C9511	C9512	C9590	C9591	C9592	D45	D821
E230	E291	E300	E3430	E3431	E34328	E34329	E3439
E83110	E8359	F70	F71	F72	F73	F78A1	F78A9
F800	F801	F802	F804	F8089	F810	F812	F8181
F8189	F819	F82	F840	F88	F900	F901	F902
F908	H0589	H9325	I77810	I77811	I77812	I77819	M2600
M2601	M2602	M2603	M2604	M2605	M2606	M2607	M2609
N4601	N4611	N6482	N910	N911	N913	N914	N949
N970	N978	O010	O011	O019	O021	O0289	O09511
O09512	O09513	O09521	O09522	O09523	O3500X0	O3500X1	O3500X2
O3500X3	O3500X4	O3500X5	O3500X9	O3501X0	O3501X1	O3501X2	O3501X3
O3501X4	O3501X5	O3501X9	O3502X0	O3502X1	O3502X2	O3502X3	O3502X4
O3502X5	O3502X9	O3503X0	O3503X1	O3503X2	O3503X3	O3503X4	O3503X5
O3503X9	O3504X0	O3504X1	O3504X2	O3504X3	O3504X4	O3504X5	O3504X9
O3505X0	O3505X1	O3505X2	O3505X3	O3505X4	O3505X5	O3505X9	O3506X0
O3506X1	O3506X2	O3506X3	O3506X4	O3506X5	O3506X9	O3507X0	O3507X1
O3507X2	O3507X3	O3507X4	O3507X5	O3507X9	O3508X0	O3508X1	O3508X2
O3508X3	O3508X4	O3508X5	O3508X9	O3509X0	O3509X1	O3509X2	O3509X3
O3509X4	O3509X5	O3509X9	O3510X0	O3510X1	O3510X2	O3510X3	O3510X4

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Diagnosis Codes							
O3510X5	O3510X9	O3511X0	O3511X1	O3511X2	O3511X3	O3511X4	O3511X5
O3511X9	O3512X0	O3512X1	O3512X2	O3512X3	O3512X4	O3512X5	O3512X9
O3513X0	O3513X1	O3513X2	O3513X3	O3513X4	O3513X5	O3513X9	O3514X0
O3514X1	O3514X2	O3514X3	O3514X4	O3514X5	O3514X9	O3515X0	O3515X1
O3515X2	O3515X3	O3515X4	O3515X5	O3515X9	O3519X0	O3519X1	O3519X2
O3519X3	O3519X4	O3519X5	O3519X9	O352XX0	O352XX1	O352XX2	O352XX3
O352XX4	O352XX5	O352XX9	P2930	P2938	Q000	Q001	Q002
Q010	Q011	Q012	Q018	Q02	Q030	Q031	Q038
Q040	Q041	Q042	Q045	Q046	Q048	Q050	Q051
Q052	Q054	Q055	Q056	Q057	Q058	Q062	Q064
Q068	Q0701	Q0702	Q0703	Q078	Q079	Q100	Q101
Q102	Q103	Q104	Q106	Q107	Q110	Q111	Q112
Q113	Q120	Q121	Q123	Q124	Q128	Q129	Q130
Q131	Q132	Q133	Q134	Q135	Q1381	Q1389	Q140
Q141	Q142	Q143	Q148	Q150	Q158	Q159	Q160
Q161	Q162	Q163	Q164	Q165	Q169	Q170	Q171
Q172	Q173	Q174	Q175	Q178	Q179	Q180	Q181
Q182	Q183	Q184	Q185	Q186	Q187	Q188	Q189
Q200	Q201	Q202	Q203	Q204	Q205	Q206	Q208
Q209	Q210	Q2110	Q2111	Q2112	Q2113	Q2114	Q2115
Q2116	Q2119	Q2120	Q2121	Q2122	Q2123	Q213	Q214
Q218	Q219	Q220	Q221	Q222	Q223	Q224	Q225
Q228	Q230	Q231	Q232	Q233	Q234	Q2381	Q2382
Q2388	Q240	Q241	Q242	Q243	Q244	Q245	Q246
Q248	Q249	Q250	Q251	Q2521	Q2529	Q253	Q2540
Q2541	Q2542	Q2543	Q2544	Q2545	Q2546	Q2547	Q2548
Q2549	Q2572	Q259	Q260	Q261	Q262	Q263	Q265
Q266	Q268	Q269	Q270	Q271	Q272	Q2730	Q2731
Q2732	Q2733	Q2734	Q274	Q278	Q279	Q280	Q281
Q282	Q283	Q288	Q289	Q300	Q301	Q302	Q303
Q308	Q309	Q310	Q311	Q312	Q313	Q315	Q318
Q320	Q321	Q322	Q323	Q324	Q330	Q331	Q332
Q333	Q334	Q335	Q336	Q338	Q339	Q348	Q349
Q351	Q353	Q359	Q360	Q369	Q370	Q371	Q372
Q373	Q374	Q375	Q380	Q381	Q382	Q383	Q384
Q385	Q386	Q387	Q388	Q391	Q392	Q393	Q394
Q395	Q396	Q398	Q400	Q401	Q402	Q408	Q409
Q410	Q411	Q412	Q419	Q420	Q421	Q422	Q423
Q428	Q430	Q431	Q432	Q433	Q434	Q435	Q437
Q438	Q440	Q441	Q442	Q443	Q444	Q445	Q446

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Diagnosis Codes							
Q4470	Q4471	Q4479	Q450	Q451	Q452	Q453	Q458
Q459	Q5001	Q5002	Q501	Q502	Q5031	Q5032	Q5039
Q504	Q505	Q506	Q510	Q5110	Q5111	Q5121	Q5122
Q5128	Q515	Q516	Q517	Q51811	Q51821	Q51828	Q520
Q5210	Q52120	Q52121	Q52122	Q52123	Q52124	Q52129	Q522
Q523	Q524	Q525	Q526	Q5270	Q5271	Q5279	Q528
Q529	Q5300	Q5301	Q5302	Q5310	Q53111	Q53112	Q5312
Q5313	Q5320	Q53211	Q53212	Q5322	Q5323	Q539	Q540
Q541	Q542	Q543	Q544	Q548	Q550	Q551	Q5521
Q5522	Q5523	Q5529	Q553	Q554	Q555	Q5561	Q5562
Q5563	Q5564	Q5569	Q558	Q559	Q560	Q561	Q562
Q563	Q564	Q600	Q601	Q603	Q604	Q606	Q6101
Q6119	Q612	Q613	Q614	Q615	Q618	Q619	Q6211
Q6212	Q622	Q6231	Q6239	Q624	Q625	Q6261	Q6262
Q6263	Q628	Q630	Q631	Q632	Q633	Q638	Q640
Q6410	Q6411	Q6412	Q6419	Q642	Q6431	Q6432	Q6433
Q6439	Q644	Q645	Q646	Q6471	Q6472	Q6473	Q6474
Q6475	Q649	Q6501	Q6502	Q651	Q6531	Q6532	Q654
Q6581	Q6582	Q6589	Q6600	Q6601	Q6602	Q6610	Q6611
Q6612	Q66211	Q66212	Q66219	Q66221	Q66222	Q66229	Q6630
Q6631	Q6632	Q6640	Q6641	Q6642	Q6651	Q6652	Q666
Q6670	Q6671	Q6672	Q6681	Q6682	Q6689	Q6690	Q6691
Q6692	Q670	Q671	Q672	Q673	Q674	Q675	Q676
Q677	Q678	Q680	Q681	Q682	Q683	Q684	Q688
Q690	Q691	Q692	Q699	Q7001	Q7002	Q7003	Q7011
Q7012	Q7013	Q7021	Q7022	Q7023	Q7031	Q7032	Q7033
Q709	Q7101	Q7102	Q7103	Q7111	Q7112	Q7113	Q7131
Q7132	Q7133	Q7141	Q7142	Q7143	Q7151	Q7152	Q7153
Q7161	Q7162	Q7163	Q71811	Q71812	Q71813	Q71891	Q71892
Q71893	Q7191	Q7192	Q7193	Q7201	Q7202	Q7203	Q7211
Q7212	Q7213	Q7231	Q7232	Q7233	Q7241	Q7242	Q7243
Q7251	Q7252	Q7253	Q7261	Q7262	Q7263	Q7271	Q7272
Q7273	Q72811	Q72812	Q72813	Q72891	Q72892	Q72893	Q7291
Q7292	Q7293	Q730	Q731	Q738	Q740	Q742	Q743
Q748	Q749	Q75001	Q75002	Q75009	Q7501	Q75021	Q75022
Q75029	Q7503	Q75041	Q75042	Q75049	Q75051	Q75052	Q75058
Q7508	Q751	Q752	Q753	Q754	Q755	Q758	Q759
Q760	Q761	Q762	Q763	Q76411	Q76412	Q76413	Q76414
Q76415	Q76425	Q76426	Q76427	Q76428	Q7649	Q765	Q766
Q767	Q768	Q770	Q771	Q772	Q774	Q775	Q776

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Diagnosis Codes							
Q777	Q780	Q781	Q782	Q783	Q784	Q788	Q789
Q790	Q791	Q792	Q793	Q794	Q7959	Q7960	Q7961
Q7962	Q7963	Q7969	Q798	Q799	Q800	Q801	Q802
Q803	Q804	Q808	Q820	Q821	Q822	Q823	Q824
Q825	Q826	Q828	Q830	Q831	Q832	Q833	Q838
Q840	Q841	Q842	Q843	Q844	Q845	Q846	Q848
Q849	Q8503	Q851	Q8581	Q8582	Q8583	Q8589	Q859
Q870	Q8711	Q8719	Q87410	Q87418	Q8742	Q8743	Q8782
Q8783	Q8784	Q8785	Q8786	Q8787	Q8788	Q8901	Q8909
Q891	Q892	Q893	Q894	Q897	Q8981	Q8989	Q899
Q900	Q901	Q902	Q909	Q910	Q911	Q912	Q913
Q914	Q915	Q916	Q917	Q920	Q921	Q922	Q925
Q9261	Q9262	Q927	Q928	Q930	Q931	Q932	Q933
Q934	Q9351	Q9352	Q9359	Q937	Q9381	Q9382	Q9388
Q9389	Q950	Q952	Q958	Q960	Q961	Q962	Q963
Q964	Q968	Q969	Q970	Q971	Q972	Q973	Q978
Q980	Q981	Q984	Q985	Q986	Q987	Q988	Q990
Q991	Q992	Q99811	Q99812	Q99813	Q99818	Q99819	Q9989
Q999	R480	Z31430	Z31438	Z315	Z317	Z360	Z361
Z362	Z363	Z364	Z365	Z3681	Z3682	Z3683	Z3684
Z3688	Z3689	Z368A	Z369	Z810	Z8279	Z8482	Z8489

Cytogenetics testing may be reimbursed with the following procedure codes and limitations:

Procedure Code	Quantity Allowed
Tissue Culture Procedure Codes and Limitations	
88230	1 per day any provider
88233	1 per day any provider
88235	1 per day any provider
88237	1 per day any provider
88239	1 per day any provider
Chromosome Analysis Procedure Codes and Limitations	
88245	1 per day any provider
88248	1 per day any provider
88249	1 per day any provider
88261	1 per day any provider
88262	1 per day any provider
88263	1 per day any provider
88264	1 per day any provider
88280	1 per day any provider

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Procedure Code	Quantity Allowed
88283	1 per day any provider
88285	1 per day any provider
88289	1 per day any provider
Molecular Cytogenetics Procedure Codes and Limitations	
88271	16 per provider per day
88272	10 per provider per day
88273	3 per provider per day
88274	5 per provider per day
88275	10 per provider per day
Interpretation and Report Procedure Code	
88291	As medically necessary

9.2.42.7 Maternal Serum Alpha-Fetoprotein (MSAFP)

MSAFP may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim. Procedure code 82105 should be used for MSAFP.

9.2.43 Pharmacogenetics

Pharmacogenetic testing of cytochrome p450 (CYP450) metabolic pathway may be considered medically necessary only if the results of the testing are necessary to differentiate between treatment options.

The use of pharmacogenetics may be considered medically necessary once in a lifetime to determine effective response to drug therapy for the following:

Procedure Code	Drug Treatment	Diagnosis Restriction	Prior Authorization
81225	Clopidogrel		Required
81226	Eliglustat	E7522	Required for repeat testing
	Tetrabenzine in a dosage greater than 50mg per day	G10	
81227	Warfarin		Required

9.2.43.1 Testing of Polymorphic 2C19

Pharmacogenetics testing of polymorphic 2C19 (procedure code 81225) may be considered for clopidogrel treatment and requires prior authorization and may be considered medically necessary when all of the following conditions are met:

- The client has never received genetic testing of the 2C19 alleles.
- The client has never received clopidogrel treatment.
- The clopidogrel treatment will be used for one of the following diseases or conditions:
  - ST elevated and non-ST elevated myocardial infarction (STEMI and NSTEMI)
  - Subsequent STEMI and NSTEMI
  - Dressler's syndrome
  - Unstable angina

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- Cerebral infarction due to embolism of cerebral arteries
- Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction
- Peripheral vascular disease, including unspecified

Note: *The routine use of genetic testing to screen patients treated with clopidogrel who are undergoing percutaneous coronary intervention (PCI) is not a benefit of Texas Medicaid.*

9.2.43.2 Testing of Polymorphic 2D6

Pharmacogenetics testing of polymorphic 2D6 (procedure code 81226) may be considered medically necessary when all of the following conditions are met:

- Group one:
  - The client has never received genetic testing of the 2D6 alleles
  - The client has a diagnosis of Gaucher disease type 1
  - Treatment with eliglustat (Cerdelga®) is being considered
- Group two:
  - The client has never received genetic testing of the 2D6 alleles
  - The client has a diagnosis of Huntington's disease
  - Treatment with tetrabenzine (Xenazine®) is being considered in a dosage greater than 50mg per day.

Prior authorization is not required for the initial pharmacogenetic testing of polymorphic 2D6 (procedure code 81226) that is performed on a client. Prior authorization is required for repeat testing.

9.2.43.3 Testing of Polymorphic 2C9

Pharmacogenetics testing of polymorphic 2C9 (procedure code 81227) requires prior authorization and may be considered for warfarin treatment and may be considered medically necessary when all of the following conditions are met:

- The client has never received genetic testing of the 2C9 alleles
- The client has never received warfarin (vitamin K antagonists) treatment
- The warfarin treatment will be used for one of the following diseases or conditions:
  - Irregular heartbeat or rhythm
  - Prosthetic (replacement or mechanical) heart valves
  - Myocardial infarction
  - Risk of venous thrombosis (swelling and blood clot in a vein)
  - Risk of pulmonary embolism (a blood clot in the lung)

9.2.43.4 Prior Authorization Requirements

Prior authorization is required for requests for pharmacogenetic testing for more than once in a lifetime. Prior authorization requests must be submitted on the Special Medical Prior Authorization (SMPA) Request Form. The form must be completed, signed, dated, and submitted by the prescribing or ordering provider.

Prior authorization requests from laboratories will not be processed. The requesting provider must share the prior authorization number with the laboratory submitting the claim.

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The prior authorization request must include the following:

- Laboratory NPI in section D of the SMPA Request Form
- Proposed or current treatment plan, including the drug name, dosage, and frequency that support the medical necessity of the service requested
    - This information may be documented in the "Statement of medical necessity" field under Section C of the SMPA Request Form or submitted separately with the prior authorization request.
- For prior authorization of procedure code 81225, the ordering provider must include a statement on the SMPA Request Form attesting that the client has never received clopidogrel treatment.
- For prior authorization of procedure code 81227, the ordering provider must include a statement on the SMPA Request Form attesting that the client has never received warfarin treatment.

Prior authorization requests to repeat the same test (procedure code 81225, 81226, or 81227) will be reviewed by the medical director when one of the following criteria is met:

- The client has Huntington's disease and a history of pharmacogenetic testing of 2D6 (procedure code 81226) for tetrabenzine treatment, and the new request is for the same testing of 2D6 but for eliglustat to treat Gaucher disease type 1.
- The client has Gaucher disease type 1 and a history of pharmacogenetic testing of 2D6 (procedure code 81226) for eliglustat treatment, and the new request is for the same testing of 2D6 but for tetrabenzine to treat Huntington's disease.
- Previous test results are unavailable. Every reasonable effort must be made to obtain the test results from the client's provider or laboratory who previously ordered or conducted testing. Documentation of these efforts must be submitted with the prior authorization request.

9.2.43.5 Exclusions

The following services are not a benefit of Texas Medicaid:

- Pharmacogenetics tests of polymorphisms in a p450 superfamily other than 2D6, 2C19, or 2C9, which are performed for the purpose of aiding in the choice of drug or dose to increase efficacy or avoid toxicity, as they are considered experimental and investigational
- The routine clinical use of genetic testing to screen patients treated with clopidogrel who are undergoing percutaneous coronary intervention (PCI)
- The use of any of the 2D6, 2C19, or 2C9 tests for the following conditions, drugs, or treatments:
    - Opioid pain medicines (codeine, oxycodone, hydrocodone, tramadol, fentanyl, and methadone)
    - Selective serotonin reuptake inhibitors (SSRIs)
    - Selective norepinephrine reuptake inhibitors (SNRIs)
    - Beta blockers
    - Selective tricyclic antidepressants
    - Selective antipsychotic drugs
    - Efavirenz and other antiretroviral therapies for human immunodeficiency virus (HIV) infection
    - Immunosuppressants for organ transplantation
    - Aricept® (donepezil) for individuals with Alzheimer's disease
    - p450 polymorphisms test panels for any of the 3 alleles 2C19, 2D6, or 2C9

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9.2.44 Lung Volume Reduction Surgery (LVRS)

LVRS is a benefit for clients who are not high risk but have a presence of severe, upper-lobe emphysema (as defined by radiologist assessment of upper-lobe predominance on CT scan) or who are not high risk but have a presence of severe, non-upper-lobe emphysema with low exercise capacity.

Note: *Clients who have low exercise capacity are those whose maximal exercise capacity is at or below 25 watts for women and 40 watts for men after completion of the pre-operative therapeutic program in preparation for LVRS. Exercise capacity is measured by incremental, maximal, symptom-limited exercise with a cycle ergometer utilizing a 5- or 10-watt-per-minute ramp on 30-percent oxygen after 3 minutes of unloaded pedaling.*

LVRS must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization
- Approved by Medicare as a lung or heart-lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client's potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6- to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
- Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client's medical, psychosocial, and nutritional needs
- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place

Clients must have surgical clearance by a licensed cardiologist for any of the following conditions:

- Unstable angina
- Left ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram
- LVEF less than 45 percent
- Dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction
- Arrhythmia (more than 5 premature ventricular contractions (PVC) per minute)
- Cardiac rhythm other than sinus
- PVCs on electrocardiogram (EKG) at rest

For clients with cardiac ejection fraction less than 45 percent, there must be no history of congestive heart failure or myocardial infarction within six months of consideration for surgery.

Clients must have surgical clearance by a licensed pulmonologist, thoracic surgeon, and anesthesiologist after completion of pre-operative rehabilitation.

Procedure codes 32491, G0302, G0303, G0304, and G0305 are limited to one per rolling year per client for any provider.

Pre-operative pulmonary rehabilitation services for preparation for LVRS (procedure codes G0302, G0303, and G0304) and post-discharge pulmonary surgery services LVRS (procedure code G0305) will be restricted to diagnosis codes J430, J431, J432, J438, and J983.

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Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

9.2.44.1 Prior Authorization for Lung Volume Reduction Surgery

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. The following documentation must be submitted with the request for prior authorization:

- The client's history and physical examination is consistent with emphysema
- BMI less than 31.1 kg/m2 (men) or less than 32.3 kg/m2 (women)
- Pulmonary status that is stable with less than 20 mg prednisone (or equivalent) per day
- A radiographic high resolution computer tomography (HRCT) scan has been conducted that shows evidence of bilateral emphysema.
- The forced expiratory volume in one second (FEV1) (maximum of pre- and postbronchodilator values) is less than or equal to 45 percent of the predicted value. If the client is 70 years of age and older, FEV1 is 15 percent of the predicted value or more.
- The total lung capacity (TLC) greater than 100 percent predicted postbronchodilator
- Residual volume (RV) greater than 150 percent predicted postbronchodilator found on prerehabilitation pulmonary function study.
- Arterial blood gas level (pre-rehabilitation):
  - Partial pressure of carbon dioxide (PaCO2) less than or equal to 60 mm Hg (PaCO2 less than or equal to 55 mm Hg if one mile above sea level)
  - Partial pressure of oxygen (PaO2) greater than or equal to 45 mm Hg on room air (PaO2 greater than or equal to 30 mm Hg if one mile above sea level)
- The plasma cotinine is less than or equal to 13.7 ng/ml (if the client is not using nicotine products) or the carboxyhemoglobin is less than or equal to 2.5 percent (if the client is using nicotine products).
- Nonsmoking for four months prior to initial interview and throughout evaluation for surgery
- Successful 6-minute walk test equal to or greater than 140 meters following pre-operative rehabilitation
- Successful completion of three minute unloaded pedaling in an exercise tolerance test both before and after pre-operative rehabilitation

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

- Requisition forms from the laboratory are not sufficient for verification of the personal and family history.
- Medical documentation that is submitted by the physician must verify the client's diagnosis or family history.

Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation for LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

9.2.44.1.1 Noncovered Conditions

LVRS is not a benefit in any of the following clinical circumstances:

- A client with characteristics that carry a high risk for perioperative morbidity and/or mortality

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- A disease that is unsuitable for LVRS
- A medical condition or other circumstance that makes it likely that the client will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery
- The client presents with FEV1 less than or equal to 20 percent of predicted value, and either a homogeneous distribution of emphysema on the CT scan or a carbon monoxide diffusing capacity of less than or equal to 20 percent of predicted value (a high-risk group identified in October 2001 by the NETT)
- The client satisfies the criteria outlined above and has severe, non-upper-lobe emphysema with a high-exercise capacity. High-exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 watts for women or 40 watts for men (under the measurement conditions for cycle ergometry).
- A previous LVRS (laser or excision) on the same lung
- A pleural or interstitial disease which precludes surgery
- A giant bulla (greater than 1/3 the volume of the lung in which the bulla is located)
- A clinically significant bronchiectasis
- A pulmonary nodule requiring surgery
- A previous lobectomy
- Uncontrolled hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg)
- Oxygen requirement greater than 6 liters per minute during resting to keep oxygen saturation greater than or equal to 90 percent
- A history of recurrent infections with clinically significant production of sputum
- Unplanned weight loss greater than 10 percent within 3 months before the consideration of surgery
- Pulmonary hypertension, defined as the mean pulmonary artery pressure of 35 mmHg or greater on the right heart catheterization or peak systolic pulmonary artery pressure of 45 mmHg or greater. Right heart catheterization is required to rule out pulmonary hypertension if the peak systolic pulmonary artery pressure is greater than 45 mmHg on an echocardiogram
- Resting bradycardia (less than 50 beats per minute)
- Frequent multifocal premature ventricular contractions (PVCs) of complex ventricular arrhythmia or sustained supraventricular tachycardia (SVT)
- Evidence of a systemic disease or neoplasia that is expected to compromise survival

9.2.45 Diagnostic and Therapeutic Breast Procedures

Diagnostic, mastectomy, and breast reconstruction procedures are benefits of Texas Medicaid.

These are physician-directed services including, but not limited to diagnostic and surgical breast procedures provided by physicians in the office, outpatient, or inpatient hospital settings, and external breast prostheses provided by durable medical equipment (DME) providers in the home setting.

Categories of service include:

- Diagnostic breast procedures
- Mastectomy
- Reconstructive breast procedures
- Treatment of complications of breast reconstruction

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- External breast prostheses

9.2.45.1 Diagnostic Procedures

Diagnostic breast procedures for a condition or malignancy of the breast may include:

- Puncture aspiration
- Mastotomy
- Injection procedure for ductogram or galactogram
- Percutaneous biopsy, with or without imaging guidance
- Incisional biopsy
- Nipple exploration
- Excision of the following:
  - Lactiferous duct fistula
  - Benign or malignant breast lesion
  - Chest wall tumor

The following procedure codes may be reimbursed for diagnostic breast procedures:

Procedure Codes									
19000	19001	19020	19030	19081	19082	19083	19084	19085	19086
19100	19101	19110	19112	19120	19125	19126	19281	19282	19283
19284	19285	19286	19287	19288					

The following services are not benefits of Texas Medicaid:

- Mastectomy for a diagnosis of fibrocystic disease in the absence of documented risk factors.
- Cosmetic services performed primarily to improve appearance.
- Commercial or "decorative" tattooing.
- Replacement of external breast prostheses when the damage is due to abuse or neglect by the client, client's family, or the caregiver.

9.2.45.2 Therapeutic Procedures

9.2.45.2.1 Mastectomy Procedures

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, and segmentectomy) are benefits when it is medically necessary to remove a breast or portion of a breast for conditions including, but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

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The following procedure codes for mastectomy are benefits of Texas Medicaid:

Procedure Codes					
19301	19302	19303	19305	19306	19307

Procedure codes 19301, 19302, 19303, 19305, 19306, and 19307 may be reimbursed without prior authorization for services rendered to male or female clients who are 18 years of age and older.

Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Procedure codes 19303, 19305, 19306, and 19307 are limited to 1 service per breast per lifetime.

9.2.45.2.2 Prophylactic Mastectomy

Prophylactic mastectomy is a benefit after a thorough assessment of a client's unique risk factors, health, and the level of concern. Prophylactic mastectomy is limited to clients who are at moderate- to high-risk for the development of breast cancer.

Moderate- to high-risk clients are those who meet one or more of the following criteria for development of breast cancer:

- Current or previous diagnosis of breast cancer
- Family history of breast cancer in mother, sister, or daughter, especially before the age of 50
- Presence of any of the following genetic mutations:
  - Breast cancer gene 1 (BRCA1)
  - Breast cancer gene 2 (BRCA2)
  - Tumor protein 53 (TP 53)
  - Phosphatase and tensin homolog (PTEN)
- Lobular carcinoma in situ (LCIS)
- Radiation therapy to the chest before a client reaches 30 years of age

Refer to: Subsection 3.5, "Breast Cancer Gene 1 and 2 (BRCA) Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Documentation that supports medical necessity for prophylactic mastectomy must include the information listed above.

Documentation that as a candidate for prophylactic mastectomy, the client has undergone counseling regarding cancer risks. Counseling must include assessment of all of the following:

- The client's ability to understand the risks and long-term implications of the surgical procedure, and
- The client's informed choice to proceed with the surgical procedure.

9.2.45.2.3 Mastectomy for Pubertal Gynecomastia

Mastectomy for pubertal gynecomastia is a benefit with prior authorization for males who are 20 years of age and younger. Procedure code 19300 may be reimbursed for mastectomy for pubertal gynecomastia.

The following documentation must be submitted with the prior authorization request for procedure code 19300:

- The gynecomastia classification (grade II, III, or IV) as defined by the American Society of Plastic Surgeons classification.
- Evidence that puberty is near completion, as indicated by the following:

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  - 95 percent of adult height based on bone age, and
  - Tanner stage V has been achieved.
- Evidence that the client has been off gynecomastia inducing drugs or other substances for a minimum of one year when this is identified as the cause of the gynecomastia.
- Evidence of resolution as supported by appropriate test results and treatment for hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas, and hypogonadism, for a minimum of one year when identified as the cause of the gynecomastia.
- Evidence of a psychiatric assessment performed by a psychiatrist or psychologist.
- Client's history and treatment plan including planned surgical procedure and timelines.
- Identification of which breast or breasts, require mastectomy.

Documentation that supports medical necessity for mastectomy for pubertal gynecomastia must be maintained in the client's medical record, and must include the following:

- A complete medical and family history, including:
  - Gynecomastia classification
  - Bone age
  - Tanner stage
  - Use of any gynecomastia inducing drugs or substances and date last ingested
  - Hormonal causes of gynecomastia, treatment, and length of treatment
  - Psychiatric assessment performed by a psychiatrist or psychologist and outcome
  - Affected breast or breasts
- A thorough physical examination
- Medically indicated laboratory testing and any other testing including results

9.2.45.3 Breast Reconstruction

Breast reconstruction may be performed in a single stage or several stages. Breast reconstruction is a benefit when all of the following criteria are met:

- The client has a documented history of one or more of the following:
  - Mastectomy
  - Congenital defect
  - Developmental abnormality
  - Trauma or injury to the chest wall
- The client meets age and gender criteria for the requested procedure.
- The physician has documented a treatment plan in the client's medical record that addresses the recommended breast reconstruction.
- Reconstruction to attain symmetry is required and may include a surgical procedure to the contra-lateral breast and may be either a reduction or an augmentation.

Procedure options for breast reconstruction following a mastectomy include, but are not limited to the following:

- Superficial inferior epigastric artery (SIEA) flap
- Deep inferior epigastric artery (DIEP) flap

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- Transverse rectus abdominis myocutaneous (TRAM) flap
- Breast implants (saline or silicone)
- Reduction mammoplasty
- Mastopexy
- Reconstruction of the nipple or areola (small flaps)
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

Documentation that supports medical necessity for breast reconstruction, including tattooing, must include the following:

- Diagnosis resulting in the need for breast reconstruction,
- Date of mastectomy, when appropriate,
- Date of any previous breast reconstruction procedures, when appropriate,
- Treatment plan to include planned surgical procedures and timeline for completion, and
- When appropriate, identification of the complication.

All Medicaid services, including breast reconstruction after breast cancer surgery, are covered for Medicaid Breast and Cervical Cancer (MBCC) clients who are receiving active cancer treatment. "Active treatment" is defined as medical treatment following a cancer diagnosis that is intended to cure or otherwise treat a diagnosed cancer.

Active treatment may include some or all of the following:

- Surgery
- Chemotherapy
- Radiotherapy
- Medication (e.g., ongoing hormonal treatments for estrogen and progesterone breast cancer)
- Active disease surveillance for triple negative receptor breast cancer

Reconstructive surgery (e.g., breast reconstruction) is considered "active treatment" if it is intended to permanently correct a physical condition resulting from either the diagnosed cancer or the treatment of the diagnosed cancer.

Ongoing treatment of a persistent condition resulting from a diagnosed cancer or treatment of a diagnosed cancer is not considered "active treatment" if cancer is no longer present or in need of treatment.

The following breast reconstruction procedure codes may be reimbursed without prior authorization for services rendered to clients who are 18 years of age and older:

Procedure Codes									
11970	11971	19316*	19325*	19340*	19342*	19350	19355	19357*	19361
19364	19367	19368	19369	19396*	S2068				
***Procedure codes are limited to females only.**									

Prior authorization is required for services rendered to clients who are 17 years of age and younger or when the client does not meet gender or age criteria.

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Procedure codes 11920, 11921, and 11922 may be reimbursed when performed as part of breast reconstruction.

Breast reconstruction claims denied for no history of previous mastectomy may be appealed with supporting documentation indicating the date of mastectomy, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.45.3.1 Tattooing to Correct Color Defects of the Skin

Tattooing to correct color defects of the skin (procedure codes 11920, 11921, and 11922) are limited to two services per lifetime.

Tattooing claims denied for no history of breast reconstruction may be appealed with supporting documentation indicating the date of breast reconstruction, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.45.3.2 Treatment for Complications of Breast Reconstruction

The treatment of complications related to breast reconstruction may be reimbursed using procedure codes 19328, 19330, 19370, 19371, and 19380.

Procedure codes 19328, 19330, 19370, and 19371 may be reimbursed for services rendered to female clients only.

9.2.45.3.3 Chest Wall Procedures

Excision of chest wall tumors may be reimbursed using procedure codes 21601, 21602, and 21603.

Procedure code 21603 is limited to once per lifetime.

9.2.45.3.4 External Breast Prostheses

External breast prostheses are available through a durable medical equipment (DME) provider for a female client with a history of a medically necessary mastectomy procedure.

The following procedure codes may be reimbursed for external breast prostheses services rendered to female clients of any age:

Procedure Codes									
L8000	L8001	L8002	L8015	L8020	L8030	L8031	L8032	L8033	L8035
L8039									

To be considered for reimbursement, an LT or RT modifier must be appropriately appended to the submitted diagnostic and therapeutic breast procedure codes or external breast prostheses procedure codes.

The external breast prosthesis procedure codes are limited as follows:

Procedure Code	**Limitation**
L8000	4 per rolling year
L8001	4 per rolling year, per modifier
L8002	4 per rolling year
L8015	2 per rolling year
L8020	1 per 6 rolling months
L8030	per 2 rolling years
L8031	per 2 rolling years
L8032	8 per rolling year

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Procedure Code	Limitation
L8033	8 per rolling year
L8035	Requires prior authorization
L8039	Requires prior authorization

Replacement of external breast prostheses may be considered at any time, through the prior authorization with documentation.

For a new or replacement external breast prosthesis procedure code outside the limitations, all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8035 (custom prosthesis), all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8039 (other prosthesis), all of the following documentation must be submitted with the prior authorization request:

- A clear, concise description of the breast prosthesis requested
- Reason for recommending the requested prosthesis
- A CPT or HCPCS procedure code, which is comparable to the procedure being requested
- Documentation that this breast prosthesis is not investigational or experimental
- The provider's intended fee for the requested prosthesis

9.2.45.4 Prior Authorization Requirements for Diagnostic and Therapeutic Breast Procedures

Prior authorization is not required for the following when all of the following criteria are met:

- The procedure is a mastectomy or breast reconstruction for clients who are 18 year of age or older.
- The request is for one of the following external breast prosthesis procedure codes: L8000, L8001, L8002, L8015, L8020, or L8030.
- The procedure is for partial mastectomy procedure codes 19301 and 19302 for clients of any age.

Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client is 17 years of age or younger, or does not meet gender criteria
- Mastectomy for pubertal gynecomastia
- Procedure code 19499 (unlisted procedure)
- External breast prosthesis procedure codes L8035 (custom prosthesis) and L8039 (other prosthesis)
- Any request for new or replacement external breast prosthesis outside of the limitations

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9.2.45.4.1 Unlisted Breast Procedure

All of the following documentation must be submitted for procedure code 19499 with the prior authorization request:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code, which is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service the procedure is to be performed
- The provider's intended fee for this procedure

9.2.45.4.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization Requirements" section above, the following requirements apply:

- All services are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and must support the medical necessity for the services provided.
- Services not supported by documentation are subject to recoupment.

9.2.46 Neurostimulators

Neurostimulator and neuromuscular stimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting conductive garments are a benefit of Texas Medicaid when medically necessary.

Durable medical equipment (DME) is defined as medical equipment/appliances that are manufactured to withstand repeated use, ordered by a physician or allowed practitioner for use in the home, and required to correct or ameliorate the client's disability, condition, or illness. Since there is no single authority (such as a federal agency) that confers the official status of "durable medical equipment" on any device or product, the Health and Human Services Commission (HHSC) retains the right to make such determinations with regard to DME provided by Texas Medicaid. DME provided by Texas Medicaid must either have a well-established history of efficacy, or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a Medicaid-eligible medical condition or functional disability.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or clinical nurse specialist (CNS).*

Neurostimulator devices are considered DME, so providers must complete both the Home Health (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX Form) to prescribe the DME and the DME Certification and Receipt Form to show receipt of the DME by the client. Both forms must be maintained in the client's medical record.

Refer to: Subsection 2.2.2, "Durable Medical Equipment (DME) and Supplies" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for more information about DME.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

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Items and/or services addressed in the sections below are either reimbursed at a maximum fee determined by HHSC or are manually priced. If an item is manually priced, the manufacturer's suggested retail pricing (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are reimbursed at the MSRP minus a discount (18 percent) as determined by HHSC.

9.2.46.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator or neuromuscular stimulator device require prior authorization.

A completed Special Medical Prior Authorization (SMPA) Request Form prescribing the device and related procedures must be signed and dated by a physician familiar with the client before requesting prior authorization for the device and related procedures. The completed SMPA Request Form must include the procedure codes and quantities for services requested.

Note: *It is not necessary to include the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form when submitting the SMPA Prior Authorization Request Form.*

The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the requesting provider must fax or mail the completed form to the SMPA Department. To complete the prior authorization process electronically, the requesting provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment, supplies and services requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the equipment and supplies.

A neurostimulator device that has been purchased is anticipated to last a maximum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. At that time, replacement of the device will be considered. Replacement devices require prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

9.2.46.2 Neuromuscular Electrical Stimulation (NMES)

NMES application and the rental or purchase of devices and conductive garments are a benefit of Texas Medicaid when medically necessary and prior authorized. Prior authorization requests for NMES must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

NMES may be reimbursed using the following procedure codes:

Procedure Codes									
64580	E0731	E0745	E0762	E0764	A4556	A4557	A4560	A4595	

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9.2.46.2.1 NMES Rental

The rental of a NMES device may be considered before purchase and is limited to a one-month trial period with consideration for one additional month's trial with documentation of medical necessity. Supplies are considered to be part of the rental and will not be separately reimbursed. Garments may be considered for reimbursement during the rental period when medically necessary.

9.2.46.2.2 NMES Purchase

The purchase of a NMES device is limited to once per five years, and may be reimbursed when there is documentation of successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by the following:

- A demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

Garments may be considered for reimbursement during the purchase period when medically necessary.

9.2.46.2.3 NMES for Muscle Atrophy

NMES may be reimbursed when used to treat muscle disuse atrophy when brain, spinal cord, and peripheral nerve supply to the muscle is intact, as well as other non-neurological conditions. Examples of NMES treatment for non-neurological conditions include, but are not limited to, casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery until orthotic training begins.

9.2.46.2.4 NMES for Walking in Clients with Spinal Cord Injury (SCI)

The type of NMES that is used to enhance the ability to walk of SCI clients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

The use of NMES/FES is limited to SCI clients who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months.

The trial period of physical therapy will enable the treating physician or allowed practitioner to properly evaluate the client's ability to use NMES/FES devices frequently and for the long term.

Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program. The goal of physical therapy must be to train SCI clients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

NMES/FES is a benefit for SCI clients who have all of the following characteristics:

- Clients with intact lower motor unit (L1 and below) (both muscle and peripheral nerve).
- Clients with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright posture while standing independently for at least three minutes.
- Clients who demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction.
- Clients who possess high motivation, commitment, and cognitive ability to use such devices for ambulation, as established by provider interview and documentation.
- Clients who can transfer independently.
- Clients who can demonstrate hand and finger function to manipulate controls.
- Clients with at least six-month post recovery spinal cord injury and restorative surgery.

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- Clients with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.

NMES and FES used for walking is not a benefit in SCI clients with any of the following:

- Cardiac pacemakers
- Severe scoliosis or severe osteoporosis
- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dysflexia

9.2.46.3 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS involves the attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated.

TENS may be reimbursed for the treatment of acute postoperative pain or chronic pain that is refractory to conventional therapy.

TENS may be reimbursed using the following procedure codes:

Procedure Codes									
E0720	E0730	E0731	E0733	E0736	A4556	A4557	A4595		

Procedure code E0733 requires prior authorization and is limited to diagnosis code G500.

Procedure code E0736 is limited to clients who are 18 years of age or older.

TENS is for the treatment of overactive bladder (OAB) and is limited to clients who have had the following:

- An evaluation that has been performed by an appropriate specialist, usually a urologist or urogynecologist, who has determined that the client is a candidate for posterior tibial nerve stimulation (PTNS)
- A medical record that includes the following documentation:
  - The client has been compliant with and has failed a trial of symptom-appropriate behavioral therapy of sufficient length to evaluate potential efficacy.
  - The client has been compliant with and has failed or been unable to tolerate a trial of at least two appropriate medications administered for four to eight weeks.
  - The client's voiding diary shows continued findings of OAB.
  - The client has documented a willingness to attend in-office treatment sessions, to comply with behavioral therapies, and to continue to keep voiding diaries that include documentation of behavioral therapy compliance.

9.2.46.3.1 TENS Rental

Rental of a TENS device will be considered for prior authorization when there is documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS device is limited to one-month trial period with consideration for one additional month's trial with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be separately reimbursed. Garments may be considered during the rental period when medically necessary.

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When the TENS device is rented for a trial period rather than supplied by the provider, the combined payment made for professional services and the rental of the stimulator must not exceed the amount which would be reimbursed for the total service, including the stimulator, if furnished by the provider alone.

9.2.46.3.2 TENS Purchase

The purchase of a TENS device is limited to once every five years and may be reimbursed with prior authorization when there is documentation of the following:

- A condition that indicates chronic pain that is refractory to conventional therapy.
- A successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

9.2.46.4 NMES and TENS Garments

The rental of the NMES/TENS garment is not covered during the trial rental period unless the client has a documented skin problem prior to the start of the trial period, and HHSC or its designee determines that use of such an item is medically necessary for the client based on the documentation submitted.

The purchase of conductive garments for NMES/TENS devices may be considered when:

- The garment has been prescribed by a physician or allowed practitioner for use in providing covered NMES/TENS treatment.
- A NMES/TENS device has been purchased for the client's use.
- The conductive garment is necessary for one of the medical indications outlined below:
  - The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
  - The client cannot manage the treatment for chronic intractable pain without the conductive garment because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
  - The client has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires.

9.2.46.5 NMES and TENS Supplies

Supplies for purchased devices are limited as follows:

- Procedure code A4438 is limited to clients who are 18 years of age or older.
- Procedure codes A4541 and A4595 are limited to 1 per month.
- Procedure code A4541 is restricted to diagnosis code G500.
- If additional electrodes are required, procedure code A4556 may be considered for reimbursement at a maximum of 15 per month.
- If additional lead wires are required, procedure code A4557 may be considered for reimbursement at a maximum of 2 per month.
- Procedure code A4560 is limited to 1 unit every 12 weeks, or 4 units per year.

Supplies are included in the rental and will not be reimbursed separately.

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Supply procedure codes A4438, A4541, A4556, A4557, A4560 or A4595 may be reimbursed for clients with a purchased device and a claims history of an NMES/TENS procedure within the last five years. Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required.

9.2.46.6 Diaphragm-Pacing Neuromuscular Stimulation

Diaphragm-pacing neuromuscular stimulation is a benefit of Texas Medicaid when medically necessary and prior authorized.

Diaphragm-pacing neuromuscular stimulation is the electrical stimulation to one or both of the phrenic nerves or to the phrenic motor point regions of the diaphragm muscles that cause contraction of one or both of the two hemidiaphragms rhythmically to produce inspiration.

Diaphragm-pacing neuromuscular stimulation implantation may be reimbursed when billed with the following procedure codes:

Procedure Codes									
33276	33277	33278	33279	33280	33281	33287	33288	64575	64590
93150	93151	93153							

9.2.46.6.1 Prior Authorization for Diaphragm-Pacing Neuromuscular Stimulation

The surgical implantation of the diaphragm-pacing neuromuscular stimulator and purchase of a device are considered for prior authorization when medically necessary for individuals with severe, chronic respiratory failure that requires mechanical ventilation for any of the following reasons:

- Improvement of ventilatory function in stable, non-acute members with spinal cord injury (SCI) with high quadriplegia at or above C-3
- Alveolar hypoventilation, either primary or secondary to brainstem disorder
- Amyotrophic lateral sclerosis

Prior authorization for diaphragm-pacing neuromuscular stimulation may be considered with any of the following diagnosis codes:

Diagnosis Codes							
G1220	G1222	G1223	G1224	G1225	G1229	G128	G129
G4735	G8250	G8251	G8252	G8253	G8254	G8389	J9610
J9611	J9612	J9620	J9621	J9622	R0681	Z9911	

All of the following criteria must be met:

- The phrenic nerves are viable
- Diaphragmatic function is sufficient to accommodate chronic stimulation
- Pulmonary function is known to be adequate
- The client has normal chest anatomy, a normal level of consciousness, and has the ability to participate in and complete the training and rehabilitation associated with the use of the device

9.2.46.7 Dorsal Column Neurostimulator (DCN)

DCN involves the surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space. The neurostimulator system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

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DCN implantation may be reimbursed using procedure codes 63650, 63655, or 63685.

Conditions that may indicate chronic intractable pain include, but are not limited to, the following:

- Post-amputation "ghost" pain
- Cancer with bone metastasis
- Causalgia of upper/lower limb
- Herniated disc
- Radiculitis
- Spinal stenosis
- Spinal surgery
- Tic douloureux (trigeminal neuralgia)

9.2.46.7.1 Prior Authorization for Dorsal Column Neurostimulators

DCN electrode implantation and the purchase of devices is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation of DCN device may be considered for prior authorization for clients who have chronic intractable pain with documentation that indicates the following:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.
- There has been evidence of pain relief during a trial period for DCN with a temporarily implanted electrode or electrodes preceding the permanent implantation.

  Note: *A trial period including device and supplies is considered part of DCN procedures and will not be separately reimbursed.*

- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and the client's follow-up are available.

9.2.46.8 Gastric Electrical Stimulation (GES)

GES involves electrical stimulation of the lower stomach (antrum) with a fully implantable system that consists of two unipolar intramuscular leads (thin wires) and a neurostimulator device.

GES is a benefit of Texas Medicaid when medically necessary and prior authorized for the treatment of chronic intractable nausea and vomiting that is secondary to gastroparesis that has proven to be refractory to medical management.

GES may be reimbursed with procedure codes 43647, 43881, and 64590.

GES is a benefit for Texas Medicaid clients with the following conditions:

- Organic obstruction or pseudo-obstruction
- A primary eating or swallowing disorder
- Chemical dependency
- Pregnancy

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9.2.46.8.1 Prior Authorization for GES

The surgical implantation of a GES and purchase of a device are considered for prior authorization for chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology when all of the following criteria are met:

- Gastric emptying is significantly delayed as documented by standard scintigraphic imaging of solid food.
- Patient is refractory or intolerant of two out of three classes of prokinetic medications and two out of three antiemetic medications.
- The client's nutritional status is sufficiently low that all of the following criteria for total parenteral nutrition are met:
  - Adequate trials of dietary adjustment, oral supplements, or tube enteral nutrition have demonstrated that the patient can receive no more than 30 percent of his/her caloric needs orally and/or by tube.
  - The patient must be in a stage of wasting as indicated by all of the following:
    - Weight is significantly less than normal body weight for a patient's height and age in comparison with pre-illness weight.
    - Serum albumin is less than 3.4 grams.
    - BUN is less than 10 mg.
    - Phosphorus level is less than 2.5 mg.

9.2.46.9 Intracranial Neurostimulators

The surgical implantation, revision, and removal of intracranial deep brain stimulators (DBS) are a benefit for the relief of chronic intractable pain when more conservative methods, such as TENS, PENS, or pharmacological management have failed or were contraindicated.

Intracranial neurostimulation may be reimbursed using the following procedure codes:

Procedure Codes								
61781	61850	61860	61863	61864	61867	61868	61885	61886

9.2.46.9.1 Prior Authorization for Intracranial Neurostimulators

Intracranial neurostimulation involves the stereotactic implantation of electrodes in the brain and is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation and purchase of an intracranial neurostimulation device may be considered for prior authorization for chronic intractable pain or treatment of intractable tremors.

Requests for prior authorization must include documentation of the following:

- Other treatment modalities, including pharmacological, surgical, physical, and psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and assessment by a multidisciplinary team prior to implantation.
- The client has reported pain relief with a temporarily implanted electrode preceding the permanent implantation.
- All the facilities, equipment, and support personnel required for the proper assessment, treatment, training, and client's follow-up are available.

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Prior authorization will not be given for the treatment of motor function disorders such as multiple sclerosis; however, the implantation, revision, and removal of deep brain stimulators may be reimbursed for the treatment of intractable tremors due to the following:

- Idiopathic Parkinson's disease
- Essential tremor

9.2.46.10 Pelvic Floor Stimulation

Purchase of a non-implantable pelvic floor stimulator (procedure code E0740) is a benefit of Texas Medicaid for the treatment of stress or urge incontinence in clients who have failed conservative treatment, such as Kegel exercises, behavior management, bladder training, or medication.

Purchase of the pelvic floor stimulator device is limited to once per five years. All accessories and supplies are considered part of the purchase price and are not reimbursed separately.

9.2.46.10.1 Prior Authorization for Pelvic Floor Stimulation

Prior authorization is required for the purchase of a pelvic floor stimulator device.

Documentation submitted with the prior authorization request must demonstrate that the client:

- Has a diagnosis of stress or urge incontinence.
- Has completed a six-month trial of pelvic muscles exercises with no significant clinical improvement.

9.2.46.11 Percutaneous Electrical Nerve Stimulation (PENS)

PENS is a benefit of Texas Medicaid when medically necessary and prior authorized. Devices and supplies are considered a part of the service and are not separately reimbursable.

PENS is a diagnostic procedure for the treatment of chronic pain involving the stimulation of peripheral nerves by a needle electrode inserted through the skin.

9.2.46.11.1 Prior Authorization for PENS

PENS services may be reimbursed with prior authorization for clients who meet the following criteria:

- The client has a diagnosis that indicates chronic pain, which is refractory to conventional therapy.
- Treatment with TENS has failed or is contraindicated for the client.

PENS may be reimbursed using the following procedure codes: 64553, 64555, 64590, 64596, 64597, or 64598. The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed without prior authorization using procedure code 64595.

9.2.46.12 Sacral Nerve Stimulators (SNS)

SNS are a benefit of Texas Medicaid when medically necessary and prior authorized. SNS implantation may be reimbursed using procedure code 64561, 64581, or 64590.

SNS involves the use of pulse generators that transmit electrical impulses to the sacral nerves through a surgically implanted wire for treatment of urinary retention, urinary frequency, and urinary/fecal incontinence.

9.2.46.12.1 Prior Authorization for SNS

The surgical implantation of SNS and purchase of a device may be considered for prior authorization with the following:

- Urinary incontinence secondary to urethral instability and/or detrusor muscle instability.
- Chronic voiding dysfunction.

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- Non-obstructive urinary retention.
- Fecal incontinence.

Additionally, the medical record of the client must have documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, and/or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

9.2.46.13 Vagal Nerve Stimulators (VNS)

VNS are a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of intractable partial onset seizures.

VNS involves the use of devices that deliver electrical pulses to the cervical portion of the vagus nerve by an implanted generator.

9.2.46.13.1 Prior Authorization for VNS

The surgical implantation and purchase of VNS devices may be considered for prior authorization for clients with partial onset intractable seizures when there is failure, contraindication, or intolerance to all suitable medical and pharmacological management.

The surgical implantation of VNS may be reimbursed using procedure code 61885, 61886, 64553, or 64568.

VNS are not a benefit of Texas Medicaid in the following cases:

- For the treatment of clients with an absent left vagus nerve
- For the treatment of clients with depression
- For the treatment of clients with diseases or conditions with a poor prognosis or are progressively terminal in nature

Incapacities due to intellectual disabilities or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of intellectual disabilities or cerebral palsy exists, the treating physician must document in the client's medical record how VNS will measurably benefit the client in spite of intellectual disabilities or cerebral palsy.

9.2.46.14 Hypoglossal Nerve Stimulators (HNS)

Hypoglossal Nerve Stimulators (HNS) is a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of obstructive sleep apnea (OSA) and seizures.

HNS involves the use of devices that deliver electrical pulses to the hypoglossal nerve by an implanted generator.

The surgical implantation of HNS may be reimbursed using procedure codes 64582, C8007, or C8011.

The revision or removal of HNS may be reimbursed using procedure codes 64583, 64584, C8008, C8009, C8012, or C8013. Procedure codes 64583, 64584, C8008, C8009, C8012, and C8013 do not require prior authorization.

9.2.46.14.1 Prior Authorization for HNS

The surgical implantation of HNS (procedure code) and purchase of a device may be considered for prior authorization with documentation of the following criteria:

- Client has a documented diagnosis of OSA or seizures by a qualified health care provider.

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- For an OSA diagnosis, documentation that continuous positive airway pressure (CPAP) compliance for a minimum of 1 month (5 nights per week for at least 4 hours per night) has not been successful or is unable to be tolerated.
- For an OSA diagnosis, absence of complete concentric collapse at the soft palate level as seen in a drug-induced sleep endoscopy (DISE) procedure.
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

9.2.46.15 Prior Authorization of Neurostimulator Devices Procedure Codes

The following device procedure codes may be reimbursed with prior authorization:

Procedure Codes									
C1607	L8681	L8682	L8683	L8684	L8685	L8686	L8687	L8688	L8689
L8695									

Neuromuscular devices and the implantation codes must be billed on the same day by any provider.

To identify the service as a VNS device, procedure code L8686 must be submitted with modifier TG. Only one similar device code may be reimbursed per date of service for any provider.

9.2.46.16 Supplies for Neurostimulators

Supply procedure codes A4290, C1883, C1897, L8678, L8680, and L8696 may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the past five years. Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number and purchasing entity of the initial implantable device may be required. Supplies for implantable devices may be considered for reimbursement on appeal with documentation of a prior neurostimulator or a neuromuscular stimulator implantation procedure for clients with a history that is more than five years or for those who have a neurostimulator that was not received through Texas Medicaid.

To identify the service as a VNS implantable electrode, procedure code L8680 must be submitted with modifier TG.

9.2.46.17 Electrocorticogram of Implanted Neurostimulator

Electrocorticogram (procedure code 95836) is a benefit of Texas Medicaid and may be reported only once per each 30 day period.

9.2.46.18 Electronic Analysis for Neurostimulators

The following procedure codes may be reimbursed without prior authorization for the electronic analysis of the implanted neurostimulator and neuromuscular stimulation:

Procedure Codes									
95970	95971	95972	95976	95977	95980	95981	95982	95983	95984

9.2.46.19 Revision or Removal of Neurostimulator Devices

The revision or removal of implantable neurostimulators may be reimbursed without prior authorization using the following procedure codes:

Procedure Codes									
43648	43882	61781	63661	63662	63663	63664	63688	61880	61888
64569	64570	64585	64595						

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9.2.46.20 Noncovered Neurostimulator Services

The following services are not a benefit of Texas Medicaid:

- VNS is not a benefit when provided for the treatment of depression.
- Neurostimulation and neuromuscular stimulation services for indications other than those outlined above.

9.2.47 Newborn Services

The newborn period is defined as the time from birth through 28 days of life. This section addresses routine newborn care, attendance at delivery, newborn resuscitation, neonatal critical care, and intensive (noncritical) low birth weight services.

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

All newborn E/M procedure codes must have a newborn outcome diagnosis code included on the claim. Modifier 25 may be used to identify a significant separately identifiable E/M provided on the same day by the same physician as a procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Note: *Some of the services addressed in this section may also be used for care beyond 28 days of life.*

Refer to: Subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in this handbook.

Refer to: Subsection 2.2.23.13, "Cardiorespiratory Monitor (CRM)" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for authorization of cardiorespiratory monitors.

9.2.47.1 Circumcisions for Newborns

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54160.

9.2.47.2 Hospital Visits and Routine Care

The following procedure codes may be reimbursed for neonatal care and intensive care services:

Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Initial hospital E/M admission	99221 99222 99223	If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission. Reimbursed one per day, any provider.
Hospital discharge	99238 99239	Reimbursed for the client's discharge from the hospital.
Subsequent hospital and hospital consultation services	99252 99253 99254 99255	Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99252, 99253, 99254, and 99255).
Initial newborn care	99460*	May be reimbursed once per lifetime, any provider.

*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.**
**** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**

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Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Normal newborn care	99461*	May be reimbursed once per lifetime, any provider. Subsequent visits must be billed using an appropriate visit code based on the place of service.
Subsequent hospital care	99462	Reimbursable once per day in the hospital and limited to a total of seven days. Restricted to clients who are birth through seven days of age. If the client is diagnosed with a condition that requires more complex care and/or must stay more than 8 days, the provider must bill subsequent neonatal and pediatric care critical or intensive care (procedure codes 99469, 99478, 99479, or 99480). If the client is readmitted, the provider must bill an initial hospital E/M admission (procedure code 99221, 99222, 99223, or 99468) and the appropriate code for inpatient neonatal critical care (procedure code 99469). Procedure code 99462 is not reimbursable in the birthing center.
Newborn admission and discharge, same date	99463**	May be reimbursed once per lifetime when submitted by any provider. Reimbursed for newborns who are admitted and discharged on the same day from the hospital or birthing room setting (either hospital or birthing center).
Attendance at delivery	99464	May be reimbursed once, and only on the day of delivery, when billed by a physician other than the delivering physician.
Newborn resuscitation	99465	Reimbursed for the resuscitation of the newborn.
Initial hospital care and initial intensive care	99477	Reimbursed for those neonates who require intensive observation, frequent interventions, and other intensive services. Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Initial neonatal critical and intensive care (procedure codes 99468 and 99477) may be reimbursed once per admission, any provider. ***Note:*** *For subsequent admissions during the first 28 days of life, procedure codes 99468 and 99477 may be considered for reimbursement upon appeal.*

*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.**
**** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**

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Service	Procedure Code(s)	Benefit(s) and Limitation(s)
Subsequent intensive care	99478 99479 99480	Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Subsequent critical and intensive care (procedure codes 99469, 99478, 99479, and 99480) will be considered for reimbursement once per day, any provider. Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99252, 99253, 99254, and 99255). Procedure codes 99478, 99479, and 99480 must be billed for subsequent neonatal intensive (noncritical) services. The present body weight of the neonate or infant determines the appropriate procedure code that must be billed. When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) must be billed.
*** Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.** **** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).**		

Note: *Services for a newborn's unsuccessful resuscitation may be billed under the mother's Texas Medicaid number using procedure code 99499.*

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for a list of the required components for an initial THSteps exam.

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

In the following table, procedure codes in Column A will be denied when billed with the same date of service by the same provider as a procedure code in Column B:

Column A (Denied)	Column B
99238, 99239	99460, 99461, 99463
99462	99238, 99239
36410, 96361, 99292, 99307	99468, 99469
36410, 96361, 99471, 99472	99477
36410, 96361, 99291, 99292, 99307, 99471, 99472, 99478	99478
36410, 94761, 96361, 99291, 99292, 99307, 99471, 99472, 99478, 99479	99479
36410, 96361, 99291, 99292, 99307, 99308, 99309, 99310, 99471, 99472, 99478, 99479, 99480	99480

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9.2.47.3 Newborn Hearing Screening

The newborn hearing screening procedure is a screening procedure, not diagnostic, and will not be reimbursed separately from the usual inpatient newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants. For more information on newborn hearing screening, providers may contact:

Texas Early Hearing Detection and Intervention
PO Box 149347, MC-1918
Austin, TX. 78714-9347
1-512-458-7111, Ext. 2600
www.dshs.texas.gov/tehdi

Refer to: Section 2, "Nonimplantable Hearing Aid Devices and Related Services" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about hearing screenings.

9.2.48 Occupational Therapy (OT) Services

Occupational therapy (OT) is a payable benefit to physicians.

Refer to: Section 4, "Therapy Services Overview" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about occupational therapy services provided by a physician.

9.2.49 Ophthalmology

When an ophthalmologist sees a client for a minor condition that does not require a complete eye exam, such as conjunctivitis, providers are to use the appropriate office E/M code.

Providers are to use the eye exam procedure codes with a diagnosis of ophthalmological disease or injury.

Refer to: Subsection 4.3.5, "Vision Testing" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.49.1 Corneal Transplants

Corneal transplants are benefits of Texas Medicaid. Corneal transplants are subject to global surgery fee guidelines. Procedure codes 65710, 65730, 65750, 65755, 65756, and 65757 are used for this surgery.

Bioengineered cornea transplants remain investigational at this time and are not considered for reimbursement under Texas Medicaid.

Procurement of the cornea is not reimbursed separately.

9.2.49.2 Eye Surgery by Laser

Eye surgery by laser is a benefit of Texas Medicaid when medically necessary and meets the conditions and limitations stated in this section.

Authorization is not required for eye surgery by laser.

All procedure codes in this section are subject to multiple surgery guidelines. For bilateral procedures, the following modifiers must be added to the claim to indicate that the procedures were performed on the right and left eyes:

- Modifier RT to indicate the right eye
- Modifier LT to indicate the left eye

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All procedures may be reimbursed only to physicians and are limited to reimbursement once every 90 days for the same eye with the exception of infants from birth through 23 months of age. Procedures performed on infants from birth through 23 months of age are not subject to any frequency restrictions.

9.2.49.2.1 Other Eye Surgery Procedures

Anterior Segment of the Eye–The Cornea

Laser surgery to the cornea by laser-assisted in situ keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of Texas Medicaid.

Reimbursement for laser surgery to the cornea, procedure codes 65450, 65855, and 65860 is limited to once every 90 days for the same eye.

Anterior Segment of the Eye–The Iris, Ciliary Body

Laser surgery to the anterior segment of the eye–the iris, ciliary body may be reimbursed only when billed with one of the following procedure codes:

Procedure Codes									
66600	66605	66710	66711	66761	66762	66770			

Reimbursement for procedure codes 66600, 66605, 66710, 66711, 66761, 66762, and 66770 is limited to once every 90 days for the same eye.

Claims for iridectomy (66600, 66605, 66625, 66630, or 66635) or iridotomy (66500 or 66505) are not reimbursed when billed for the same date of service as a trabeculectomy (66170 or 66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends for review.

An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (66600 or 66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

Procedure Codes									
65920	66840	66850	66852	66920	66930	66940	66983	66984	66985
66986									

Posterior Segment of the Eye–Retina or Choroid

Laser surgery to the retina or choroid may be reimbursed only when billed with one of the following procedure codes:

Procedure Codes									
67105	67107	67108	67110	67113	67145	67210	67220	67221	67225
67228	67229	G0186							

Procedure code 67229 is restricted to clients who are birth through 1 year of age.

When billed for the same date of service, same eye, any provider, procedure code 67031 will be denied as part of any of the following procedure codes:

Procedure Codes									
67036	67108	67110	67120	67121	67141	67145	67208	67210	67218

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Procedure Codes									
67227	67228								

When billed for the same date of service, same eye, any provider, only one of the following procedure codes may be reimbursed: 67220, 67221, 67225, or G0186.

When billed for the same date of service, same eye, by any provider, procedure codes 67025, 67028, 67031, 67036, 67039, 67040, and 67105 will be denied as part of 67108.

Posterior Segment of the Eye, Vitreous–Vitrectomy

Laser surgery to the vitreous may be reimbursed only when billed with one of the following procedure codes: 67031, 67039, 67040, and 67043.

Reimbursement for procedure codes 67031, 67039, 67040, and 67043 is limited to once every 90 days for the same eye.

When billed for the same date of service, same eye, any provider procedure code 67500 will be denied as part of 66821.

Procedure code 66821 is denied as part of 66830, 67031, and 67228.

Procedure codes 66820, 66984, 66985, and 67036 will pay according to multiple surgery guidelines when billed with procedure code 66821.

When billed for the same date of service, same eye, different provider procedure codes 66821, 67005, and 67010 will be denied as part of 67031.

When billed for the same date of service, same eye, any provider procedure code 67031 will be denied as part of any of the following procedure codes: 67036, 67108, 67110, 67120, 67121, 67208, 67218, 67227, and 67228.

9.2.49.3 Eye Surgery by Incision

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 66500, 66505, 66605, 66625, 66630, and 66635 are denied as part of another procedure when billed with the following cataract surgeries: 65920, 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984, 66985, and 66986. Claims may be appealed with additional documentation to demonstrate the medical necessity.
- Procedure code 66020 is denied as part of another procedure when billed with any related eye surgery procedure code.
- Procedure code 67036 may be reimbursed when billed alone.
- Procedure code 67036 is denied as part of another procedure when billed with procedure codes 67039, 67040, 67041, 67042, 67043, or 67108.
- Procedure codes 67039 and 67040 are combined and reimbursed as procedure code 67108 when billed by the same provider for the same date of service.
- For clients who are 8 years of age and younger, the following cataract extraction and vitrectomy procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

Procedure Codes									
66840	66850	66852	66920	66930	66940	66983	66984	67005	67010
67015	67025	67027	67028	67030	67031	67036	67039	67040	67041
67042	67043								

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- For clients who are nine years of age and older, the following procedure codes will be paid when performed on the same eye as a cataract extraction:

Procedure Codes									
67005	67010	67015	67025	67027	67028	67030	67031	67036	67039
67040	67041	67042	67043						

- For clients who are nine years of age and older, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye:

Procedure Codes									
66840	66850	66852	66920	66930	66940	66983	66984		

Reimbursement for procedure codes 67041, 67042, and 67043 is limited to once every 90 days for the same eye.

9.2.49.4 Intraocular Lens (IOL)

An IOL (V2630, V2631, and V2632) may be reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer's invoice for procedure code V2631 to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed five percent of the acquisition cost.

Medicaid does not reimburse physicians who supply IOLs to ASCs/HASCs.

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

9.2.49.5 Intravitreal Drug Delivery System

Procedure codes 67027 and 67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to deny when billed concurrently.

9.2.49.6 Other Eye Surgery Limitations

The following procedure codes require modifier LT or RT to identify the eye for which the surgery is being performed:

Procedure Codes									
65205	67311	67312	67314	67316	67318	67320	67331	67332	67334
67345	67414	67800	67801	67805	67808	V2790			

In the following table, the procedure codes in Column A may be reimbursed only when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

Column A Procedure Codes	Column B Procedure Codes
66990	65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, or 67113
67320, 67331, 67332, 67334	67311, 67312, 67314, 67316, or 67318
67335, 67340	67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, or 67334
V2790	65780

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9.2.50 Extracapsular Cataract Removal

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

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

Diagnosis Codes					
H401111	H401112	H401121	H401122	H401131	H401132

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

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

9.2.51 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, intestine, lung, liver, kidney, or pancreas are a benefit of Texas Medicaid.

Solid organ transplants are a benefit of Texas Medicaid when medically necessary based on safety and efficacy, as demonstrated by scientific evidence and by controlled clinical studies, in accordance with the Texas Administrative Code (TAC). Solid organ transplants are limited to clients with a critical medical condition who are expected to have a successful clinical outcome that will result in a return to improved functional independence. Benefits are not available for the following experimental or investigational services:

- Artificial and bioartificial livers
- Xenotransplantation of solid organs

Solid organ transplants and post-transplant care will only be covered if the organ procurement is in alignment with the National Organ Transplant Act (NOTA). Only organs harvested voluntarily from within the United States under the oversight of the Health Resources and Services Administration (HRSA) and the United Network of Organ Sharing (UNOS) will be covered. Organs harvested for a fee or sponsorship or organs obtained from any country outside of the United States will not be covered for transplant or post-transplant care.

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent transplant because of organ rejection.

Solid organ transplants require prior authorization and may be reimbursed only when performed in a Medicaid-enrolled facility that is a designated children's hospital with a transplant unit or program, or certified for the procedure by the United Network for Organ Sharing (UNOS).

The facility must be in Texas, unless there are no Texas facilities certified by UNOS or designated as a Children's Hospital with a transplant unit or program for the requested procedure.

All requests for out-of-state (OOS) services, whether for pre-transplant evaluation, transportation, or post-transplant monitoring, must be sent to the medical director for prior authorization review. Texas Medicaid will consider authorizing OOS services when the following criteria are met:

- The client does not leave Texas to receive care that can be received in Texas.
- An in-state facility approved for the procedure has declined to accept the client and documentation is submitted to explain why the in-state team cannot perform the procedure.
- There is no physician provider or facility with the level of expertise required to perform the necessary procedure available in Texas, or the client has received an initial transplant at the OOS facility and requires additional transplant services due to complications or graft loss.

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- There is reasonable assurance that the client meets the clinical criteria required by Texas Medicaid for transplant approval.
- The service is necessary, reasonable, and federally allowable, and the facility and physicians agree to accept Medicaid reimbursement for these services.
- The OOS facility must be certified by UNOS or designated as a Children's Hospital with a transplant unit or program.

When requesting an OOS prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an OOS solid organ pre-transplant evaluation.

When requesting an OOS prior authorization for transplant of a solid organ, the provider must submit a copy of the transplant evaluation performed by a Texas facility and a copy of the transplant evaluation performed by the OOS facility to support the need for an OOS solid organ transplant.

When requesting an OOS prior authorization for post-transplant monitoring or other post-transplant services, the provider must submit documentation that the client received the initial transplant at the same OOS facility to include complications or graft loss if present, in order to support the need for OOS solid organ post-transplant monitoring or other post-transplant services.

Expenses incurred for the procurement of a living donor's organ are not a benefit of Texas Medicaid.

Refer to: Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the transplant facility approval criteria.

Subsection 3.2.5.2, "Transplant Benefits and Limitations" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about organ/tissue transplant program limitations.

9.2.51.1 General Prior Authorization Requirements

Solid organ transplant prior authorization requests must include all of the following:

- A complete history and physical
- A statement of the current medical conditions and status of the transplant recipient
- Documentation of how the client meets the prior authorization criteria specified for the transplant requested
- Documentation of the absence of co-morbidities or contraindications such as the following:
  - Severe pulmonary hypertension
  - End-stage cardiac, renal, hepatic, or other organ dysfunction unrelated to the primary disorder
  - Uncontrolled HIV infection or AIDS defining illness
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
  - Ongoing or recurrent active infections that are not effectively treated
  - Psychiatric instability severe enough to jeopardize incentive for adherence to medical regimen
  - Active alcohol or chemical dependency that might interfere with compliance to a medical regimen
- History of compliance with other medical treatments, regimen, and plan of care

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Backbench procedures do not require prior authorization but may only be reimbursed when a corresponding transplant procedure has been paid for the same date of service.

Note: *Clients who are birth through 20 years of age and who do not meet the criteria for coverage may be considered through the Comprehensive Care Program (CCP).*

Additional prior authorization criteria, if applicable, specific to each type of transplant are outlined in the following sections.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g., laboratory services, status post visits, radiology services). However, coverage for other services needed as a result of complication of the transplant or for services unrelated to the transplant may be considered when medically necessary, reasonable, and federally allowable.

Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

9.2.51.2 Heart Transplants

9.2.51.2.1 Prior Authorization for Heart Transplants

A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Procedure code 33945 may be considered for prior authorization with medical necessity documentation that indicates a New York Heart Association (NYHA) Class III or IV cardiac disease with one of the following medical conditions:

- Congenital heart disease
- Valvular heart disease
- Viral cardiomyopathy
- Familial and restrictive cardiomyopathy

9.2.51.3 Intestinal Transplants

An intestinal transplant may be considered for clients who are dependent on parental nutrition and have compromised venous access, have had two or more episodes of central line sepsis, or who have begun to manifest progressive parental nutrition associated liver dysfunction. Procedure codes 44135 and 44136 must be prior authorized.

Small bowel transplantation is considered medically necessary in clients with irreversible intestinal failure including, but not limited to:

- Short bowel syndrome
- Pseudo-obstruction
- Microvillus inclusion
- Tumor

The prior authorization request must include documentation of irreversible intestinal failure with failed total parenteral nutrition (TPN) therapy. The client has experienced TPN failure if any one of the following criteria is met:

- Impending or overt liver failure due to TPN-induced liver injury. Clinical indictors include the following:
  - Increased serum bilirubin levels
  - Increased liver enzyme levels

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- Splenomegaly
- Thrombocytopenia
- Gastroesophageal varices
- Coagulopathy
- Stomal bleeding
- Hepatic fibrosis
- Cirrhosis

- Thrombosis of major central venous channels (subclavian, jugular, or femoral veins). Thrombosis of two or more of these vessels is considered a life-threatening complication and TPN failure.
- Frequent central line-related sepsis. Two or more episodes of central-line-induced systemic sepsis per year that require hospitalization are considered TPN failure. A single episode of central-line-related fungemia, septic shock, or acute respiratory distress syndrome is considered TPN failure.
- Frequent episodes of severe dehydration despite TPN and intravenous fluid supplement. Under certain medical conditions, such as secretory diarrhea and nonconstructable gastrointestinal tract, the loss of combined gastrointestinal and pancreatobiliary secretions exceed the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system.

Diagnoses that indicate intestinal failure include, but are not limited to, the following:

- Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment
- Small bowel syndrome resulting from postsurgical conditions due to resections
- Intestinal cysts
- Mesenteric cysts
- Small bowel or other tumors involving small bowel
- Crohn's disease
- Mesenteric thrombosis
- Volvulus
- Short-gut syndrome in which there is liver function impairment (usually secondary to TPN)

9.2.51.4 Kidney Transplants

9.2.51.4.1 Prior Authorization for Kidney Transplants

Procedure codes 50360 and 50365 must be prior authorized. Medical necessity documentation of one of the following is required:

- Hemodialysis or continuous ambulatory peritoneal dialysis (CAPD).
- Chronic renal failure with anticipated deterioration to end-stage renal disease.
- End-stage renal disease, evidenced by a creatinine clearance below 20 ml/min or development of symptoms of uremia.
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12- to 18-month period.

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9.2.51.4.2 Cytogam

Procedure code J0850 is reimbursable by Texas Medicaid. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code Z940, Z941, Z942, Z943, Z944, or Z9483. Cytogam is payable only in the office or outpatient setting.

Refer to: Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the transplant facility approval criteria.

9.2.51.5 Liver Transplants

9.2.51.5.1 Prior Authorization for Liver Transplants

For a client to be considered for coverage of a liver transplant, the medical records for the client must include documentation showing the client is unresponsive to more conventional and/or standard therapies.

Authorization of procedure codes 47133 and 47135 requires medical necessity documentation of liver disease in one of the following categories:

- Primary cholestatic liver disease
- Other cirrhosis:
  - Alcoholic
  - Hepatitis C, non-A, non-B, and Hepatitis B
- Fulminant hepatic failure
- Metabolic diseases
- Malignant neoplasms
- Benign neoplasms
- Biliary atresia

9.2.51.6 Lung Transplants

9.2.51.6.1 Prior Authorization for Lung Transplants

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization of procedure codes 32851, 32852, 32853, 32854, and S2060 may be considered with medical necessity documentation of the following:

- Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation
- End-stage pulmonary diseases in one of these categories:
  - Obstructive lung disease
  - Restrictive lung disease
  - Cystic Fibrosis
  - Pulmonary hypertension

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9.2.51.7 Pancreas Transplant

9.2.51.7.1 Prior Authorization for Pancreas Transplant

A pancreas/simultaneous kidney-pancreas transplant must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

For prior authorization of procedure codes 48160 and 48554, medical necessity documentation must be submitted that shows the following:

- Recurrent, acute, and severe metabolic and potentially life-threatening complications requiring medical attentions such as:
  - Hypoglycemia
  - Hyperglycemia
  - Ketoacidosis
  - Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
  - Insensibility to hypoglycemia; or
- Satisfactory kidney function (creatinine clearance greater than 40mL/min), except for kidney-pancreas transplants; and
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management; and
- At least two of the following secondary complications:
  - Diabetic neuropathy
  - Retinopathy
  - Gastroparesis
  - Autonomic neuropathy
  - Extremely labile (brittle) insulin-dependent diabetes mellitus

9.2.51.8 Multi-Organ Transplants

Procedure codes 33935, S2053, and S2054 may be considered for prior authorization if medical necessity documentation meets the requirements for each organ.

Procedure code S2065 may be considered for prior authorization if medical necessity documentation indicates the client meets criteria for a pancreas transplant and has end-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months.

9.2.51.9 Nonsolid Organ Transplants

Nonsolid organ transplants covered by Texas Medicaid include allogeneic and autologous stem cell transplantation, allogeneic and autologous bone marrow transplantation, autologous islet cell transplantation, and hematopoietic progenitor cell (HPC) boost infusion.

9.2.51.9.1 Allogeneic and Autologous Bone Marrow and Stem Cell Transplantation

Stem cell transplantation is a process in which stem cells are obtained from either a client's or donor's bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.

Benefits are not available for any experimental or investigational services, supplies, or procedures.

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Coverage of bone marrow and stem cell transplantation is limited to the following procedure codes: 38206, 38230, 38232, 38240, 38241, 38242, and S2142.

Texas Medicaid recognizes the following covered indications for stem cell transplants:

- Allogeneic
  - Hematological malignancy
  - Lymphatic malignancy
  - Bone marrow disorders
  - Hemoglobinopathies
  - Platelet function disorders
  - Immunodeficiency disorders
  - Inherited metabolic disorders
  - Multiple myeloma/plasma cell disorders
- Autologous
  - Hematological malignancy
  - Lymphatic malignancy
  - Germ cell tumors
  - Brain tumors
  - Small round blue cell tumors of childhood
  - Multiple myeloma/plasma cell disorders
- Indications for additional infusions
  - Infusion of stem cells for failure to graft (autologous)
  - Donor leukocyte infusion for persistent or relapsed malignant disease (allogeneic)
- Indications for re-transplantation
  - Relapse of disease
  - Failure to engraft or poor graft function

9.2.51.9.2 Autologous Islet Cell Transplantation

Autologous islet cell transplantation associated with the complete or partial removal of the pancreas (procedure code 48160) is a benefit of Texas Medicaid only for clients with a diagnosis of chronic pancreatitis.

Allogeneic islet cell transplantation is not a benefit.

9.2.51.9.3 HPC Boost Infusion

Prior authorization is required for HPC boost infusion procedure code 38243. The prior authorization request must include documentation of a prior stem cell transplant.

Requests for more than two boost procedures per lifetime requires medical necessity review and approval by the medical director.

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9.2.51.9.4 Prior Authorization for Nonsolid Organ Transplants

All nonsolid organ transplants require mandatory prior authorization and must be performed in a Texas facility that is a designated children's hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization is effective for the date span specified on the prior authorization approval letter. If the transplant has not been performed by the end of the authorization period, the physician must apply for an extension.

Documentation supplied with the prior authorization request must include the following:

- A complete history and physical.
- A statement of the client's current medical condition and the expected long-term prognosis for the client from the proposed procedure.

Each subsequent transplant must be prior authorized separately.

Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but will not be approved when performed simultaneously.

If a stem cell transplant has been prior authorized for a client who is 21 years of age or older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Bone marrow harvesting (38230) or peripheral stem cell harvesting (38206) for autologous bone marrow or stem cell transplants are a benefit of Texas Medicaid and require prior authorization.

Autologous harvesting of stem cells (single or multiple sessions) may be reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.

Physician services for the storage of stem cells are not a benefit of Texas Medicaid.

Donor expenses are included in the global fee for the transplant recipient and are not reimbursed separately. Therefore, allogeneic bone marrow or stem cell harvesting procedures are not a benefit of Texas Medicaid.

Stem cell transplants for other conditions may be considered on a case by case basis. Documentation for prior authorization must be submitted to determine whether the transplant is medically necessary and appropriate.

9.2.51.10 Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized solid organ transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records.

9.2.52 Orthognathic Surgery

Orthognathic surgery is a benefit of Texas Medicaid only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery is administered and may be reimbursed as part of the medical/surgical benefit of Texas Medicaid and not as part of the Texas Medicaid Dental Program.

Treatment of malocclusion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is a benefit when it is necessary as part of the approved dental benefit.

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Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:

- Producing signs or symptoms of masticatory dysfunction
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies
- Facial skeletal discrepancies associated with documented speech impairments
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies

Orthognathic surgery may be considered for reimbursement when required for the client to access a dental service. Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of Texas Medicaid.

9.2.52.1 Prior Authorization for Orthognathic Surgery

The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons with prior authorization. A narrative explaining medical necessity must be provided with the authorization request.

Procedure Codes									
21010	21031	21032	21050	21060	21073	21100	21110	21120	21121
21122	21123	21125	21127	21137	21138	21139	21141	21142	21143
21145	21146	21147	21150	21151	21154	21155	21159	21160	21172
21175	21179	21180	21181	21182	21183	21184	21188	21193	21194
21195	21196	21198	21199	21206	21208	21209	21210	21215	21230
21235	21240	21242	21243	21244	21247	21255	21256	21260	21261
21263	21267	21268	21270	21275	21295	21296	21299	29800	29804
40840	40842	40843	40844	40845					

9.2.53 Osteopathic Manipulative Treatment (OMT)

OMT, when performed by a physician (MD or DO), is a benefit of Texas Medicaid for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component.

OMT is covered when it is performed with the expectation of restoring the patient's level of function, which has been lost or reduced by injury or illness. Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. A model of documentation that supports medical necessity for the treatment plan includes the following:

- Specific modalities/procedures to be used in treatment
- Diagnosis
- Region treated
- Degree of severity
- Impairment characteristics
- Physical examination findings (X-ray or other pertinent findings)
- Specific statements of long- and short-term goals

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- Reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and techniques used

The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made. Paper claims submitted without modifier AT will be denied; electronic claims will be rejected. The AT modifier is described as representing treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 98925, 98926, 98927, 98928, and 98929.

OMT will be denied when billed on the same date of service by the same provider as any of the following procedure codes:

Procedure Codes									
00640	51701	51702	51703	64400	64405	64408	64412	64415	64416
64417	64418	64420	64421	64425	64430	64435	64445	64446	64447
64448	64449	64450	64470	64472	64475	64476	64479	64480	64483
64484	64505	64510	64517	64520	64530	96360	96365	96372	96374
96375	99202	99203	99204	99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233	99234	99235	99236	99238
99239	99242	99243	99244	99245	99252	99253	99254	99255	99281
99282	99283	99284	99285	99291	99304	99305	99306	99307	99308
99309	99310	99315	99316	99341	99342	99344	99345	99347	99348
99349	99350	99460	99461	99462	99463	99464	99465	99468	99469
99471	99472	99478	99479	99480					

When multiples of procedure codes 98925, 98926, 98927, 98928, and 98929 are billed on the same day by any provider, the most inclusive code is paid and the others are denied.

An E/M or initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day if the client's condition requires a visit for a significant and separately identifiable service above and beyond the usual pre- and post-care associated with the OMT procedure, even if the visit and OMT are related to the same symptom or condition. Modifier 25 must be submitted with the E/M procedure code to identify a separate and distinct service rendered on the same day as OMT.

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Procedure code 97140 will be denied as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

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9.2.54 Pain Management

Pain management is a benefit of Texas Medicaid.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.

Use the following procedure codes when billing for the implantation/revision/replacement of the pump/catheter:

Procedure Codes									
62350	62351	62355	62360	62361	62362	62365			

Procedure codes 62367 and 62368 do not require prior authorization and are payable as a medical service only.

Refer to: Subsection 9.2.40, "Implantable Infusion Pumps" in this handbook for more information about implanted pumps.

9.2.54.1 Ongoing Evaluation and Management of Chronic Pain and Chronic Pain Management (CPM)

Pain Management as part of Implantable infusion pumps (IIPs) services (procedure codes G3002 and G3003) is a benefit of Texas Medicaid.

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent or recurrent pain, lasting more than three months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

The first time that procedure code G3002 is billed, the physician or qualified health practitioner must see the client in person. After the initial visit, any of the CPM in-person components included in procedure codes G3002 and G3003 may be provided through telehealth, as clinically appropriate, to increase access to care for Medicaid clients.

When using procedure code G3002, 30 minutes must be met or exceeded. List procedure code G3003 separately in addition to procedure code G3002. When using procedure code G3003, 15 minutes must be met or exceeded.

Additionally, both evaluation and management services and CPM may be billed on the same day if all requirements to report each service are met, and the time spent providing CPM services does not represent time spent for providing any other reported service.

9.2.54.2 Epidural and Subarachnoid Infusion

Epidural and subarachnoid infusion for pain management is payable for acute, chronic, and postoperative pain management.

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

Procedure code 01996 is payable to CRNAs and physicians.

9.2.55 Palivizumab Injections

RSV immune globulin, intramuscular palivizumab (*Synagis*) must be obtained through the Texas VDP. Providers must obtain prior authorization through the VDP.

Providers may not bill Texas Medicaid for RSV prophylaxis that was obtained through VDP; however providers may be reimbursed for administering the drug. Providers may refer to the HHSC Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment for more information about obtaining palivizumab for Texas Medicaid clients.

9.2.56 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits of Texas Medicaid when prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation establishing medical necessity of the service requested. This documentation must remain in the client's medical record and is subject to retrospective review.

9.2.56.1 Panniculectomy

A panniculectomy (procedure code 15830) may be reimbursed with prior authorization for one of the following conditions when the panniculus hangs to or below the level of the pubis:

- A panniculus has recurrent non-healing ulcers.
- Client is insulin dependent with recurring infection and causing the prolapse of a ventral hernia.
- Panniculus directly causes significant clinical functional impairment.

Panniculectomy is not a benefit when one of following is the primary purpose:

- To remove excess skin and fat from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To minimize the risk of ventral hernia formation of recurrence.
- For the sole purpose of treating neck or back pain.

Panniculectomy may be prior authorized when the client meets one of the following:

- Panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery.
- Panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis.
- Panniculectomy is planned with history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery.

If a panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery, or a panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis, one of the following must be met:

- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription.

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- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

If a panniculectomy is planned with a history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery, the following must be met:

- Documentation that the panniculus hangs to or below the level of the pubis and the client has maintained a significant (100 pounds or more), stable weight loss for at least six months. Documentation must include the weight loss history, prior and current height, prior and current weight, and the history and physical including all previous surgeries.
- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription. The 12-month post-gastric bypass requirement may be waived.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia. The 12-month post-gastric bypass requirement may be waived.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. The 12-month post-gastric bypass requirement may be waived. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

All medical record documentation pertinent to the client's evaluation and treatment must support medical necessity of the panniculectomy. Documentation may include the following:

- Office records
- Consultation reports
- Operative reports
- Other hospital records (examples: pathology report, history and physical)

Documentation to support the panniculectomy must be submitted with the request for prior authorization. In addition to medical record documentation, the provider may also submit a letter of support or an explanation to substantiate medical necessity.

This service is typically expected to be limited to once per lifetime, by the same provider. Repeat panniculectomies may be considered for prior authorization upon submission of supporting documentation as outlined above.

A panniculectomy provided as a secondary surgery may be considered for prior authorization when the panniculus interferes with a medically necessary intra-abdominal surgery (e.g., abdominal hernia repair or hysterectomy) or to facilitate an improved anatomical field in order to provide radiation treatment to the abdomen. Documentation of medical necessity must include:

- The comorbidity for the diagnosis of the primary surgery or for the nature of the condition undergoing radiation treatment.
- Documentation supporting the need for the panniculectomy as the panniculus hangs below the level of the pubis and will significantly interfere with a planned surgical procedure, or the abdominal structures identified as requiring radiation therapy will not be adequately treated due to the size of the panniculus.

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A panniculectomy provided as a secondary surgery may be considered when the primary surgery was performed for an urgent condition defined as a symptom or condition that is not an emergency, but requires further diagnostic workup or treatment within 24 hours to avoid a subsequent emergent situation.

The need for the panniculectomy as a secondary surgery in conjunction with a primary urgent surgery must be supported by retrospective review of submission of all of the following documentation:

- History and physical and the operative report.
- The panniculus hangs below the level of the pubis and would have significantly interfered with the urgent primary surgical procedure.

9.2.56.2 Abdominoplasty

An abdominoplasty (procedure code 15847) is a benefit for clients who are birth through 20 years of age and may be reimbursed with prior authorization for one of the following conditions:

- Prune belly
- Diastasis recti in the presence of a true midline hernia (ventral or umbilical)

Abdominoplasty is not a benefit when one of the following is the primary purpose:

- To remove excess skin and fat and tighten abdominal wall from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To repair diastases recti (unless prior authorization criteria has been met).

Abdominoplasty may be prior authorized when the client meets all of the following criteria:

- Documented diagnosis of prune belly (i.e., Eagle Barret syndrome) or repair of diastasis recti in the presence of a true midline hernia (ventral or umbilical).
- Documentation for reconstructive surgery that must include appropriate historical medical record documentation and may include any of the following:
  - Consultation reports
  - Operative reports or other applicable hospital records (examples: pathology report, history and physical)
  - Office records
  - Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)
- For repair of diastasis recti with a true midline hernia, documentation must also include all of the following:
  - The size of the hernia
  - Whether it is reducible, painful, or other symptoms
  - Whether there is a defect rather than just thinning of the abdominal fascia

This service is typically expected to be limited to once per lifetime, by the same provider. Consideration of other abdominal diagnoses may be considered for prior authorization with the submission of additional supporting documentation that may include the following:

- Consultation reports

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- Operative reports or other applicable hospital records (examples: pathology report, history and physical)
- Office records
- Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

9.2.57 Penile and Testicular Prostheses

The following services are a benefit of Texas Medicaid for male clients:

- Removal of a penile prosthesis without replacement (procedure codes 54406 and 54415).
- Insertion of testicular prosthesis for the replacement of congenitally absent testes or testes lost due to disease, injury, or surgery (procedure code 54660)—prior authorization is required.

Procedure code 54660 is a benefit for clients who are birth through 20 years of age. Insertion of a testicular prosthesis may be prior authorized with the following criteria:

- The client has lost a testicle as a result of cancer or trauma or has congenital absence of a testicle.
- The loss of the testicle has resulted in detrimental psycho-social sequelae, as evidenced by a psychiatric evaluation.

Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The request must be submitted with documentation that supports medical necessity.

9.2.58 Percutaneous Transluminal Coronary Interventions

Percutaneous transluminal coronary interventions are a therapeutic option for clients who have arteriosclerotic heart disease.

When any of the following procedure codes are performed on the same date of service and on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure code will be considered for reimbursement: 92973, 92982, 92984, 92995, and 92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels may be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

9.2.59 Physical Therapy (PT) Services

Physical therapy (PT) is a payable benefit to physicians.

Refer to: Section 4, "Therapy Services Overview" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about physical therapy services provided by a physician.

9.2.60 Physician Evaluation and Management (E/M) Services

E/M is a benefit of Texas Medicaid. Providers must follow guidelines established in the Current Procedural Terminology (CPT) Manual for Evaluation and Management Services when selecting the level of service provided.

The following E/M services are benefits of Texas Medicaid:

- Domiciliary, rest home, or custodial care services
- Emergency department services
- Group clinical visits

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- Home services
- Hospital services including inpatient, observation, critical care, discharge, and concurrent care services (includes consultation and prolonged services)
- Nursing facility services
- Office or other outpatient services for new and established patients (includes consultation and prolonged services)
- Preventive care visits
- Services outside of business hours
- Tobacco use cessation

Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days of each date of service, not 95 days of the discharge date.

Inpatient claims must indicate the facility's NPI in Block 32 or in the appropriate field of electronic software.

9.2.60.1 Office or Other Outpatient Hospital Services

9.2.60.1.1 New and Established Patient Services

A new patient is one who has not received any professional services from a physician or from another physician of the same specialty who belongs to the same group practice, within the past three years. Providers must use procedure codes 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office or an outpatient or other ambulatory facility. New patient visits are limited to one every three years, per client, per provider.

An established patient is one who has received professional services from a physician or from another physician of the same specialty within the same group practice, within the last three years. Providers must use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office or an outpatient or other ambulatory facility.

Established E/M services are limited to one per day, same provider. When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Modifier 25 must be submitted when the services rendered are performed for a significant separately identifiable service by the same physician or physician group on the same date of service. Modifier 25 is required when the provider submits a claim with the following:

- A second office or outpatient visit on the same day as another office or outpatient visit
- An office or outpatient visit beyond the usual preoperative care associated with the procedure that was performed

Note: *Office or outpatient visits provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.*

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded.

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The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

Examples of additional visits to which Modifier 25 must be appended include, but are not limited to:

- A second E/M service for the same date of service as a group visit with the required E/M visit.
- An established patient E/M service for the same date of service as a THSteps medical checkup.
- An E/M service for the same date of service as a scheduled procedure.

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

Office visit procedure code 99211, 99212, 99213, 99214, or 99215 must be billed by the same provider with the same date of service as a group clinical visit.

9.2.60.2 Office or Other Outpatient Services by Telemedicine

Providers must defer to the needs of the client receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the client's choice and not provider convenience.

Providers must provide the services to Medicaid eligible clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. In addition, providers must deliver, to include delivery by telemedicine or telehealth, services in full accordance with all applicable licensure and certification requirements.

During a Declaration of State of Disaster, the Health and Human Services Commission (HHSC) may issue direction to providers regarding the use of a telemedicine or telehealth service to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein to the extent permitted by Texas law. A Declaration of State of Disaster is when an executive order or proclamation is issued by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Synchronous Audiovisual Technology

The following office and other outpatient services may be provided by synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the client receiving services. New and established patient services provided by synchronous audiovisual technology must be billed with modifier 95.

The following procedure codes may be reimbursed for telemedicine (physician-delivered) evaluation and management to new and established clients:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Synchronous Telephone (Audio-Only) Technology

For the diagnosis, evaluation and treatment of a mental health or substance use condition, as well as non-behavioral health conditions, the following office and other outpatient services may be provided by synchronous telephone (audio-only) technology if clinically appropriate and safe, as determined by the provider, and agreed to by the client receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit, as well as the use of synchronous audiovisual technology over synchronous telephone (audio-only) technology for telemedicine and telehealth services. Therefore, providers must document in the client's medical record the reason(s) for why services were delivered by synchronous telephone (audio-only) technology. Established patient services for mental health or

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substance use conditions provided by synchronous telephone (audio-only) technology must be billed using modifier FQ. Established patient services for non-behavioral health conditions provided by synchronous telephone (audio-only) technology must be billed using modifier 93.

Procedure codes 99212, 99213, 99214, and 99215 may be billed for established patient services.

Procedure code 99211 may be delivered by synchronous telephone (audio-only) technology during certain public health emergencies only.

Modifiers - Office and Other Outpatient Services - Psychiatric Care Only	Description
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
FQ	The service was furnished using audio-only communication technology

Modifiers – Office and Other Outpatient Services Non–Psychiatric Care	Description
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

Documentation requirements for a telemedicine or telehealth service are the same as for an in-person visit and must accurately reflect the services rendered. The documentation must identify the means of delivery when provided by telemedicine or telehealth.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth requirements to include documentation, informed consent, privacy, and security requirements.

9.2.60.3 Group Clinical Visits

Texas Medicaid may reimburse physicians for group clinical visits (procedure code 99078) providing clinical services and educational counseling to a group of clients with the same condition.

To be considered for reimbursement, procedure code 99078 must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215.

Group clinical visits may be reimbursed for established patients only. The client's plan of care must be determined and documented in the medical record by the physician before attending group clinical visits.

Participation of established patients in a group clinical visit is optional. Informed consent must be obtained from the client and maintained in the medical record before rendering group clinical visit services.

The physician leading the group clinical visit is responsible for the effectiveness and content of the information provided during the group clinical visit.

Nationally approved curriculum on asthma and diabetes, such as that available through the American Association of Diabetic Educators and Asthma Education and Prevention Programs consistent with the National Asthma Management Guidelines and must be incorporated into the educational portion of group clinical visits.

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Group clinical visits must last at least 1 hour, but no longer than 2 hours, with a minimum of 2 clients and a maximum of 20.

To promote self-management of the chronic disease, the group visit must include a presentation that instructs and informs the client about clinical issues, including how to prevent disease exacerbation or complications, properly use medications and other therapeutic techniques, or live with chronic illness topics. Group visit presentations must include:

- Diabetic education consisting of the following:
  - What diabetes is
  - Nutrition
  - Exercise and physical activity
  - Prevention of acute complications
  - Prevention of chronic complications
  - Monitoring
  - Medication
- Asthma education consisting of the following:
  - What is asthma?
  - What are symptoms of asthma?
  - What happens during an episode of asthma?
  - What exacerbates asthma?
  - How is asthma controlled?
  - What physical activities can people with asthma do?
  - A question and answer period
  - A short (approximately 5 to 15 minutes per client) one-on-one private direct (face-to-face) encounter with the physician consisting of:
    - A physical exam
    - The gathering, monitoring, and reviewing of laboratory and diagnostic tests
    - Medical decision making that includes an individual treatment plan

Documentation in the client's medical record must support level of E/M service as per the CMS and CPT manual approved guidelines.

The documentation of the individual treatment plan retained in the client's medical record must include data collected (physical exam and lab findings), educational services provided, patient participation, and the beginning and ending time of the visit.

Group visits for conditions of diabetes or asthma are limited to a maximum of four per year for any provider.

9.2.60.3.1 Group Clinical Visits for Diabetes

Group clinical visits are benefits of Texas Medicaid for the management of the condition of diabetes when submitted with one of the following diagnosis codes:

Diagnosis Codes							
E0800	E0801	E0810	E0811	E0821	E0822	E0829	E08311

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Diagnosis Codes							
E08319	E083211	E083212	E083213	E083219	E083291	E083292	E083293
E083299	E083311	E083312	E083313	E083319	E083391	E083392	E083393
E083399	E083411	E083412	E083413	E083419	E083491	E083492	E083493
E083499	E083511	E083512	E083513	E083519	E083521	E083522	E083523
E083529	E083531	E083532	E083533	E083539	E083541	E083542	E083543
E083549	E083551	E083552	E083553	E083559	E083591	E083592	E083593
E083599	E0836	E0837X1	E0837X2	E0837X3	E0837X9	E0839	E0840
E0841	E0842	E0843	E0844	E0849	E0851	E0852	E0859
E08610	E08618	E08620	E08621	E08622	E08628	E08630	E08638
E08641	E08649	E0865	E0869	E088	E089	E0900	E0901
E0910	E0911	E0921	E0922	E0929	E09311	E09319	E093211
E093212	E093213	E093219	E093291	E093292	E093293	E093299	E093311
E093312	E093313	E093319	E093391	E093392	E093393	E093399	E093411
E093412	E093413	E093419	E093491	E093492	E093493	E093499	E093511
E093512	E093513	E093519	E093521	E093522	E093523	E093529	E093531
E093532	E093533	E093539	E093541	E093542	E093543	E093549	E093551
E093552	E093553	E093559	E0936	E093591	E093592	E093593	E093599
E0937X1	E0937X2	E0937X3	E0937X9	E0939	E0940	E0941	E0942
E0943	E0944	E0949	E0951	E0952	E0959	E09610	E09618
E09620	E09621	E09622	E09628	E09630	E09638	E09641	E09649
E0965	E0969	E098	E099	E1010	E1011	E1021	E1022
E1029	E10311	E10319	E103211	E103212	E103213	E103219	E103291
E103292	E103293	E103299	E103311	E103312	E103313	E103319	E103391
E103392	E103393	E103399	E103411	E103412	E103413	E103419	E103491
E103492	E103493	E103499	E103511	E103512	E103513	E103519	E103521
E103522	E103523	E103529	E103531	E103532	E103533	E103539	E103541
E103542	E103543	E103549	E103551	E103552	E103553	E103559	E103591
E103592	E103593	E103599	E1036	E1037X1	E1037X2	E1037X3	E1037X9
E1039	E1040	E1041	E1042	E1043	E1044	E1049	E1051
E1052	E1059	E10610	E10618	E10620	E10621	E10622	E10628
E10630	E10638	E10641	E10649	E1065	E1069	E108	E109
E10A0	E10A1	E10A2	E1100	E1101	E1110	E1111	E1121
E1122	E1129	E11311	E11319	E113211	E113212	E113213	E113219
E113291	E113292	E113293	E113299	E113311	E113312	E113313	E113319
E113391	E113392	E113393	E113399	E113411	E113412	E113413	E113419
E113491	E113492	E113493	E113499	E113511	E113512	E113513	E113519
E113521	E113522	E113523	E113529	E113531	E113532	E113533	E113539
E113541	E113542	E113543	E113549	E113551	E113552	E113553	E113559
E113591	E113592	E113593	E113599	E1136	E1137X1	E1137X2	E1137X3
E1137X9	E1139	E1140	E1141	E1142	E1143	E1144	E1149

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Diagnosis Codes							
E1151	E1152	E1159	E11610	E11618	E11620	E11621	E11622
E11628	E11630	E11638	E11641	E11649	E1165	E1169	E118
E119	E11A	E1300	E1301	E1310	E1311	E1321	E1322
E1329	E13311	E13319	E133211	E133212	E133213	E133219	E133291
E133292	E133293	E133299	E133311	E133312	E133313	E133319	E133391
E133392	E133393	E133399	E133411	E133412	E133413	E133419	E133491
E133492	E133493	E133499	E133511	E133512	E133513	E133519	E133521
E133522	E133523	E133529	E133531	E133532	E133533	E133539	E133541
E133542	E133543	E133549	E133551	E133552	E133553	E133559	E133591
E133592	E133593	E133599	E1336	E1337X1	E1337X2	E1337X3	E1337X9
E1339	E1340	E1341	E1342	E1343	E1344	E1349	E1351
E1352	E1359	E13610	E13618	E13620	E13621	E13622	E13628
E13630	E13638	E13641	E13649	E1365	E1369	E138	E139

9.2.60.4 Group Clinical Visits for Asthma

Group clinical visits are benefits of Texas Medicaid for the management of the condition of asthma when submitted with one of the following diagnosis codes:

Diagnosis Codes							
J440	J441	J4489	J449	J4520	J4521	J4522	J4530
J4531	J4532	J4540	J4541	J4542	J4550	J4551	J4552
J45901	J45902	J45909	J45990	J45991	J45998		

9.2.60.4.1 Group Clinical Visits for Pregnancy

Group clinical visits are benefits of Texas Medicaid for the management of the condition of pregnancy when submitted with procedure code 99078 and modifier TH, along with one of the following diagnosis codes:

Diagnosis Codes							
O0900	O0901	O0902	O0903	O0910	O0911	O0912	O0913
O09211	O09212	O09213	O09219	O09291	O09292	O09293	O09299
O0930	O0931	O0932	O0933	O0940	O0941	O0942	O0943
O09511	O09512	O09513	O09519	O09521	O09522	O09523	O09529
O09611	O09612	O09613	O09619	O09621	O09622	O09623	O09629
O0970	O0971	O0972	O0973	O09811	O09812	O09813	O09819
O09821	O09822	O09823	O09829	O09891	O09892	O09893	O09899
O0990	O0991	O0992	O0993	O09A0	O09A1	O09A2	O09A3
Z331	Z3400	Z3401	Z3402	Z3403	Z3480	Z3481	Z3482
Z3483	Z3490	Z3491	Z3492	Z3493			

Providers are encouraged to provide a comprehensive curriculum or use materials from the Centering Pregnancy Program that will be incorporated into the educational portion of the group clinical visit.

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Comprehensive curriculums will allow clinical issues to be identified to promote a healthy pregnancy. The education material may include screenings and preparations, health maintenance, counseling, and birth plans:

- Screenings and preparations may consist of the following:
  - Expected course of the pregnancy
  - Anticipated outline of the scheduled visits
  - Signs and symptoms, which should be reported to the physician as soon as possible
  - Laboratory services
  - Appropriate use of medications
  - Proper weight monitoring
  - Immunizations (e.g., hepatitis, varicella, or RhoGAM)
  - Complications of pregnancy that may occur (e.g., preeclampsia, diabetes, or edema)
- Health maintenance may consist of the following:
  - Hygiene (e.g., hot tubs or baths)
  - Sexual activity
  - Exercise
  - Nutrition and dietary needs
- Counseling may consist of the following:
  - Use of seat belts
  - Job activity
  - Air travel
  - Dental care appointments
  - Domestic abuse or violence
  - Tobacco or drug use
- Birth planning may consist of the following:
  - What to expect during labor and delivery
  - Pain control during labor
  - Complications during delivery that may occur (e.g., Caesarean section or episiotomy)
  - Breast feeding
  - Newborn care
  - Postpartum adjustments

Group clinical visits for the management of pregnancy are restricted to female clients who are 10 through 55 years of age and are limited to a maximum of 10 visits per 270 days for any provider.

To be considered for reimbursement, procedure code 99078 with modifier TH must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215 with modifier TH.

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9.2.60.4.2 Preventive Care Visits

Adult preventive services must be provided in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations with grades A or B. USPSTF recommendations, with specific age and frequency guidelines, are listed on the USPSTF website. The following are recommended screens in addition to USPSTF and are covered separately:

- Tuberculosis screening
- Prostate cancer screening; prostate specific antigen (PSA) for men who are 50 through 64 years of age

Preventive care services are comprehensive visits that may include counseling, anticipatory guidance, and risk-factor-reduction interventions. Documentation must indicate the anticipatory guidance rendered.

Preventive health visits for clients who are birth through 20 years of age are available through THSteps medical checkups.

Refer to: Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about hearing screenings.

Adult preventive services (procedure codes 99385, 99386, 99387, 99395, 99396, and 99397) are a benefit of Texas Medicaid for clients who are 21 years of age and older. Adult preventive services are limited to one service per rolling year, any provider, and must be billed with diagnosis code Z0000, Z0001, Z01411, or Z01419.

The following USPSTF recommendations are not reimbursed separately but must be provided, when applicable, as part of the routine preventive exam:

- Counseling to prevent tobacco use and tobacco-caused disease
- Behavioral counseling in primary care to promote a healthy diet
- Behavioral interventions to promote breast feeding
- Screening for obesity in adults (with intensive counseling and interventions)
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
- Screening for depression

The USPSTF recommendation of chemoprevention of breast cancer is not a benefit of Texas Medicaid.

Laboratory, immunization, and diagnostic procedures recommended by USPSTF are covered benefits and may be billed separately, as clinically indicated, using the most appropriate diagnosis code that represents the client's condition. Diagnosis code Z0000 or Z0001 may each be used once per rolling year for each screen if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.

Services that exceed USPSTF recommendations are not considered part of a screening and require medical documentation to justify medical necessity of the services performed.

For clients who are 21 years of age and older, breast exams and Pap smears are available through programs related to women's health, including Texas Medicaid family planning services and the Healthy Texas Women (HTW) program.

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

Section 2, "Healthy Texas Women (HTW) Program Overview" in the *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*).

9.2.60.4.3 Smoking and Tobacco Use Cessation Counseling

Smoking and tobacco use cessation counseling is a benefit for male and female clients who are 10 years of age and older and must be submitted with procedure codes 99406 and 99407. Smoking and tobacco use cessation counseling services delivered in a group setting will be limited to a maximum of 8 participants per group and must be submitted with modifier HQ.

Modifier	Description
HQ	Group Counseling

Procedure codes 99406 and 99407 may be reimbursed when submitted with the following diagnosis codes:

Diagnosis Codes							
F17200	F17201	F17203	F17208	F17209	F17210	F17211	F17213
F17218	F17219	F17220	F17221	F17223	F17228	F17229	F17290
F17291	F17293	F17298	F17299				

Procedure codes 99406 and 99407 may be billed in any combination by the same or a different provider, whether individual or group counseling, and are limited to eight services per rolling year.

Additional services require documentation of medical necessity to exceed the established limit.

Procedure codes 99406 and 99407 are limited to once per day, same or different procedure code, any provider.

Refer to: Subsection 4.1.16, "Smoking and Tobacco Use Cessation Counseling" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information related to the smoking and tobacco use cessation counseling and additional covered diagnoses related to pregnancy.

9.2.60.4.4 Office and Outpatient Consultation Services

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. The consultation must meet the following requirement:

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

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary.

The visit is not considered a consultation if any of the following applies:

- If diagnostic or therapeutic treatment is initiated during a consultation and the patient returns for follow-up care, the follow-up visit is considered an established patient visit, and must be billed as an established patient visit.
- If the purpose of the referral is to transfer care.

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

Providers must use procedure code 99242, 99243, 99244, or 99245 when billing new or established patient consultations in the office, or in an outpatient or other ambulatory facility.

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

9.2.60.4.5 Physician Services Provided in the Emergency Department

Providers must use procedure codes 99281, 99282, 99283, 99284, and 99285 when billing emergency department services. If an emergency department visit is billed by the same provider with the same date of service as an office visit, outpatient consultation, inpatient consultation, or subsequent nursing facility service, the emergency department visit may be reimbursed and the other services will be denied.

If an emergency department visit is billed by the same provider with the same date of service as an initial nursing facility service, the initial nursing facility service may be reimbursed and the emergency department visit will be denied.

Multiple emergency department visits provided by the same provider for the same client on the same day must have the times for each visit documented on the claim form. Also, more than one visit billed with the same date of service can be indicated by adding the appropriate modifier to the claim form. Medical documentation is required to support this service.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for nonemergent and nonurgent physicians' services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The emergency department procedure code that is submitted on the claim is used to determine the appropriate reimbursement for these services. The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered by the physician in the hospital's emergency department. The reimbursement for each service is determined by multiplying the base allowable fee by 60 percent.

Refer to: Section 4, "Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for information on emergency department services by facilities (room and ancillary).

Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

9.2.60.4.6 After-Hours Services

Texas Medicaid limits reimbursement for after-hours charges to office-based providers rendering services after routine office hours.

An office-based provider must bill an after-hours charge in addition to a visit charge for providing services after routine office hours. This after-hours charge must be billed when a provider judges it medically necessary to provide after-hours care for a patient with an emergent condition. A provider's routine office hours are the hours posted at the physician's office as the usual office hours. Medicaid reimburses office-based physicians an inconvenience or after-hours charge when any of the following situations exist:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours.

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- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.

Charges for inconvenience or after-hours services by emergency department-based physicians or emergency department-based groups are not allowed.

After-hours procedure codes are limited to one per day, same provider.

Providers must use procedure codes 99050, 99056, or 99060 to report after-hours services.

9.2.60.5 Other Inpatient and Outpatient Hospital Services

A hospital care visit submitted by the same provider for the same client within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or for a similar diagnosis must be submitted as a subsequent care visit.

Refer to: Subsection 9.2.74.6, "Global Fees" in this handbook for more information about global services.

9.2.60.6 Prolonged Physician Services

Prolonged services (procedure code 99417 or 99418) involve face-to-face patient contact and may be utilized in the office, outpatient hospital, or inpatient hospital settings. The face-to-face patient contact must exceed the time threshold of the following E/M procedure codes submitted for the date of service and be beyond the usual service.

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	99221
99222	99223	99231	99232	99233	99242	99243	99244	99245	99252
99253	99254	99255	99341	99342	99344	99345	99347	99348	99349
99350									

Prolonged services that are less than 30 minutes in duration cannot be reported separately.

Procedure code 99417 should only be used when an office or other outpatient services, office consultation, or other outpatient evaluation and management service has been selected using time alone as the basis, and the time required to report the highest level (procedure code 99205, 99215, 99245, 99345, or 99350) service has been exceeded by 15 minutes.

Procedure code 99418 is only used when an inpatient or observation evaluation and management service has been selected using time alone as the basis, and only after the time required to report the highest level service (procedure code 99223, 99233, 99236, 99255, 99306, or 99310) has been exceeded by 15 minutes.

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

Prolonged services in the inpatient setting involving face-to-face client contact that is beyond the usual service may be reimbursed when provided on the same day as an initial hospital visit (procedure codes 99221, 99222, 99223, 99252, 99253, 99254, and 99255) or a subsequent hospital visit (99231, 99232, 99233).

Prolonged physician services are denied when billed with critical care or emergency room visits billed with the same date of service, same provider.

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Prolonged physician services without a face-to-face contact (procedure codes 99358 and 99359) are not a benefit of Texas Medicaid.

Note: *For non-face-to-face prolonged physician services, and for use of the unlisted evaluation and management procedure code for clients who are birth through 20 years of age, refer to subsection 2.6.1.1.5, "Non-Face-to-Face Prolonged Services" in the Children's Services Handbook (Vol. 2, Provider Handbooks).*

Refer to: Subsection 4.2.2, "Psychotherapy Services" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about prolonged psychotherapy services.

Physician standby services are not a benefit of Texas Medicaid.

9.2.60.6.1 Inpatient or Observation Services

Inpatient hospital visits must be submitted using procedure codes 99221, 99222, 99223, 99231, 99232, and 99233.

If a subsequent hospital visit (procedure code 99231, 99232, or 99233) following admission is billed by the same provider with the same date of service as any of the following emergency department visits, office visits, or outpatient consultations, the subsequent hospital visit may be reimbursed and the other visits will be denied:

Procedure Code									
99281	99282	99283	99284	99285	99202	99203	99204	99205	99211
99212	99213	99214	99215	99242	99243	99244	99245		

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A subsequent hospital visit (procedure code 99231, 99232, or 99233) will be denied when billed on the same day to the same provider as critical care services (procedure codes 99291 and 99292).

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

Refer to: Subsection 9.2.47, "Newborn Services" in this handbook for information about newborn services.

Hospital observation is for professional services for a period of more than 6 hours but fewer than 24 hours regardless of the hour of the initial contact, even if the client remains under physician care past midnight.

If dialysis treatment and physician observation visits are billed on the same day by the same provider, and same specialty other than an internist or nephrologist, the dialysis treatment will be paid and the physician observation visit will be denied.

9.2.60.6.2 Concurrent Care

Concurrent care exists when services are provided to a patient by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the patient in accordance with accepted standards of good medical practice. Concurrent care may be reimbursed to providers of different specialties when the services are for unrelated diagnoses involving different organ systems.

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Concurrent care will be denied when billed for providers of the same specialty for the same or related diagnoses. Denied concurrent care may be appealed when accompanied by documentation of medical necessity.

Each appeal submitted for concurrent care must contain the following information:

- Documentation of the medical necessity for the physician's services (care and treatment)
- Diagnosis and indication of the severity of the client's condition (acute or critical)
- Role of the physician in the care of the client, including the name of the admitting physician
- Specialty and subspecialty of each physician and any limitations of practice

Claims appealed without clear documentation of medical necessity as described above will be denied.

Important: *If the attending physician requests only a consultation, the request must be clearly stated in the orders.*

All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and must include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician.
- The name of the requesting physician by the physician rendering concurrent care.

9.2.60.6.3 Consultations

Consultations provided to hospital inpatients, observation patients, residents of nursing facilities, or patients in a partial hospital setting must be billed using procedure codes 99252, 99253, 99254, and 99255.

One initial inpatient or observation consultation (procedure code 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period for the same diagnosis. Subsequent consultations billed as initial consultations during this time period will be denied.

Refer to: Subsection 9.2.60.4.4, "Office and Outpatient Consultation Services" in this handbook for additional criteria information.

9.2.60.6.4 Critical Care

Critical care includes the care of critically ill clients that require the constant attention of the physician. The physician must either be at bedside or immediately available to the client. The physician's full attention must be devoted to the client so that the physician cannot render E/M to any other client during the same period of time. Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit, or the emergency department care facility. The following procedure codes are used to bill critical care services:

Procedure Code	Limitations
99291	A per day charge for the first 30 to 74 minutes of critical care (time spent by the physician does not have to be continuous on that day).
99292	A per day charge for each additional 30 minutes beyond the first 74 minutes of critical care for up to 6 units or 3 hours per day.*
99471	A per day charge for initial inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.
99472	A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age.
*** If the number of units is not stated on the claim, a quantity of one is allowed.**	

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Procedure Code	Limitations
99475	A per day charge for initial inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.
99476	A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age.
*** If the number of units is not stated on the claim, a quantity of one is allowed.**	

Services for a client who is not critically ill and unstable but who was treated in a critical care unit must be reported using subsequent hospital visit codes or hospital consultation codes.

If the same provider who performed a major surgery must also perform critical care on the same day for the same client, the provider must bill the critical care with documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure.

Critical care (procedure codes 99291, 99292, 99471, 99472, 99475, and 99476) may be reimbursed only to the provider rendering the critical care service at the time of crisis. Critical care involves high-complexity decision-making to access, manipulate, and support vital system functions. While providers from various specialties may be consulted to render an opinion and assist in the management of a particular portion of the care, only the provider managing the care of the critically ill patient during a life threatening crisis may bill the critical care procedure codes.

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

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

Time spent under the following circumstances may not be reported as critical care:

- Activities that occur outside of the unit or off the floor
- Activities that do not directly contribute to the treatment of the client
- While performing separately reportable procedures or services

Critical care of less than 30 minutes total duration per day must be reported with the appropriate E/M procedure code.

If critical care that meets the initial 30-minute time requirement is provided to the same client by different physicians, the initial provider's claim may be reimbursed. The second provider's claim will be denied but may be appealed. The time spent by each physician cannot overlap; two physicians cannot bill critical care for care delivered at the same time. Supporting medical record documentation that includes the time in which the critical care was rendered must be provided by the second physician. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill patient during the life threatening crisis.

If the provider's time exceeds the 74-minute threshold for procedure code 99291, procedure code 99292 may be billed for each additional 30 minutes. Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider's group practice and is limited to 6 units per day for any provider.

Inpatient critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care procedure codes 99471 and 99472. The pediatric critical care procedure codes are reported as long as the infant or young child qualifies for critical care services during the hospital stay through 24 months of age.

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Pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge. Only one physician can bill pediatric critical care per day. If an inpatient or outpatient E/M service is billed by the same provider with the same date of service as pediatric critical care, the E/M service is denied.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room), which does not result in admission must be billed using procedure codes 99291 and 99292. Critical care provided to a neonatal or pediatric client in both the outpatient and inpatient settings on the same day must be billed using the appropriate neonatal or pediatric critical care procedure code.

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

Claims may be subject to retrospective review to ensure documentation supports the medical necessity of the service when billing the claim.

Critical care procedure codes 99291 and 99292 will be denied when submitted with the same date of service by the same provider as neonatal intensive care procedure code 99468, 99469, 99478, 99479, or 99480.

9.2.60.6.5 Hospital Inpatient or Observation Discharge

Hospital inpatient or observation discharge must be submitted using procedure code 99238 or 99239.

Hospital inpatient or observation discharge management billed by the same provider with the same date of service as the admission will be denied.

Discharge management billed by the same provider with the same date of service as an emergency room visit will be considered for reimbursement and the emergency visit will be denied.

Subsequent hospital inpatient or observation visits billed by the same provider with the same date of service as discharge management will be denied.

9.2.60.6.6 Nursing Facility Services

Providers must use the following procedure codes when billing initial nursing facility assessments, subsequent nursing facility care, and annual nursing facility assessments in a nursing facility:

Procedure Codes									
99304*	99305*	99306*	99307	99308	99309	99310	99315	99316	

Initial nursing facility assessments (marked with an asterisk in the table above) include all services related to an admission to the nursing facility.

Comprehensive initial nursing facility assessments performed by the same provider for the same diagnosis are limited to one every six months. The second initial nursing facility assessment within the six-month period will be denied.

Prolonged services in the nursing facility involving direct (face-to-face) patient contact that is beyond the usual service may be reimbursed on the same day as a nursing facility visit (procedure code 99304, 99305, 99306, 99307, 99308, 99309, or 99310).

All E/M services, regardless of setting, are considered part of the initial nursing facility care when performed by the same provider on the same day as the admission.

Subsequent nursing facility care E/M procedure codes 99307, 99308, 99309, and 99310 are limited to one per day regardless of diagnosis.

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9.2.60.6.7 Observation

When a patient is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This is an acceptable billing practice under Texas Medicaid when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement.

9.2.60.7 Home or Residence Services

Home or residence services are provided in a private residence, temporary lodging, or short-term accommodation (e.g, hotel, campground, hostel, or cruise ship), assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility. New patient visits are limited to once every three years. Providers may use procedure codes 99341, 99342, 99344, and 99345 when billing for new patient services provided in the home/residence setting.

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

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

Established E/M services are limited to one per day, same provider.

9.2.60.8 Referrals

A *referral* is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services must be billed using the appropriate E/M visit code.

When a Texas Medicaid provider refers a Texas Medicaid client to another provider for additional treatment or services, the referring provider must forward notification of the client's eligibility and his NPI. The client must be made aware that the provider he/she is referred to does or does not participate in Texas Medicaid. Some clients not eligible for Medicaid are eligible for family planning through the HHSC Family Planning Program. These clients should be referred to contracted agency providers for family planning services.

9.2.60.8.1 Referral Requirements for Children with Disabilities

All health-care professionals are required by state and federal legislation to refer children who are 35 months of age or younger with developmental delays to early childhood intervention services provided under the authority of the Texas Health and Human Services Commission (HHSC).

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

9.2.61 Physician Services in a Long Term Care (LTC) Nursing Facility

HHSC requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician's office or the nursing facility.

Additional information is available on the HHSC website at https://hhs.texas.gov.

9.2.62 Podiatry and Related Services

Podiatry and related services are a benefit of Texas Medicaid.

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9.2.62.1 Clubfoot Casting

Procedure code 29450 is limited to clients who are birth through 3 years of age and is payable to a physician in the management of clubfoot when a previous surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. Procedure code 29750 is limited to clients who are birth through 3 years of age and is payable to a physician in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting and wedging are benefits if the client has one of the following conditions:

Diagnosis Codes							
M21541	M21542	M21549	Q6600	Q6601	Q6602	Q6610	Q6611
Q6612	Q66211	Q66212	Q66219	Q66221	Q66222	Q66229	Q6630
Q6631	Q6632	Q6640	Q6641	Q6642	Q6651	Q6652	Q666
Q6670	Q6671	Q6672	Q6681	Q6682	Q6689	Q6690	Q6691
Q6692							

9.2.62.2 Flat Foot Treatment

Reimbursement for treatment of deformities of the foot and lower extremity that includes flat foot as a component of the deformity may be considered when the client presents with significant pain in the foot, leg, or knee, resulting in a loss of or decrease in function, along with a secondary condition such as valgus deformity or plantar fasciitis.

Treatment of flat foot (flexible pes planus) that is solely cosmetic in nature is not a benefit of Texas Medicaid.

9.2.62.3 Routine Foot Care

Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to one service every six months per client, regardless of provider specialty: 11055, 11056, 11057, 11719, and G0127.

9.2.63 Prostate Procedures for Benign Prostatic Hyperplasia (BPH)

Prostate procedures are a benefit of Texas Medicaid and include surgical, minimally invasive, and laser procedures. Prostate procedures treat lower urinary tract symptoms (LUTS) attributed to benign prostatic hyperplasia (BPH).

BPH is an overgrowth of cells in the prostate gland and is increasingly common as men age. BPH does not require treatment and is not the target of interventions; however, BPH can lead to an enlargement of the prostate (benign prostatic enlargement [BPE]).

BPE can result in lower urinary tract symptoms (LUTS) which includes urinary frequency, urinary retention, inability to completely empty the bladder, blood in the urine, and kidney disease. Symptoms can be mild, moderate or severe.

LUTS attributable to BPH may significantly worsen the quality of life of male patients.

Treatment of LUTS attributable to BPH include a continuum of interventions ranging from lifestyle modifications, pharmacological management, minimally invasive therapy (MIST), laser therapy, to surgery.

Various prostate procedure services may be provided in the inpatient hospital, outpatient hospital, ambulatory surgical center or office settings.

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In some cases, surgical or minimally invasive therapies might be appropriate as a first line of therapy without a trial of pharmacological management for reasons of patient preference or for reasons including inability to empty the bladder, urinary reflux, kidney disease, repeated urinary infections, kidney stones, or hematuria resulting from BPH.

Pharmacological management may be the first line treatment of BPH. Medication therapy may not be tolerated due to adverse effects including low blood pressure, dizziness, fatigue, and impaired sexual function.

Surgical therapies may have longer durability, but often require an inpatient setting using general anesthesia and result in a longer recovery time.

TURP (Transurethral Resection of the Prostate) has been a preferred surgical treatment of BPH for many years and is the standard by which other treatments are compared. TURP may have a high rate of durability which may be contrasted with an increased rate of complications.

Minimally invasive therapies (MISTs) have developed as an alternative to the surgical approach of TURP, however they may have less durability than TURP.

MIST may be performed in an office setting, ambulatory surgical center or outpatient hospital under local anesthesia.

MIST may offer a short recovery time and patients are able to return to normal activity faster. MIST often preserves sexual functioning. After lifestyle modifications and medication, the next line of treatment may include minimally invasive therapy.

9.2.63.1 Minimally Invasive Therapies (MIST) for BPH

Minimally invasive therapy is an option for patients who wish a less invasive technique that may be performed in a lower acuity setting, as well as higher surgical risk patients.

9.2.63.1.1 Types of Minimally Invasive Therapy

Prostatic Urethral Lift (PUL) involves placement of one or more implants in the lateral lobes of the prostate using a transurethral delivery device, with minimal side effects. Procedure codes 52441, 52442, C9739, and C9740, are a covered benefit when the following restrictions are met:

- Client is 45 years of age and older
- Prostate gland volume is ≤ 80 gm and verified absence of an obstructive middle lobe
- International Prostate Symptom Score (IPSS) ≥ 12
- Pharmacological management has been unsuccessful or side effects intolerable
- No current urinary tract infection
- No allergy to nickel
- Surgical intervention is required

Transurethral water vapor therapy, also known as water vapor energy ablation (procedure code 53854) causes transurethral destruction of prostate tissue by radiofrequency and is indicated in prostate volumes <80 gm.

Transurethral Microwave Thermotherapy (TUMT) (procedure code 53850) is indicated for BPH when patients have a prostate length of 30-55 mm and have failed pharmacological management. The procedure is contraindicated for patients with:

- Prostate cancer
- Penile or metallic implants
- Lack of bladder control due to nerve problems

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- Nerve problems caused by diabetes
- Narrowing of the urethra due to scarring
- Prior prostate surgery or pelvic radiation therapy

Transurethral Needle Ablation (TUNA) (procedure code 53852) destroys prostate tissue by radiofrequency thermotherapy and is suitable for prostates ≤ 60 gm with predominantly lateral lobes. The procedure is an option when invasive surgery is not possible due to comorbidities.

Laser Therapy as an option for treating BPH, is indicated when there is an increased bleeding risk.

9.2.63.1.2 Types of Laser Procedures

Photoselective Vaporization of the Prostate (PVP), procedure code 52648, is a laser vaporization of prostate suitable for all patients, including those taking anticoagulation or antiplatelet medication.

Contact Laser ablation of the Prostate (CLAP) (procedure code 52648) may be reimbursed when the following is present:

- High risk of bleeding
- Prostates >100 gm
- Urinary retention

Holmium Laser Procedures of the Prostate (HoLAP), Holmium Laser Enucleation of the Prostate (HoLEP), and Homium Laser Resection of the Prostate (HoLRP), (procedure code 52649) may be used for all patients, but particularly if anticoagulant or antiplatelet therapy is used.

Surgical Therapy is a first-line treatment if the patient is unable to completely empty the bladder, has urinary reflux possibly resulting in backflow of urine into the kidney causing swelling of the kidney, or kidney disease caused by BPH, frequent urinary infections, kidney stones, bladder stones, or continuing blood in the urine caused by BPH. Surgical therapy may be necessary after failing medications or other treatments.

9.2.63.1.3 Types of Surgical Therapy

Transurethral resection of the prostate (TURP) (procedure codes 52597, 52601, 52630, and 52640) are the gold standard for treating moderate to severe BPH after failing medication and when minimally invasive procedures are contraindicated.

Procedure code 52597 is restricted to diagnosis codes N400 and N401.

Transurethral incision of the prostate (TUIP) (procedure code 52450) is utilized when minimally invasive procedures are contraindicated, and patient is not a good candidate for TURP. Usually used to treat small prostates ≤ 30 grams and it has a lower risk of blood transfusion than TURP. Services are limited to once per day.

Prostatectomy Perineal (procedure code 55801), Suprapubic (procedure code 55821), and Retropubic, (procedure code 55831) are suitable treatments for larger prostates > 50 grams and for men who are also good surgical candidates.

Prostatectomy, Laparoscopy (procedure code 55867) is a procedure suitable for prostates > 100 grams and for men who are also good surgical candidates.

Urethral Stent Temporary (procedure code 53855) is designed for short term use (6 months to 3 years) and is suitable for high-risk patients especially those with urinary retention.

Urethral Stent Permanent (procedure code 52282) is utilized in men ≥ 60 years or < 60 years who are poor surgical candidates' w/ prostate ≥ 2.5 cm long. The procedure is considered for high-risk patients especially with urinary retention.

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9.2.63.2 Prior Authorization and Documentation Requirements

Prior authorization is required for:

- Prostatic Urethral Lift (PUL) add on procedure code 52442 utilizing more than 6 implants.
- Assistant surgeons for holmium laser procedures of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate (HoLRP).

Note: *All other services addressed in this section do not require prior authorization.*

Requests for prior authorization must be received and approvals must be obtained before services are rendered. Requests received after the service date will be denied.

The SMPA form must be submitted, signed, and dated within 60 days before the date of service. Services will not be authorized prior to the ordering provider's signature date.

To facilitate determination of medical necessity and avoid unnecessary denials, the provider must maintain correct and complete information, including documentation for medical necessity for the test requested. The provider must maintain documentation of medical necessity in the client's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies, and to confirm eligibility criteria are met for the benefit.

Prior authorization requests must be submitted on a SMPA Request Form and must include the following documentation: the client's diagnosis, medical necessity for choosing the procedure, the expected total number of implants required for the procedure, and a brief statement addressing the medical necessity for the number of implants requested.

Medical necessity must be documented for assistant surgeons for holmium laser procedures of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate, (HoLRP).

In addition to documentation requirements outlined in this section, if any, of the following requirements apply: all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Documentation in the medical record should include a diagnosis of BPH and LUTS that in the opinion of the provider requires a procedure as an intervention for treatment.

Reimbursement is restricted for holmium laser procedure of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate (HOLRP), unless there is an approved prior authorization for an assistant surgeon obtained before the procedure.

Refer to: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for detailed information about prior authorization requirements.

9.2.63.3 Reimbursement Billing Guidelines

The following procedure codes may be reimbursed for prostate procedures:

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BPH Procedures Reimbursement Information		
Service Category	**Procedure Codes**	**Additional Information**
Minimally Invasive Therapy (MIST) Prostatic Urethral Lift (PUL)	52441, 52442, C9739, C9740	Only Prostatic Urethral Lift (PUL) procedure code 52442 requires prior authorization if more than 6 total implants. Procedure codes 52441, C9739, and C9740 may only be billed once per lifetime.
Minimally Invasive Therapy (MIST)-Other	53850, 53852, 53854	Procedure codes 53850, 53852, and 53854 utilize heat or energy transfer techniques to reduce prostate size by tissue necrosis.
Laser Therapy	52648, 52649	Procedure codes 52648 and 52649 are not covered in an office setting.
Surgical Therapy	52597, 52601, 52630, 52640, 52450	Procedure code 52601 may be billed for the first TURP and may be billed again if the first TURP is staged with modifier 58. Procedure codes 52630 and 52640 may not be billed on the same day of service. Procedure codes 52597, 52601, 52630, 52640, and 52450 are all limited to once per day.
Prostatectomy	55801, 55821, 55831	Suitable for larger prostates and requires hospital admission and services are limited to one service per day.
Urethral Stent	52282, 53855	May be temporary or permanent procedure code 52282, and is limited to men who are 60 years of age or older.

Modifier	Use For
58	Procedure code 52601 if billed a second time in a staged procedure

The Prostatic Urethral Lift (PUL) procedure in an office setting or a hospital outpatient department is billed as procedure code 52441 for the first implant and each subsequent implant is billed separately as procedure code 52442.

If the PUL procedure is billed with procedure code 52442, then procedure code 52441 must also be billed for the same date of service.

The PUL procedure in an ambulatory surgical center setting is billed as procedure code C9739 for the first through third implants and four or more subsequent implants are billed separately as procedure code C9740.

The PUL procedure is limited to one procedure per lifetime. The PUL procedure is billed with only one set of codes, either procedure codes 52441 and 52442 in an office setting or outpatient hospital setting OR procedure codes C9739 and C9740 in an ambulatory surgical center setting. More than 7 implants will require prior authorization. Procedure code 52442 (2 or more implants) will require prior authorization if procedure code 52442 is billed for more than 6 implants.

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A TURP may be billed with procedure code 52597, 52601, 52630, or 52640 and may be reimbursed to the physician performed in a hospital, an outpatient hospital setting, and an ambulatory surgical center with only one service per day.

If a provider submits separate charges for any of the TURP procedure codes listed above and procedure code 52351 or 52354, the charges for procedure codes 52351 and 52354 will be denied as part of the TURP procedure billed as procedure code 52601.

If the first TURP is performed as a staged procedure, the first procedure may be billed as procedure code 52601. The next part of the staged TURP procedure may also be billed as procedure code 52601 but must also include Modifier 58.

A subsequent TURP (not including the staged TURP for procedure code 52601 with modifier 58) may be billed as either procedure code 52630 or procedure code 52640.

A TUMT, procedure code 53850, may be performed in an office as well as hospital setting, and reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center and may be performed only once per day.

A TUNA, procedure code 53852, reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center setting or an office setting and may be performed only once per day.

Transurethral water vapor therapy, procedure, code 53854, may be performed in an office, and reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center.

A TUIP, procedure code 52450, is reimbursed to the physician in the inpatient hospital setting as well in an ambulatory surgical center and may be performed only once per day.

A PVP, procedure code 52648, may be reimbursed to the physician in the inpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

Holmium Laser Procedures of the Prostate (HoLAP), Holmium Laser Enucleation of the Prostate (HoLEP), and Holmium Laser Resection of the Prostate (HoLRP), procedure code 52649, may be reimbursed to the physician in the inpatient and outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day and may allow for an assistant surgeon.

A permanent urethral stent, procedure code 52282, may be performed in an office and may be reimbursed to the physician in the inpatient or outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

A temporary urethral stent, procedure code 53855, may be performed in an office and may be reimbursed to the physician in the inpatient or outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

9.2.64 Radiation Therapy

Radiation treatment management may be reimbursed by Texas Medicaid as defined in the *Current Procedure Terminology* (CPT) manual under the "Radiation Treatment Management" section.

The following radiation therapy services are limited to once per day unless documentation submitted with an appeal supports the need for the service to be provided more frequently:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment

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- Intracavitary radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization
- Radioisotope therapy

Laboratory and diagnostic radiological services provided in the office setting may be reimbursed to physicians as a total component. Radiation treatment centers may also be reimbursed for the total component for these services in the outpatient hospital setting. Injectable medications given during the course of therapy in any setting may be reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be reimbursed on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

The professional component and the technical component will be denied when billed with the total component. The total component includes the professional and the technical components.

The professional component may be reimbursed for services rendered in the inpatient hospital setting, radiation treatment center setting, or outpatient hospital setting. Physicians billing client services rendered in the office setting or in a facility recognized by Medicaid as a radiation treatment center may be reimbursed for total components.

9.2.64.1 Brachytherapy

9.2.64.1.1 Prior Authorization for Brachytherapy

Prior authorization is not required for brachytherapy.

9.2.64.1.2 Other Limitations on Brachytherapy

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied as part of another service when billed with the same date of service as clinical brachytherapy services.

An office visit will be denied as part of another service when billed with the same date of service by the same provider as clinical treatment planning and clinical brachytherapy.

Normal follow-up care by the same physician will be denied as part of another service when billed with the same dates of service as any therapeutic radiology service. Any other E/M office visit will be denied as part of another service when billed with the same date of service by the same provider as the radiation treatment or radiation treatment complication.

Providers may use modifier 25 to indicate that the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available upon request.

Each service provided using procedure codes 77321 and 77470 are limited to once per two calendar months.

Documentation that supports the provision of special procedures must be maintained in the client's medical record and made available upon request.

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9.2.64.2 Stereotactic Radiosurgery

9.2.64.2.1 Prior Authorization for Stereotactic Radiosurgery

The following procedure codes are a benefit of Texas Medicaid with prior authorization and documentation of medical necessity:

Procedure Codes									
32701	61781	61782	61783	61796	61797	61798	61799	61800	63620
63621	76145	77336	77370	77371	77372	77373	77399	77423	77520
77522	77523	77525	G0339	G0340	G0563	S8030			

Prior authorization requests received after the requested start date of service will be denied for dates of service prior to the date the request was received.

Prior authorization requirements for stereotactic radiosurgery and stereotactic body radiation therapy may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in chest, abdomen, or pelvis
- Trigeminal neuralgia refractory to medical management
- Pediatric cancers

Stereotactic radiosurgery and stereotactic body radiation therapy are considered investigational and not a benefit of Texas Medicaid for all other indications including, but not limited to, epilepsy, chronic pain, and pancreatic adenocarcinoma.

Prior authorization requirements for proton beam (procedure codes 77520, 77522, 77523, 77525, and S8030) and helium ion radiosurgery (procedure code 77423) may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low-grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
- Pituitary neoplasms
- Other central nervous system tumors located near vital structures
- Pediatric cancers

Proton beam radiation therapy (procedure codes 77520, 77522, 77523, 77525, and S8030) is a benefit of Texas Medicaid for pediatric cancer diagnoses in clients who are 20 years of age or younger with prior authorization.

Prior authorization for neutron beam radiosurgery may be considered for malignant neoplasms of the salivary gland.

Prior authorization requirements for procedure code 77399 include, but are not limited to, diagnosis, documentation of medical necessity, a specific description of the procedure to be performed, and an indication that the procedure would not be covered by a more specific procedure code.

Stereotactic radiosurgery and stereotactic body radiation therapy will not be prior authorized for clients with metastatic disease and a projected life span of less than six months or for clients with widespread cerebral or extracranial metastasis that is not responsive to systemic therapy.

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9.2.64.2.2 Other Limitations on Stereotactic Radiosurgery

In the following table, the procedure codes in Column A may be reimbursed when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

Column A Procedure Code	Column B Procedure Code
61797	61796, 61798
61799	61798
61800	61796, 61798
63621	63620

Procedure codes 61796 and 63620 must not be billed more than once per course of treatment.

Procedure codes 61797 and 61799 must not be billed more than once per lesion, and may only be billed up to four times for the entire course of treatment, regardless of the number of lesions treated.

Procedure code 63621 may only be billed up to two times for the entire course of treatment, regardless of the number of lesions treated.

Procedure codes 77336 and 77370 may be reimbursed to the ordering physician if consultation is performed with a qualified medical physicist for stereotactic radiosurgery, brachytherapy, or any other method of radiation therapy for which medical necessity is determined.

Procedure code 77336 will be limited to once per week of treatment.

Procedure code 77370 will be limited to once per course of treatment. A special medical physics consultation may be reimbursed when the input and complex analysis of a qualified medical physicist are beyond that of a continuing medical physics consultation and are necessary to address a patient-specific reason or scenario.

9.2.65 Radiology Services

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to Texas Medicaid. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation of procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist's office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.

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A separate charge for an X-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall work-up and treatment of the patient.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.

Oral preparations for X-rays are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

9.2.65.1 Diagnosis Requirements

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms
- Venography
- Chest X-rays
- Cardiac blood pool imaging
- Echography

Radiologists are required to identify the referring provider by full name and credentials in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to Texas Medicaid, baseline screening and/or comparison studies are not a benefit.

9.2.65.2 Cardiac Blood Pool Imaging

Cardiac blood pool imaging may be reimbursed with procedure codes 78472, 78473, 78481, 78483, 78494, and 78496. Prior authorization is required for outpatient diagnostic services.

Refer to: Subsection 9.2.26.9, "Myocardial Perfusion Imaging" in this handbook for more information about myocardial perfusion imaging.

Section 4, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.65.3 Chest X-Rays

All providers including radiologists billing for chest X-rays must supply a diagnosis code.

Screening, baseline, or rule-out studies do not qualify for reimbursement.

9.2.65.4 Magnetic Resonance Angiography (MRA)

MRA is an effective diagnostic tool used to detect, diagnose, and aid the treatment of heart disorders, stroke, and blood vessel diseases.

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Refer to: Section 4, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.65.5 Magnetic Resonance Imaging (MRI)

MRIs may be an effective diagnostic tool for detecting defects, diseases, and trauma.

Refer to: Section 4, "Radiological and physiological laboratory services" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information and authorization requirements.

9.2.65.6 Technetium TC 99M

Procedure codes A9500 (Sestamibi) and A9502 (Tetrofosmin) are limited to three per day when billed by the same provider.

9.2.66 Magnetoencephalography (MEG)

Magnetoencephalography is a benefit of Texas Medicaid when medically necessary for the presurgical evaluation of clients with intractable epilepsy (i.e., refractory or drug-resistant epilepsy), brain tumors, vascular malformations of the brain, or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information.

MEG is a noninvasive method of measuring magnetic fields in the brain and is used to precisely localize both the essential functional cortex (i.e., eloquent cortex) and abnormal epileptogenic brain activity as part of a presurgical evaluation. The origin of abnormal MEG brain activity can be precisely localized (source localization) and displayed as a map or image.

The term magnetic source imaging (MSI) refers to an imaging technique that combines a MEG scan with an anatomic magnetic resonance imaging (MRI) image of the brain to map or visualize brain activity.

MEG may assist in guiding the placement of intracranial Electroencephalography (EEG) and, in some patients, avoid an unnecessary intracranial EEG. In the case of pre-surgical mapping of patients with operable lesions, MEG provides non-invasive localization of eloquent cortices (e.g., motor, sensory, language, auditory, or visual).

Physicians must provide MEG services in a comprehensive level IV epilepsy center or a physiological laboratory. A neurologist, epileptologist, or neurosurgeon must order the MEG test.

MEG is not a stand-alone test. Pre-surgical evaluation with MEG testing must include a comprehensive evaluation by the medical team.

Procedure codes 95965, 95966, and 95967 may be reimbursed for MEG services. Procedure code 95967 is an add-on code and must be submitted with procedure code 95966.

Physicians may be reimbursed for the professional component of MEG services.

9.2.66.1 Prior Authorization for MEG

Prior authorization is required for MEG. Prior authorization requests must be submitted using the Special Medical Prior Authorization (SMPA) Request Form. The ordering physician must sign and date the form and submit it to the SMPA department. Requests must include documentation supporting the medical necessity of the study. The ordering physician must maintain all documentation.

Providers must include information about the MEG test facility. This information must be documented on the SMPA form.

Prior authorization requests must include a completed SMPA request form and all of the following documentation:

- Documentation of one of the following conditions: intractable epilepsy, brain tumors, or vascular malformations of the brain

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- The statement of medical necessity from the ordering physician, which must support the need for MEG with identified medical conditions as applicable, including:
  - History of treatment methods used
  - Length of treatment and treatment outcomes
  - Date of onset of supporting diagnoses
  - Types of previous diagnostic testing used or considered and documentation that indicates how these tests have failed to provide the necessary information to address the client's medical needs or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information

Documentation from the ordering physician outlining how the MEG test will assist in identifying the area to be resected in instances when an MEG test is needed due to a tumor and surgery is the first option.

Documentation that includes the name and number of medications, tried and failed, to control the client's seizure activity when the MEG request is related to intractable epilepsy.

The date of prior MEG, the results of the previous MEG tests, and supporting medical documentation outlining the medical reasons for the repeat MEG requested if the request is for a repeat MEG.

Providers may submit prior authorization requests electronically, through the provider website, fax, or by standard mail.

The provider may complete and submit the required prior authorization documentation through any approved electronic method. The provider must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, in order to complete the prior authorization process electronically.

The provider may complete and submit the required prior authorization documentation through fax or standard mail and must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, to complete the prior authorization process by paper.

Providers must include correct and complete information, such as documentation of medical necessity for the service(s) requested, in order to avoid unnecessary denials. Providers must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request.

Requests for prior authorization with documentation supporting the medical necessity for the number of studies requested must be received on, or before, the requested date(s) of service.

Note: *Requests received after the services are performed will be denied for dates of service that occurred before the date the request was received.*

9.2.66.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization for MEG" section, the following requirements apply:

- All MEG services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.
- Magnetic Source Imaging procedure code S8035 is not a benefit of Texas Medicaid, but it may be used for informational purposes.

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9.2.66.3 Noncovered Services

The following MEG services are not benefits of Texas Medicaid:

- MEG when used as a stand-alone test for epilepsy
- MEG used as a first-line diagnostic screening
- MEG when used for evaluation of:
  - Alzheimer's disease
  - Autism
  - Cognitive and mental disorders
  - Developmental dyslexia
  - Learning disorders
  - Migraines
  - Multiple sclerosis
  - Parkinson's disease
  - Schizophrenia
  - Stroke rehabilitation
  - Traumatic brain injury

Note: *This list is not all inclusive.*

9.2.67 Reduction Mammaplasties

9.2.67.1 Prior Authorization for Reduction Mammaplasty

Procedure code 19318 is the removal of breast tissue and is a benefit of Texas Medicaid when prior authorized.

For prior authorization of reduction mammaplasty, a completed "Medicaid Certificate of Medical Necessity for Reduction Mammaplasty" form signed and dated by the physician, must be submitted and include at least one of the following criteria:

- Evidence of severe neck and/or back pain with incapacitation from the pain.
- Evidence of ulnar pain or paresthesia from thoracic nerve root compression.
- Submammary dermatological conditions such as intertrigo and acne that are refractory to conventional medication.
- Shoulder grooving with ulceration due to breast size.

In addition to the above criteria, documentation must indicate:

- The minimum weight of tissue expected to be removed from each breast with consideration to height and weight is as follows:

Height and Weight Chart		
Under 5'	<140 lb	300 grams per breast
5'-5'.4"	up to 180 lb	350 grams per breast
5'.4"-5'.7"	up to 220 lb	400 grams per breast
5'.7"- and up	211 lb and up	500 grams per breast

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- The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer.

The following services are *not* a benefit of Texas Medicaid:

- Reduction mammaplasty for cosmetic purposes (such as the equalization of breast size)
- Augmentation mammaplasty to increase breast size

The physician is required to maintain the following documentation in the client's clinical records:

- A complete history and physical
- Pulmonary function studies results
- Past treatments, therapies, and outcomes for pain control and weight reduction

The physician is required to maintain preoperative photographs (frontal and lateral views) in the client's clinical records and must be made available to Texas Medicaid upon request.

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

When submitting for prior authorization, requests *must* be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammaplasty to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax 1-512-514-4213

9.2.68 Renal Disease

9.2.68.1 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all POSs except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.

9.2.68.1.1 Physician Supervision of Dialysis Patients

Physician supervision of outpatient ESRD services includes services provided in the course of office visits where any of the following occur:

- The routine monitoring of dialysis.
- The treatment or follow-up of complications of dialysis, including:
  - The evaluation of related diagnostic tests and procedures.
  - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts.

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

Procedure Codes									
90951	90952	90953	90954	90955	90956	90957	90958	90959	90960

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Procedure Codes									
90961	90962	90963	90964	90965	90966	90967	90968	90969	90970

The procedure codes must be billed as described below:

- In the circumstances where the client is not on home dialysis and has had a complete assessment visit during the calendar month and ESRD-related services are provided for a full month, procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be used, determined by the number of face-to-face visits the physician has had with the client during the month, and the client's age.
- When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure codes 90963, 90964, 90965, or 90966 must be used, determined by the client's age.
- Report procedure codes 90967, 90968, 90969, and 90970 when ESRD related services are provided for less than a full month, per day, under the following conditions:
  - The client is seen for a partial month and is not on home dialysis and received one or more face-to-face visits but did not receive a complete assessment.
  - The client is on home dialysis and received less than a full month of services.
  - The client is a transient client.
  - The client was hospitalized during a month of services before a complete assessment could be performed.
  - Dialysis was stopped due to recovery or death of client.
  - The client received a kidney transplant.
- Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing procedure code 90967, 90968, 90969, or 90970, the date of service must indicate each day that supervision was provided.
- Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed within the same calendar month by any provider as procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966.
- Procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966 are limited to once per calendar month by any provider, and only one service may be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of ESRD dialysis but are considered non-routine and may be billed separately:

- Declotting of shunts when performed by the physician.
- Physician services to inpatient clients. If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician must bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days. If a client has a complete assessment during a month in which the client is hospitalized, procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month, and the client's age. The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.

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- Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP. The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the patient's renal condition that cause the number of physician-patient contacts to increase. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

Use procedure codes 90935, 90937, 90945, and 90947 for inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis. These codes are not payable for a cursory visit by the physician; hospital visit codes must be used for a cursory visit.

The hospital procedure codes 90935, 90937, 90945, and 90947 are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician must bill the appropriate hospital visit code. The inpatient dialysis code must not be submitted for payment.

Only one of procedure code 90935, 90937, 90945, or 90947 may be reimbursed per day, any provider.

Procedure codes 90935, 90937, 90945, and 90947 may also be used for outpatient dialysis services for non-ESRD clients.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly, may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.
- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.
- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the monthly capitation payment for physician supervision rendered to maintenance facility clients.

9.2.68.2 Laboratory Services for Dialysis Patients

Texas Medicaid may reimburse for laboratory services performed for dialysis patients.

Charges for routine laboratory services performed according to established frequencies are included in the facility's composite rate billed to Texas Medicaid regardless of where the tests were performed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by a renal dialysis facility, unless they are inclusive tests.

Nonroutine laboratory services for people dialyzing in a facility and all laboratory work for people on CAPD may be billed separately from the dialysis charge.

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

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9.2.68.3 Self-Dialysis Patients

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient's training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 90989 and 90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, bill procedure code 90989. The date of service indicates the date training was completed, and the quantity is 1.
- When dialysis training is not completed, bill procedure code 90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided.

The amount of reimbursement of subsequent training is determined by prorating the physician's payment for initial training sessions. The amount of payment for each additional training session does not exceed $20.

9.2.68.3.1 Physician Supervision

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients.
- Review of family and home status and environment, and counseling and training of family members.
- Review of training progress.

9.2.68.3.2 Dialysis Supervision

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings.
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
- Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications.
- General support services (for example, arranging for supplies).

9.2.68.3.3 Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

- A change from the client's treatment machine to one the client had not been trained to use in the initial training course
- A change in setting
- A change in dialysis partner

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

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Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of Texas Medicaid, including the lease or purchase of dialysis machines and disposable supply kits.

9.2.69 Sacroiliac Joint Fusion

Sacroiliac (SI) joint fusion (procedure code 27278) is a benefit for clients who are 18 years of age or older and requires prior authorization. Requests must be submitted on the Special Medical Prior Authorization (SMPA) Request Form and be signed within 30 days of the start of care date.

Note: *Prior authorization requests must be submitted before the requested start date of service. Any request for dates of service that occur before the date on which the request was received will be denied.*

9.2.69.1 Prior Authorization Criteria

The prior authorization request must be submitted with a provider statement or attestation that the client needs an SI joint fusion and the indications for that determination, including attestation that the following diagnoses have been ruled out:

- Lumbar disc herniation (diagnosis code M5126)
- Lumbar spondylolisthesis (diagnosis code M4316)
- Lumbar spinal stenosis (diagnosis codes M48061 and M48062)
- Lumbar facet degeneration (diagnosis code M4696)
- Lumbar vertebral body fracture (diagnosis code S32009A or S32009D)

The submitted documentation must also include observed evidence of at least three out of five positive test results from SI joint pain provocative tests, such as the following:

- SI joint compression test
- Posterior pelvic pain provocation test—P4 (thigh thrust)
- Patrick's test (Fabere test)
- Sacroiliac distraction test
- Gaenslen's test

Documentation of the following must be included with the prior authorization request:

- Six months of conservative efforts have failed to improve the client's pain by 50–70%.
- The client successfully achieved 50–75% temporary pain reduction with SI joint injections.

9.2.70 Sign Language Interpreting Services

Sign language interpreting services are benefits of Texas Medicaid. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and T1013 with modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, same provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day, same provider.

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a Medicaid client if the parent or guardian is deaf or hard of hearing.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from Texas Medicaid for providing this service.

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Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A through H) issued by either the Office of Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI) or the National Registry of Interpreters for the Deaf (RID).

Certification Levels:

- BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic)
- BEI Basic and RID NIC (National Interpreter Certificate) Certified
- BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate)
- BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter)
- BEI Advanced and RID NIC Advanced
- BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal)
- BEI V/VI
- BEI Master; and RID NIC Master

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by HHSC or its designee.

9.2.71 Skin Therapy

Skin therapy is a benefit of Texas Medicaid and may be reimbursed with the following procedure codes:

Procedure Codes									
15782	15783	15792	15793	17000	17003	17004	17106	17107	17108
17110	17111	17250	17260	17261	17262	17263	17264	17266	17270
17271	17272	17273	17274	17276	17280	17281	17282	17283	17284
17286	17311	17312	17313	17314	17315	17340	17999	11900	11901
96900	96910	96912	96913	96920	96921	96922	96999		

Claims for incision and drainage of acne when the diagnosis states there is infection or pustules may be paid.

Procedure codes 96900, 96910, 96912, 96913, 96920, 96921, and 96922 are covered benefits for the following diagnosis codes:

Diagnosis Codes							
A672	B070	B081	B550	B551	B552	B559	C8401
C8402	C8403	C8404	C8405	C8406	C8407	C8408	C8409
H02731	H02732	H02734	H02735	L100	L101	L102	L103
L104	L105	L1081	L1089	L120	L121	L122	L128

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Diagnosis Codes							
L130	L131	L138	L139	L200	L2081	L2082	L2083
L2084	L2089	L210	L211	L218	L219	L22	L230
L231	L232	L233	L235	L236	L237	L2381	L240
L241	L242	L243	L244	L245	L246	L247	L2481
L24A0	L24A1	L24A2	L24A9	L24B0	L24B1	L24B2	L24B3
L270	L271	L272	L278	L279	L300	L301	L302
L303	L304	L305	L400	L401	L402	L403	L404
L4050	L4051	L4052	L4053	L4054	L4059	L408	L410
L411	L412	L413	L414	L415	L418	L42	L440
L560	L561	L562	L563	L564	L565	L570	L571
L572	L573	L574	L575	L580	L581	L700	L701
L702	L703	L704	L705	L708	L710	L711	L718
L730	L80						

Intralesional injection(s) may be considered for reimbursement in addition to an office visit.

Procedure codes 11900 and 11901 are covered benefits for intralesional injections for the following diagnosis codes:

Diagnosis Codes							
B070	B081	B550	B551	B552	B559	D863	L400
L401	L402	L403	L404	L4050	L4051	L4052	L4053
L4054	L4059	L408	L410	L411	L412	L413	L414
L415	L418	L42	L440	L700	L701	L702	L703
L704	L705	L708	L710	L711	L718	L730	L732
L910	L928	T2000XA	T2000XD	T2000XS	T20011A	T20011D	T20011S
T20012A	T20012D	T20012S	T2002XA	T2002XD	T2002XS	T2003XA	T2003XD
T2003XS	T2004XA	T2004XD	T2004XS	T2005XA	T2005XD	T2005XS	T2006XA
T2006XD	T2006XS	T2007XA	T2007XD	T2007XS	T2009XA	T2009XD	T2009XS
T2010XA	T2010XD	T2010XS	T20111A	T20111D	T20111S	T20112A	T20112D
T20112S	T2012XA	T2012XD	T2012XS	T2013XA	T2013XD	T2013XS	T2014XA
T2014XD	T2014XS	T2015XA	T2015XD	T2015XS	T2016XA	T2016XD	T2016XS
T2017XA	T2017XD	T2017XS	T2019XA	T2019XD	T2019XS	T2020XA	T2020XD
T2020XS	T20211A	T20211D	T20211S	T20212A	T20212D	T20212S	T2022XA
T2022XD	T2022XS	T2023XA	T2023XD	T2023XS	T2024XA	T2024XD	T2024XS
T2025XA	T2025XD	T2025XS	T2026XA	T2026XD	T2026XS	T2027XA	T2027XD
T2027XS	T2029XA	T2029XD	T2029XS	T2030XA	T2030XD	T2030XS	T20311A
T20311D	T20311S	T20312A	T20312D	T20312S	T2032XA	T2032XD	T2032XS
T2033XA	T2033XD	T2033XS	T2034XA	T2034XD	T2034XS	T2035XA	T2035XD
T2035XS	T2036XA	T2036XD	T2036XS	T2037XA	T2037XD	T2037XS	T2039XA
T2039XD	T2039XS	T2040XA	T2040XD	T2040XS	T20411A	T20411D	T20411S
T20412A	T20412D	T20412S	T2042XA	T2042XD	T2042XS	T2043XA	T2043XD

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Diagnosis Codes							
T2043XS	T2044XA	T2044XD	T2044XS	T2045XA	T2045XD	T2045XS	T2046XA
T2046XD	T2046XS	T2047XA	T2047XD	T2047XS	T2049XA	T2049XD	T2049XS
T2050XA	T2050XD	T2050XS	T20511A	T20511D	T20511S	T20512A	T20512D
T20512S	T2052XA	T2052XD	T2052XS	T2053XA	T2053XD	T2053XS	T2054XA
T2054XD	T2054XS	T2055XA	T2055XD	T2055XS	T2056XA	T2056XD	T2056XS
T2057XA	T2057XD	T2057XS	T2059XA	T2059XD	T2059XS	T2060XA	T2060XD
T2060XS	T20611A	T20611D	T20611S	T20612A	T20612D	T20612S	T2062XA
T2062XD	T2062XS	T2063XA	T2063XD	T2063XS	T2064XA	T2064XD	T2064XS
T2065XA	T2065XD	T2065XS	T2066XA	T2066XD	T2066XS	T2067XA	T2067XD
T2067XS	T2069XA	T2069XD	T2069XS	T2070XA	T2070XD	T2070XS	T20711A
T20711D	T20711S	T20712A	T20712D	T20712S	T2072XA	T2072XD	T2072XS
T2073XA	T2073XD	T2073XS	T2074XA	T2074XD	T2074XS	T2075XA	T2075XD
T2075XS	T2076XA	T2076XD	T2076XS	T2077XA	T2077XD	T2077XS	T2079XA
T2079XD	T2079XS	T2100XA	T2100XD	T2100XS	T2101XA	T2101XD	T2101XS
T2102XA	T2102XD	T2102XS	T2103XA	T2103XD	T2103XS	T2104XA	T2104XD
T2104XS	T2106XA	T2106XD	T2106XS	T2107XA	T2107XD	T2107XS	T2110XA
T2110XD	T2110XS	T2111XA	T2111XD	T2111XS	T2112XA	T2112XD	T2112XS
T2113XA	T2113XD	T2113XS	T2114XA	T2114XD	T2114XS	T2116XA	T2116XD
T2116XS	T2117XA	T2117XD	T2117XS	T2119XA	T2119XD	T2119XS	T2120XA
T2120XD	T2120XS	T2121XA	T2121XD	T2121XS	T2122XA	T2122XD	T2122XS
T2123XA	T2123XD	T2123XS	T2124XA	T2124XD	T2124XS	T2126XA	T2126XD
T2126XS	T2127XA	T2127XD	T2127XS	T2130XA	T2130XD	T2130XS	T2131XA
T2131XD	T2131XS	T2132XA	T2132XD	T2132XS	T2133XA	T2133XD	T2133XS
T2134XA	T2134XD	T2134XS	T2136XA	T2136XD	T2136XS	T2137XA	T2137XD
T2137XS	T2140XA	T2140XD	T2140XS	T2141XA	T2141XD	T2141XS	T2142XA
T2142XD	T2142XS	T2143XA	T2143XD	T2143XS	T2144XA	T2144XD	T2144XS
T2146XA	T2146XD	T2146XS	T2147XA	T2147XD	T2147XS	T2150XA	T2150XD
T2150XS	T2151XA	T2151XD	T2151XS	T2152XA	T2152XD	T2152XS	T2153XA
T2153XD	T2153XS	T2154XA	T2154XD	T2154XS	T2156XA	T2156XD	T2156XS
T2157XA	T2157XD	T2157XS	T2159XA	T2159XD	T2159XS	T2160XA	T2160XD
T2160XS	T2161XA	T2161XD	T2161XS	T2162XA	T2162XD	T2162XS	T2163XA
T2163XD	T2163XS	T2164XA	T2164XD	T2164XS	T2166XA	T2166XD	T2166XS
T2167XA	T2167XD	T2167XS	T2170XA	T2170XD	T2170XS	T2171XA	T2171XD
T2171XS	T2172XA	T2172XD	T2172XS	T2173XA	T2173XD	T2173XS	T2174XA
T2174XD	T2174XS	T2176XA	T2176XD	T2176XS	T2177XA	T2177XD	T2177XS
T2200XA	T2200XD	T2200XS	T22011A	T22011D	T22011S	T22012A	T22012D
T22012S	T22021A	T22021D	T22021S	T22022A	T22022D	T22022S	T22031A
T22031D	T22031S	T22032A	T22032D	T22032S	T22041A	T22041D	T22041S
T22042A	T22042D	T22042S	T22049A	T22049D	T22049S	T22051A	T22051D
T22051S	T22052A	T22052D	T22052S	T22061A	T22061D	T22061S	T22062A

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Diagnosis Codes							
T22062D	T22062S	T22091A	T22091D	T22091S	T22092A	T22092D	T22092S
T2210XA	T2210XD	T2210XS	T22111A	T22111D	T22111S	T22112A	T22112D
T22112S	T22121A	T22121D	T22121S	T22122A	T22122D	T22122S	T22131A
T22131D	T22131S	T22132A	T22132D	T22132S	T22141A	T22141D	T22141S
T22142A	T22142D	T22142S	T22151A	T22151D	T22151S	T22152A	T22152D
T22152S	T22161A	T22161D	T22161S	T22162A	T22162D	T22162S	T22191A
T22191D	T22191S	T22192A	T22192D	T22192S	T2220XA	T2220XD	T2220XS
T22211A	T22211D	T22211S	T22212A	T22212D	T22212S	T22221A	T22221D
T22221S	T22222A	T22222D	T22222S	T22231A	T22231D	T22231S	T22232A
T22232D	T22232S	T22239A	T22239D	T22239S	T22241A	T22241D	T22241S
T22242A	T22242D	T22242S	T22249A	T22249D	T22249S	T22251A	T22251D
T22251S	T22252A	T22252D	T22252S	T22261A	T22261D	T22261S	T22262A
T22262D	T22262S	T22291A	T22291D	T22291S	T22292A	T22292D	T22292S
T2230XA	T2230XD	T2230XS	T22311A	T22311D	T22311S	T22312A	T22312D
T22312S	T22321A	T22321D	T22321S	T22322A	T22322D	T22322S	T22331A
T22331D	T22331S	T22332A	T22332D	T22332S	T22341A	T22341D	T22341S
T22342A	T22342D	T22342S	T22351A	T22351D	T22351S	T22352A	T22352D
T22352S	T22361A	T22361D	T22361S	T22362A	T22362D	T22362S	T22369A
T22369D	T22369S	T22391A	T22391D	T22391S	T22392A	T22392D	T22392S
T2240XA	T2240XD	T2240XS	T22411A	T22411D	T22411S	T22412A	T22412D
T22412S	T22421A	T22421D	T22421S	T22422A	T22422D	T22422S	T22431A
T22431D	T22431S	T22432A	T22432D	T22432S	T22441A	T22441D	T22441S
T22442A	T22442D	T22442S	T22451A	T22451D	T22451S	T22452A	T22452D
T22452S	T22461A	T22461D	T22461S	T22462A	T22462D	T22462S	T22491A
T22491D	T22491S	T22492A	T22492D	T22492S	T2250XA	T2250XD	T2250XS
T22511A	T22511D	T22511S	T22512A	T22512D	T22512S	T22521A	T22521D
T22521S	T22522A	T22522D	T22522S	T22531A	T22531D	T22531S	T22532A
T22532D	T22532S	T22541A	T22541D	T22541S	T22542A	T22542D	T22542S
T22551A	T22551D	T22551S	T22552A	T22552D	T22552S	T22561A	T22561D
T22561S	T22562A	T22562D	T22562S	T22591A	T22591D	T22591S	T22592A
T22592D	T22592S	T2260XA	T2260XD	T2260XS	T22611A	T22611D	T22611S
T22612A	T22612D	T22612S	T22621A	T22621D	T22621S	T22622A	T22622D
T22622S	T22631A	T22631D	T22631S	T22632A	T22632D	T22632S	T22641A
T22641D	T22641S	T22642A	T22642D	T22642S	T22649A	T22649D	T22649S
T22651A	T22651D	T22651S	T22652A	T22652D	T22652S	T22661A	T22661D
T22661S	T22662A	T22662D	T22662S	T22691A	T22691D	T22691S	T22692A
T22692D	T22692S	T2270XA	T2270XD	T2270XS	T22711A	T22711D	T22711S
T22712A	T22712D	T22712S	T22721A	T22721D	T22721S	T22722A	T22722D
T22722S	T22731A	T22731D	T22731S	T22732A	T22732D	T22732S	T22741A
T22741D	T22741S	T22742A	T22742D	T22742S	T22751A	T22751D	T22751S

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Diagnosis Codes							
T22752A	T22752D	T22752S	T22761A	T22761D	T22761S	T22762A	T22762D
T22762S	T22791A	T22791D	T22791S	T22792A	T22792D	T22792S	T23001A
T23001D	T23001S	T23002A	T23002D	T23002S	T23011A	T23011D	T23011S
T23012A	T23012D	T23012S	T23021A	T23021D	T23021S	T23022A	T23022D
T23022S	T23031A	T23031D	T23031S	T23032A	T23032D	T23032S	T23041A
T23041D	T23041S	T23042A	T23042D	T23042S	T23051A	T23051D	T23051S
T23052A	T23052D	T23052S	T23061A	T23061D	T23061S	T23062A	T23062D
T23062S	T23071A	T23071D	T23071S	T23072A	T23072D	T23072S	T23091A
T23091D	T23091S	T23092A	T23092D	T23092S	T23101A	T23101D	T23101S
T23102A	T23102D	T23102S	T23111A	T23111D	T23111S	T23112A	T23112D
T23112S	T23121A	T23121D	T23121S	T23122A	T23122D	T23122S	T23131A
T23131D	T23131S	T23132A	T23132D	T23132S	T23141A	T23141D	T23141S
T23142A	T23142D	T23142S	T23151A	T23151D	T23151S	T23152A	T23152D
T23152S	T23161A	T23161D	T23161S	T23162A	T23162D	T23162S	T23171A
T23171D	T23171S	T23172A	T23172D	T23172S	T23191A	T23191D	T23191S
T23192A	T23192D	T23192S	T23201A	T23201D	T23201S	T23202A	T23202D
T23202S	T23211A	T23211D	T23211S	T23212A	T23212D	T23212S	T23221A
T23221D	T23221S	T23222A	T23222D	T23222S	T23231A	T23231D	T23231S
T23232A	T23232D	T23232S	T23241A	T23241D	T23241S	T23242A	T23242D
T23242S	T23251A	T23251D	T23251S	T23252A	T23252D	T23252S	T23261A
T23261D	T23261S	T23262A	T23262D	T23262S	T23271A	T23271D	T23271S
T23272A	T23272D	T23272S	T23291A	T23291D	T23291S	T23292A	T23292D
T23292S	T23301A	T23301D	T23301S	T23302A	T23302D	T23302S	T23311A
T23311D	T23311S	T23312A	T23312D	T23312S	T23321A	T23321D	T23321S
T23322A	T23322D	T23322S	T23331A	T23331D	T23331S	T23332A	T23332D
T23332S	T23341A	T23341D	T23341S	T23342A	T23342D	T23342S	T23351A
T23351D	T23351S	T23352A	T23352D	T23352S	T23361A	T23361D	T23361S
T23362A	T23362D	T23362S	T23371A	T23371D	T23371S	T23372A	T23372D
T23372S	T23391A	T23391D	T23391S	T23392A	T23392D	T23392S	T23401A
T23401D	T23401S	T23402A	T23402D	T23402S	T23411A	T23411D	T23411S
T23412A	T23412D	T23412S	T23421A	T23421D	T23421S	T23422A	T23422D
T23422S	T23431A	T23431D	T23431S	T23432A	T23432D	T23432S	T23441A
T23441D	T23441S	T23442A	T23442D	T23442S	T23451A	T23451D	T23451S
T23452A	T23452D	T23452S	T23461A	T23461D	T23461S	T23462A	T23462D
T23462S	T23471A	T23471D	T23471S	T23472A	T23472D	T23472S	T23491A
T23491D	T23491S	T23492A	T23492D	T23492S	T23501A	T23501D	T23501S
T23502A	T23502D	T23502S	T23511A	T23511D	T23511S	T23512A	T23512D
T23512S	T23521A	T23521D	T23521S	T23522A	T23522D	T23522S	T23531A
T23531D	T23531S	T23532A	T23532D	T23532S	T23541A	T23541D	T23541S
T23542A	T23542D	T23542S	T23551A	T23551D	T23551S	T23552A	T23552D

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Diagnosis Codes							
T23552S	T23561A	T23561D	T23561S	T23562A	T23562D	T23562S	T23571A
T23571D	T23571S	T23572A	T23572D	T23572S	T23591A	T23591D	T23591S
T23592A	T23592D	T23592S	T23601A	T23601D	T23601S	T23602A	T23602D
T23602S	T23611A	T23611D	T23611S	T23612A	T23612D	T23612S	T23621A
T23621D	T23621S	T23622A	T23622D	T23622S	T23631A	T23631D	T23631S
T23632A	T23632D	T23632S	T23641A	T23641D	T23641S	T23642A	T23642D
T23642S	T23651A	T23651D	T23651S	T23652A	T23652D	T23652S	T23661A
T23661D	T23661S	T23662A	T23662D	T23662S	T23671A	T23671D	T23671S
T23672A	T23672D	T23672S	T23691A	T23691D	T23691S	T23692A	T23692D
T23692S	T23701A	T23701D	T23701S	T23702A	T23702D	T23702S	T23711A
T23711D	T23711S	T23712A	T23712D	T23712S	T23721A	T23721D	T23721S
T23722A	T23722D	T23722S	T23731A	T23731D	T23731S	T23732A	T23732D
T23732S	T23741A	T23741D	T23741S	T23742A	T23742D	T23742S	T23751A
T23751D	T23751S	T23752A	T23752D	T23752S	T23761A	T23761D	T23761S
T23762A	T23762D	T23762S	T23771A	T23771D	T23771S	T23772A	T23772D
T23772S	T23791A	T23791D	T23791S	T23792A	T23792D	T23792S	T24001A
T24001D	T24001S	T24002A	T24002D	T24002S	T24011A	T24011D	T24011S
T24012A	T24012D	T24012S	T24021A	T24021D	T24021S	T24022A	T24022D
T24022S	T24031A	T24031D	T24031S	T24032A	T24032D	T24032S	T24091A
T24091D	T24091S	T24092A	T24092D	T24092S	T24101A	T24101D	T24101S
T24102A	T24102D	T24102S	T24111A	T24111D	T24111S	T24112A	T24112D
T24112S	T24121A	T24121D	T24121S	T24122A	T24122D	T24122S	T24131A
T24131D	T24131S	T24132A	T24132D	T24132S	T24191A	T24191D	T24191S
T24192A	T24192D	T24192S	T24201A	T24201D	T24201S	T24202A	T24202D
T24202S	T24211A	T24211D	T24211S	T24212A	T24212D	T24212S	T24221A
T24221D	T24221S	T24222A	T24222D	T24222S	T24229A	T24229D	T24229S
T24231A	T24231D	T24231S	T24232A	T24232D	T24232S	T24291A	T24291D
T24291S	T24292A	T24292D	T24292S	T24301A	T24301D	T24301S	T24302A
T24302D	T24302S	T24311A	T24311D	T24311S	T24312A	T24312D	T24312S
T24321A	T24321D	T24321S	T24322A	T24322D	T24322S	T24331A	T24331D
T24331S	T24332A	T24332D	T24332S	T24391A	T24391D	T24391S	T24392A
T24392D	T24392S	T24401A	T24401D	T24401S	T24402A	T24402D	T24402S
T24411A	T24411D	T24411S	T24412A	T24412D	T24412S	T24421A	T24421D
T24421S	T24422A	T24422D	T24422S	T24431A	T24431D	T24431S	T24432A
T24432D	T24432S	T24491A	T24491D	T24491S	T24492A	T24492D	T24492S
T24501A	T24501D	T24501S	T24502A	T24502D	T24502S	T24511A	T24511D
T24511S	T24512A	T24512D	T24512S	T24521A	T24521D	T24521S	T24522A
T24522D	T24522S	T24531A	T24531D	T24531S	T24532A	T24532D	T24532S
T24591A	T24591D	T24591S	T24592A	T24592D	T24592S	T24601A	T24601D
T24601S	T24602A	T24602D	T24602S	T24611A	T24611D	T24611S	T24612A

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Diagnosis Codes							
T24612D	T24612S	T24621A	T24621D	T24621S	T24622A	T24622D	T24622S
T24631A	T24631D	T24631S	T24632A	T24632D	T24632S	T24691A	T24691D
T24691S	T24692A	T24692D	T24692S	T24701A	T24701D	T24701S	T24702A
T24702D	T24702S	T24711A	T24711D	T24711S	T24712A	T24712D	T24712S
T24721A	T24721D	T24721S	T24722A	T24722D	T24722S	T24731A	T24731D
T24731S	T24732A	T24732D	T24732S	T24791A	T24791D	T24791S	T24792A
T24792D	T24792S	T25011A	T25011D	T25011S	T25012A	T25012D	T25012S
T25021A	T25021D	T25021S	T25022A	T25022D	T25022S	T25031A	T25031D
T25031S	T25032A	T25032D	T25032S	T25091A	T25091D	T25091S	T25092A
T25092D	T25092S	T25111A	T25111D	T25111S	T25112A	T25112D	T25112S
T25121A	T25121D	T25121S	T25122A	T25122D	T25122S	T25131A	T25131D
T25131S	T25132A	T25132D	T25132S	T25191A	T25191D	T25191S	T25192A
T25192D	T25192S	T25211A	T25211D	T25211S	T25212A	T25212D	T25212S
T25221A	T25221D	T25221S	T25222A	T25222D	T25222S	T25231A	T25231D
T25231S	T25232A	T25232D	T25232S	T25291A	T25291D	T25291S	T25292A
T25292D	T25292S	T25311A	T25311D	T25311S	T25312A	T25312D	T25312S
T25321A	T25321D	T25321S	T25322A	T25322D	T25322S	T25331A	T25331D
T25331S	T25332A	T25332D	T25332S	T25391A	T25391D	T25391S	T25392A
T25392D	T25392S	T25411A	T25411D	T25411S	T25412A	T25412D	T25412S
T25421A	T25421D	T25421S	T25422A	T25422D	T25422S	T25431A	T25431D
T25431S	T25432A	T25432D	T25432S	T25491A	T25491D	T25491S	T25492A
T25492D	T25492S	T25511A	T25511D	T25511S	T25512A	T25512D	T25512S
T25521A	T25521D	T25521S	T25522A	T25522D	T25522S	T25531A	T25531D
T25531S	T25532A	T25532D	T25532S	T25591A	T25591D	T25591S	T25592A
T25592D	T25592S	T25611A	T25611D	T25611S	T25612A	T25612D	T25612S
T25621A	T25621D	T25621S	T25622A	T25622D	T25622S	T25631A	T25631D
T25631S	T25632A	T25632D	T25632S	T25711A	T25711D	T25711S	T25712A
T25712D	T25712S	T25721A	T25721D	T25721S	T25722A	T25722D	T25722S
T25731A	T25731D	T25731S	T25732A	T25732D	T25732S	T25791A	T25791D
T25791S	T25792A	T25792D	T25792S	T2601XA	T2601XD	T2601XS	T2602XA
T2602XD	T2602XS	T2611XA	T2611XD	T2611XS	T2612XA	T2612XD	T2612XS
T2621XA	T2621XD	T2621XS	T2622XA	T2622XD	T2622XS	T2631XA	T2631XD
T2631XS	T2632XA	T2632XD	T2632XS	T2641XA	T2641XD	T2641XS	T2642XA
T2642XD	T2642XS	T2651XA	T2651XD	T2651XS	T2652XA	T2652XD	T2652XS
T2661XA	T2661XD	T2661XS	T2662XA	T2662XD	T2662XS	T2671XA	T2671XD
T2671XS	T2672XA	T2672XD	T2672XS	T2681XA	T2681XD	T2681XS	T2682XA
T2682XD	T2682XS	T2691XA	T2691XD	T2691XS	T2692XA	T2692XD	T2692XS
T271XXA	T271XXD	T271XXS	T275XXA	T275XXD	T275XXS	T280XXA	T280XXD
T280XXS	T281XXA	T281XXD	T281XXS	T282XXA	T282XXD	T282XXS	T283XXA
T283XXD	T283XXS	T2840XA	T2840XD	T2840XS	T28411A	T28411D	T28411S

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Diagnosis Codes							
T28412A	T28412D	T28412S	T2849XA	T2849XD	T2849XS	T285XXA	T285XXD
T285XXS	T286XXA	T286XXD	T286XXS	T287XXA	T287XXD	T287XXS	T288XXA
T288XXD	T288XXS	T2890XA	T2890XD	T2890XS	T28911A	T28911D	T28911S
T28912A	T28912D	T28912S	T2899XA	T2899XD	T2899XS	T300	T304
T310	T3110	T3111	T3120	T3121	T3122	T3130	T3131
T3132	T3133	T3140	T3141	T3142	T3143	T3144	T3150
T3151	T3152	T3153	T3154	T3155	T3160	T3161	T3162
T3163	T3164	T3165	T3166	T3170	T3171	T3172	T3173
T3174	T3175	T3176	T3177	T3180	T3181	T3182	T3183
T3184	T3185	T3186	T3187	T3188	T3190	T3191	T3192
T3193	T3194	T3195	T3196	T3197	T3198	T3199	T320
T3210	T3211	T3220	T3221	T3222	T3230	T3231	T3232
T3233	T3240	T3241	T3242	T3243	T3244	T3250	T3251
T3252	T3253	T3254	T3255	T3260	T3261	T3262	T3263
T3264	T3265	T3266	T3270	T3271	T3272	T3273	T3274
T3275	T3276	T3277	T3280	T3281	T3282	T3283	T3284
T3285	T3286	T3287	T3288	T3290	T3291	T3292	T3293
T3294	T3295	T3296	T3297	T3298	T3299		

Procedure codes 15782, 15783, 15792, 15793, and 17999 require prior authorization. Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the anticipated procedure. This documentation must remain in the client's medical record and is subject to retrospective review. To avoid unnecessary denials, the physician must provide correct and complete information.

Dermabrasion procedures (procedure codes 15782 and 15783) and chemical peel procedures (procedure codes 15792 and 15793) may be prior authorized with documentation that the client meets all of the following criteria:

- A diagnosis of actinic keratosis with more than three lesions.
- Failed conservative treatment or documentation that conservative treatment is contraindicated.

Prior authorization requests for procedure code 17999 must include the following documentation:

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

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9.2.72 Sleep Studies

Sleep study procedure code 95806 is not a benefit of Texas Medicaid.

9.2.72.1 Actigraphy

Actigraphy (procedure code 95803) may be reimbursed in the office or outpatient hospital setting with a limit of one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Actigraphy can be performed as a stand-alone procedure or as an adjunct to polysomnography or multiple sleep latency test (MSLT).

Actigraphy (procedure code 95803) must be billed with one of the following diagnosis codes:

Diagnosis Codes							
F5104	F5105	F5113	G2581	G4700	G4701	G4709	G4710
G4711	G4712	G4713	G4714	G4719	G4720	G4721	G4722
G4723	G4724	G4725	G4726	G4727	G4729	G4761	

If the primary care physician performs the actigraphy, the technical component must be billed (procedure code 95803 with modifier TC).

Documentation of actigraphy must include a hard-copy printout or electronic file. Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording and integration of the information gathered from other professionals' analysis and observations. Documentation of the interpretation must be maintained by the interpreting physician.

Under the following conditions, actigraphy may be a useful adjunct to a detailed history, examination, and subjective sleep diary for the diagnosis and treatment of insomnia, circadian-rhythm disorders, and excessive sleepiness:

- When demonstration of multiday rest-activity patterns is necessary to diagnose, document severity, and guide the proper treatment.
- When more objective information regarding the day-to-day timing or the amount or patterns of a client's sleep is necessary for optimal clinical decision-making.
- When the severity of a sleep disturbance reported by the client or caretaker seems inconsistent with clinical impressions or laboratory findings.
- To clarify the effects of, and under some instances, compliance with pharmacologic, behavioral, phototherapeutic, or chronotherapeutic treatment.
- In symptomatic clients for whom an accurate history cannot be obtained and at least one of the following is true:
    - A polysomnographic study has already been conducted.
    - A polysomnographic study is considered unlikely to be of much diagnostic benefit.
    - A polysomnographic study is not yet clearly indicated (because of the absence of accurate historical data).
    - A polysomnographic study is not immediately available.

Actigraphy may be useful in the assessment of specific aspects of the following disorders:

- Insomnia. Assessment of sleep variability, measurement of treatment effects, and detection of sleep phase alterations in insomnia secondary to circadian rhythm disturbance.

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- Restless legs syndrome or periodic limb movement disorder. Assessment of treatment effects.

9.2.72.2 Pneumocardiograms

Pneumocardiograms (procedure code 95807) are limited to clients who are birth through 12 months of age.

Pneumocardiograms are limited to one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Procedure code 95807 must be billed with one of the following diagnosis codes:

Diagnosis Codes							
G4731	G4733	G4734	G4735	G4736	G4737	P282	P2830
P2831	P2832	P2833	P2839	P2840	P2841	P2842	P2843
P2849	P285	P2911	P2912	R063	R0681	R0902	R230
R6813							

Documentation of the complete readings associated with the pneumocardiogram and the physician's interpretation must be maintained in the client's medical record in a hard-copy printout or electronic file at the facility where the procedure is performed.

The physician's interpretation and report must include inspection and integration of the information gathered from all physiological systems and other professionals' analysis and observations.

9.2.72.3 Polysomnography

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is a benefit of Texas Medicaid.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1-to 4- lead electroencephalogram (EEG), electro-oculogram (EOG), and a limb or submental electro-myogram (EMG).

Additional parameters of sleep that are evaluated in polysomnography include, but are not limited to, the following:

- ECG
- Airflow (by thermistor or intra-nasal pressure monitoring)
- Respiratory effort
- Adequacy of oxygenation by oximetry or transcutaneous monitoring
- Extremity movement or motor activity
- EEG monitoring for sleep staging
- Nocturnal penile tumescence
- Esophageal pH or intraluminal pressure monitoring
- Continuous blood pressure monitoring
- Snoring
- Body positions
- Adequacy of ventilation by end-tidal or transcutaneous CO2 monitoring

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 95782, 95783, 95808, 95810, and 95811.

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Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is limited to one per day and two per rolling year by any provider and is allowed for the following diagnosis codes:

Diagnosis Codes							
E6601	E662	F10182	F10282	F10982	F11182	F11282	F11982
F13182	F13282	F13982	F14182	F14282	F14982	F15182	F15282
F15982	F19182	F19282	F19982	F5101	F5102	F5103	F5104
F5105	F5109	F5111	F5112	F5113	F5119	F513	F514
F515	F518	F519	G120	G121	G1221	G128	G2581
G373	G4700	G4701	G4710	G4711	G4712	G4713	G4719
G4720	G4721	G4722	G4723	G4724	G4725	G4726	G4727
G4729	G4730	G4731	G4732	G4733	G4734	G4735	G4736
G4737	G4739	G47411	G47419	G47421	G47429	G4750	G4751
G4752	G4753	G4754	G4759	G4761	G4762	G4763	G4769
G478	G479	G7100	G7101	G7102	G7109	G7120	G7121
G71220	G71228	G7129	G809	G8250	G901	G931	J353
J9610	J9611	J9612	N5201	N5202	N5203	N521	N5235
N5236	N5237	Q040	Q041	Q042	Q078	Q308	Q311
Q312	Q313	Q315	Q318	Q320	Q321	Q322	Q323
Q324	Q672	Q673	Q674	Q75001	Q75002	Q75009	Q7501
Q75021	Q75022	Q75029	Q7503	Q75041	Q75042	Q75049	Q75051
Q75052	Q75058	Q7508	Q751	Q752	Q753	Q754	Q755
Q758	Q759	Q770	Q771	Q773	Q774	Q775	Q777
Q778	Q779	Q781	Q789	Q870	R0681	R0902	

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of the polysomnography testing must be maintained in the client's medical record at the sleep facility and include approximately 1,000 pages or the electronically-stored equivalent of data during a single nighttime recording. Each record must be for sleep-wake states and stages, cardiac arrhythmias, respiratory events, motor activity, oxygen desaturations, and behavioral observations.

Documentation must also include the technologist's analysis and report, the patient's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

9.2.72.4 Multiple Sleep Latency Test (MSLT)

Multiple sleep latency test (procedure code 95805) is limited to one per day and two per rolling year by any provider, and is restricted to the following diagnosis codes:

Diagnosis Codes							
E662	F5104	F5105	G2581	G4700	G4701	G4709	G4730
G47411	G47419	G47421	G47429	G4753	G4761		

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Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95782, 95783, 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.72.5 Home Sleep Study Test

Home sleep study tests are unattended studies that are performed in the client's home using a portable monitoring device. The portable monitoring device must meet American Academy of Sleep Medicine (AASM) practice parameters and clinical guidelines.

Home sleep study testing is a benefit of Texas Medicaid only when performed in conjunction with a comprehensive sleep evaluation that has been performed by a physician who is board-certified or board-eligible, as outlined in the AASM guidelines. Documentation of the comprehensive sleep evaluation must be kept in the client's medical record. The evaluation must indicate probability of moderate to severe obstructive sleep apnea to support medical necessity for home sleep study testing.

Procedure code 95800 applies to a device that measures three or more channels, including pulse oximetry, actigraphy, and peripheral arterial tone (PAT).

Procedure codes 95800, G0398, G0399, and G0400 are a benefit for Texas Medicaid clients who are 18 years of age or older with suspected or proven simple, uncomplicated obstructive sleep apnea. Procedure codes G0398, G0399, and G0400 are restricted to diagnosis code G4733.

Home sleep study tests are payable to physicians in the office setting. Procedure codes 95800, G0398, G0399, and G0400 are limited to one per day and a combined total of two tests per rolling year, with any provider. If a client needs more than two tests in a rolling year, subsequent tests must be performed in a sleep facility.

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9.2.72.6 Sleep Facility Restrictions for Polysomnography and Multiple Sleep Latency Testing

Sleep facilities that perform services for Medicaid clients must be accredited with the AASM or the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Sleep facilities must maintain documentation with proof that the facility is accredited. Documentation is subject to retrospective review. Sleep facilities that perform services for Texas Medicaid clients must also follow current AASM practice parameters and clinical guidelines.

Physicians who provide supervision in sleep facilities must be board-certified or board-eligible, as outlined in the AASM guidelines.

Sleep facility technicians, technologists, and trainees must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist, or a physician.

  Note: *Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is provided.*

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (MD or DO).
- A polysomnographic technician provides comprehensive polysomnographic testing and analysis and associated interventions under the general supervision of a polysomnographic technologist or clinical director (MD or DO).
- The supervising physician must be readily available to the performing technologist throughout the duration of the study, but is not required to be in the building.

The sleep facility must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of the nonphysician staff who use the equipment.

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five, 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG

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- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.73 Speech Therapy (ST) Services

Speech therapy (ST) is a payable benefit to physicians.

Refer to: Section 4, "Therapy Services Overview" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about speech therapy services provided by a physician.

9.2.74 Surgery Billing Guidelines

9.2.74.1 Primary Surgeon

A primary surgeon may be reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.

A surgeon billing for a surgery and an assistant surgery fee on the same day may be reimbursed if two separate procedures are performed.

Refer to: Subsection 9.2.74.7, "Multiple Surgeries" in this handbook.

9.2.74.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. The exception to this policy is an epidural during labor and delivery.

Refer to: Subsection 9.2.7, "Anesthesia" in this handbook.

9.2.74.3 Assistant Surgeon

Assistant surgeons may be reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. Medicaid may consider reimbursement for an assistant surgeon at a teaching hospital classified by Medicare as a teaching facility with approved graduate training program if one of the following situations is present and documented on the claim:

- No qualified resident was available. (Modifier 82 may be used to document this exception.)
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).

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- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

Use of these modifiers is not required but expedites claims processing. Therefore, it is *recommended* that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 paper claim form the name, address, and NPI of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

> "I understand that section 1842(b)(6)(D) of the Social Security Act generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP."

Surgical procedures that do not ordinarily require the services of an assistant, as identified by Medicare, are denied when billed as an assistant surgery. One assistant surgeon is reimbursed for surgical procedures when appropriate.

Use modifier AS when the physician assistant is not enrolled as an individual provider and provides assistance at surgery. The claim must include the PA's name and license number. Only procedures currently allowed for assistant surgeons are payable.

PAs actively enrolled as a Medicaid provider with an assigned NPI may bill assistant surgery services on a separate claim form using the PA's individual NPI and modifiers U7 and 80.

9.2.74.4 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

Procedure Code	Modifier
29405	LT
29405	RT

9.2.74.5 Cosurgery

Cosurgery (two surgeons) may be reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons' separate contributions to the successful outcome of the procedure are considered to be of equal importance.

> ***Note:*** *No additional reimbursement will be made for an assistant surgeon.*

Cosurgeons may be reimbursed for surgical procedure codes that are billed with modifier 62 if the CMS fee schedule indicates that the procedure allows for cosurgeons. Claims will not suspend for manual review of the documentation of medical necessity. Reimbursement will be calculated at 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure's fee.

No cosurgery payment is made for claims submitted without modifier 62. In instances where the surgeons do not use modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

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9.2.74.6 Global Fees

Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

Texas Medicaid adheres to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period-Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period-Reimbursement includes the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days following the date of the surgical procedure.
- 90-day Global Period-Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days following the date of the surgical procedure.

Procedure codes that are designated as "Carrier Discretion" will have their global periods determined by HHSC.

Note: *All unlisted surgical procedure codes have a 42 day global period assigned by Texas Medicaid.*

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

Modifiers

For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

Modifiers Related to Surgical Fees					
24	25	54	55	56	57
58	62	76	77	78	79

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the physician who provides preoperative or postoperative care. Reimbursement for claims associated with modifier 54, 55, or 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

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Documentation Requirements

For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client's medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

Note: *Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.*

Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a significant, separately identifiable service may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with the identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.

E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when billed with modifier 57. The client's medical record must clearly indicate when the initial decision to perform the procedure was made.

Intraoperative Services

Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Modifier 54 indicates that the surgeon provided the surgical care only. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

Postoperative services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Postoperative follow-up visits (any place of service)
- Postoperative pain management
- Miscellaneous services, including:
  - Dressing changes
  - Local incision care

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- Platelet gel
- Removal of operative packs
- Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
- Replacement of vascular access lines
- Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
- Changes or removal of tracheostomy tubes

Note: *Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.*

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of the surgery, and modifier 54, which indicates that he or she was the surgeon.
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care.

Note: *Providers must not submit a claim for the postoperative care until after the client has been seen during a face-to-face follow-up visit.*

When a transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider assuming in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- When the transfer of care occurs after hospital discharge, the surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
- Documentation in the medical record must include all of the following:
  - A copy of the written transfer agreement.
  - The dates the care was assumed and relinquished.
- The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication and any of the following:

- It was planned at the time of the initial surgical procedure.
- It is more extensive than the initial surgical procedure.
- It is for therapy following an invasive diagnostic surgical procedure.

Note: *Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).*

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Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and, as a result, not separately billable; however, separate payment for such visits can be allowed if any of the following conditions apply:

- Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy following transplant surgery is covered separately from other postoperative services, so postoperative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery. This coverage applies regardless of the setting.
- Critical care is provided by the surgeon for a burn or trauma patient.
- The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. The submitted documentation must substantiate the reasons for providing E/M services.

- Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
- Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

Return Trips to the Operating Room

Return trips to the operating room for a repeat surgical procedure on the same part of the body may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifier 76 or 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure must be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.

Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period only the intraoperative portion will be reimbursed.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis.

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- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier.
- When a different procedure is performed with the same diagnosis.
- When a different procedure is performed with a different diagnosis.

Billing with modifier 79 initiates a new global surgical period.

9.2.74.7 Multiple Surgeries

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day at the same operative session, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.
- Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).
- Procedure code 58611 performed in conjunction with a Cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.
- When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

9.2.74.8 Office Procedures

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician's office). The medical necessity and/or special circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment. This list is not all inclusive.

Procedure Codes		
Excision benign lesions	**Excision malignant lesions**	**Manipulation (urethral)**
11400	11600	53600
11401	11601	53601
11402	11602	53620
11403	11603	53621
11404	11604	53660
11420	11620	53661
11421	11621	
11422	11622	
11423	11623	
11440	11624	
11441	11640	
11442	11641	

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Procedure Codes		
11443	11642	
11444	11643	
	11644	
Simple repairs	**Endoscopy**	**Biopsy (tongue)**
28010	31505	41100
28011		
Lesions (penile)	**Lesions (eyelid)**	
54060	67801	

9.2.74.9 Orthopedic Hardware

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon's global fee or the facility's payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post operative care period.

9.2.74.10 Second Opinions

Texas Medicaid benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim must be coded with the appropriate office or hospital visit codes, and the notation "Client Initiated Second Opinion" should be identified in Block 24D of the CMS-1500 paper claim form.

Refer to: Subsection 9.2.60.4.4, "Office and Outpatient Consultation Services" in this handbook.

9.2.74.11 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under Texas Medicaid. All supplies, including anesthetizing agents, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If any of these items are submitted separately, they are denied as included in the surgical fee. If the supplies are submitted with a place of service (POS) other than the office, these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a benefit for home use.

9.2.75 Telemedicine Services

Telemedicine services are a benefit of Texas Medicaid.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for information about telemedicine services.

9.2.76 Therapeutic Apheresis

The following conditions must be met for therapeutic apheresis:

- To perform the medical services, including all nonphysician services, and to respond to medical emergencies at all times during client care, direct supervision by a physician is required.

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- Each client must be under the care of a physician.

Procedure codes 36511, 36512, 36513, 36514, and 36516 are limited to the following diagnosis codes:

Diagnosis Codes							
C8800	C8801	C8820	C8821	C8830	C8831	C8880	C8881
C9000	C9002	C9010	C9011	C9012	C9020	C9021	C9022
C9030	C9031	C9032	C9100	C9101	C9102	C9110	C9111
C9112	C9130	C9131	C9132	C9140	C9141	C9142	C9150
C9151	C9152	C9160	C9161	C9162	C9190	C9191	C9192
C91A0	C91A1	C91A2	C91Z0	C91Z1	C91Z2	C9200	C9201
C9202	C9210	C9211	C9212	C9220	C9221	C9222	C9230
C9231	C9232	C9240	C9241	C9242	C9250	C9251	C9252
C9260	C9261	C9262	C9290	C9291	C9292	C92A0	C92A1
C92A2	C92Z0	C92Z1	C92Z2	C9300	C9301	C9302	C9310
C9311	C9312	C9330	C9331	C9332	C9391	C9392	C93Z0
C93Z1	C93Z2	C9400	C9401	C9402	C9420	C9421	C9422
C9430	C9431	C9432	C9440	C9441	C9442	C9480	C9481
C9482	C9500	C9501	C9502	C9510	C9511	C9512	C9590
C9591	C9592	D45	D472	D473	D474	D47Z2	D5700
D5701	D5702	D5703	D5704	D5709	D571	D5720	D57211
D57212	D57213	D57214	D57218	D57219	D57412	D57413	D57414
D57418	D5742	D57431	D57432	D57433	D57434	D57438	D57439
D5744	D57451	D57452	D57453	D57454	D57458	D57459	D5780
D57811	D57812	D57813	D57814	D57818	D57819	D588	D589
D590	D5910	D5911	D5912	D5913	D5919	D592	D5930
D5931	D5932	D5939	D594	D599	D6182	D65	D682
D68311	D6851	D6852	D6859	D6861	D6862	D6869	D688
D690	D691	D692	D693	D6941	D6942	D6949	D696
D698	D699	D72828	D732	D740	D748	D749	D750
D751	D7589	D759	D761	D762	D763	D77	D890
D892	D8940	D8941	D8942	D8943	D8949	E0842	E0942
E1042	E1142	E7800	E78010	E78011	E78019	E7841	E7849
G603	G610	G6181	G6182	G6189	G620	G621	G622
G6281	G6282	G63	G64	G650	G7000	G7001	G731
I00	I010	I012	I018	I019	I773	I776	I7789
K716	K7200	K7201	K7581	K759	K760	K762	K767
K7689	K77	K8041	K8043	K8045	K8047	K8061	K8063
K8065	K8081	L100	L101	L102	L103	L104	L105
L1081	L1089	L109	L900	L940	L941	L943	M05011
M05012	M05021	M05022	M05031	M05032	M05041	M05042	M05051
M05052	M05061	M05062	M05071	M05072	M0509	M05411	M05412
M05421	M05422	M05431	M05432	M05441	M05442	M05451	M05452

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Diagnosis Codes							
M05461	M05462	M05471	M05472	M0549	M05611	M05612	M05621
M05622	M05631	M05632	M05641	M05642	M05651	M05652	M05661
M05662	M05671	M05672	M0569	M069	M08011	M08012	M08021
M08022	M08031	M08032	M08041	M08042	M08051	M08052	M08061
M08062	M08071	M08072	M0809	M080A	M083	M08411	M08412
M08421	M08422	M08431	M08432	M08441	M08442	M08451	M08452
M08461	M08462	M08471	M08472	M0848	M084A	M08832	M08841
M08842	M08851	M08852	M08861	M08931	M08932	M08941	M08942
M08951	M08952	M08961	M08962	M089A	M310	M3110	M3111
M3119	M320	M3210	M3219	M328	M3300	M3301	M3302
M3309	M3310	M3311	M3312	M3319	M3320	M3321	M3322
M3329	M3390	M3391	M3392	M3399	M340	M341	M342
M3481	M3482	M3483	M3489	N000	N001	N002	N003
N004	N005	N006	N007	N008	N00A	N00B1	N00B2
N010	N011	N012	N013	N014	N015	N016	N017
N018	N01A	N02B1	N02B2	N02B3	N02B4	N02B5	N02B6
N02B9	N032	N034	N035	N037	N03A	N040	N0420
N0421	N0422	N0429	N044	N045	N047	N048	N049
N04A	N04B1	N04B2	N052	N054	N055	N058	N059
N05A	N08	N171	N172	T8690	T8691	T8692	T8693
T8699							

Procedure code 36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber LA 15) or the protein A immunoadsorption (such as Prosorba) columns.

The protein A immunoadsorption column is indicated for use in either of the following cases:

- Clients who have a platelet count of less than 100,000 mm3.
- Adult clients who have signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, DMARDs.

The LDL apheresis column is indicated for use in clients who have severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or untolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:

- Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 300 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 200 mg/dL and documented coronary heart disease.

Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four-week period and should be within 10 percent of each other, indicating a stable condition.

Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code E780.

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Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP Medical Director or designee on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

9.2.77 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of Texas Medicaid and may be billed using procedure code 99195. This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

Diagnosis Codes							
D45	D649	D750	D751	E800	E801	E8020	E8021
E8029	E8310	E83110	E83118	E8319	P611		

Therapeutic phlebotomy will be automatically denied for all other diagnosis codes.

9.2.78 Therapeutic Radiopharmaceuticals

Therapeutic radiopharmaceuticals, when used for therapeutic treatment, are a benefit of Texas Medicaid.

The following procedure codes may be submitted for therapeutic radiopharmaceuticals:

Procedure Codes								
79403	A9513	A9542	A9543	A9563	A9564	A9590	A9600	A9699

9.2.78.1 Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is required for ibritumomab tiuxetan procedure codes A9542 and A9543.

Only one ibritumomab tiuxetan (procedure codes A9542 and A9543) may be prior authorized and reimbursed once per lifetime, any provider with one of the following diagnosis codes:

Diagnosis Codes							
C8259	C8399	C8499	C84A9	C84Z9	C8519	C8529	C8589
C8599							

Ibritumomab tiuxetan may be prior authorized when all of the following criteria are met:

- Client has a diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy and the following is documented:
  - Marrow involvement is less than 26 percent.
  - Platelet count is 100,000 cell/mm3 or greater.
  - Neutrophil count is 1,500 cell/mm3 or greater.
- Client has failed a trial of rituximab.

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Prior authorization must be submitted through Special Medical Prior Authorization department.

Prior authorization is required for lutetium lu 177 dotatate (Lutathera) procedure code A9513.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 will be considered with documentation that meets all of the following criteria:

- The client has a diagnosis of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (one of the following diagnosis codes must be submitted on the prior authorization request: C7A00, C7A010, C7A011, C7A012, C7A019, C7A020, C7A021, C7A022, C7A023, C7A024, C7A025,C7A026,C7A029, C7A092, C7A094, C7A095, C7A096).
- The client is 18 years of age or older.
- The client is not pregnant or breastfeeding.
- The official pathology report documents a GEP-NET with Ki67 index less than 20 percent.
- The disease is metastatic, or locally advanced and unresectable as indicated by one of the following:
  - Positive somatostatin receptor scintigraphy with correlative magnetic resonance imaging (MRI)
  - Computed tomography (CT) imaging of metastatic measurable disease
  - 68-Ga-Dotate positron emission tomography (PET) scan positive for metastatic disease
- The client experienced disease progression while on a long-acting somatostatin analog (e.g. octreotide, lanreotide).
- The client has not had prior treatment with Peptide Receptor Radionuclide Therapy (PRRT), and has not had prior external radiation therapy to more than 25 percent of the bone marrow.
- The documentation includes an oncologist's or nuclear medicine specialist's complete written order and prescription for Lutetium lu 177 dotatate intravenous infusion.
- A treatment plan that includes all of the following documentation:
  - Lutetium lu 177 dotatate 7.4 GBq (200 mCi) every 60 days for a total of 4 doses that is administered in a facility under the control of a physician who is licensed and authorized to administer radiopharmaceuticals
  - The recommended use of premedication and concomitant medications of somatostatin analogs, antiemetics, and specialized amino acid solution
  - The restrictions and usage of long- and short-acting octreotide agents before, during, and after lutetium lu 177 dotatate intravenous infusions
  - Details of withholding the treatments for contraindicated circumstances including, but not limited to:
    - Thrombocytopenia
    - Anemia neutropenia
    - Renal toxicity
    - Hepatotoxicity
    - Other non-hematologic toxicities

Prior authorization requests must be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

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Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

An SMPA Request Form must be completed, signed, and dated by the prescribing provider. The SMPA form will not be accepted after 90 days from the date of the prescribing provider's signature.

The completed SMPA Request Form must be maintained by the prescribing provider in the client's medical record and is subject to retrospective review.

Section C of the SMPA Request Form under Statement of Medical Necessity must contain the following:

- Documentation of the client's dosage
- The administration schedule
- The number of injections to be administered during the prior authorization period
- The requested units/millicuries per injection
- The dosage calculation

To facilitate the determination of medical necessity and avoid unnecessary denials, the prescribing provider must submit correct and complete information, including documentation of medical necessity for the equipment or supplies requested, the procedure codes, and the numerical quantities for services requested. The provider must maintain documentation of medical necessity in the client's medical record.

Prior authorization must be requested through the Special Medical Prior Authorization (SMPA) department with appropriate documentation.

Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

9.2.78.1.1 Reimbursement Limitations for Ibritumomab tiuxetan and Lutetium lu 177 dotatate

Ibritumomab tiuxetan is indicated for the treatment of clients that have failed rituximab and have CD20 antigen-expressing relapsed or refractory, low grade, follicular, or transformed non-Hodgkin's lymphoma or refractory non-Hodgkin's lymphoma.

Ibritumomab tiuxetan may only be considered once per lifetime, any provider, and only one of the agents.

Lutetiem Lu 177 dotatate (Lutathera) intravenous injection (procedure code A9513) is indicated for the treatment of adult clients who are 18 years of age or older with a diagnosis of somastatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors. For all other indications, Lutetiem Lu 177 dotatate (Lutathera) injection for intravenous use is not proven to be medically effective and is considered experimental. Lutetium lu 177 dotatate (Lutathera) must be administered under the control of an oncologist or a nuclear medicine specialist who is licensed and authorized to administer radiopharmaceuticals and must be administered in an outpatient setting.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 is limited to one service every 60 days for a total of four services per lifetime, any provider.

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9.2.78.2 Other Limitations on Therapeutic Radiopharmaceuticals

Strontium-89 chloride (procedure code A9600) may be reimbursed when submitted with diagnosis code C7951 or C7952.

Strontium-89 chloride is limited to a total of 10 mci intravenously injected every 90 days, any provider.

Sodium phosphate P-32, therapeutic (procedure code A9563) may be reimbursed when submitted with the following diagnosis codes:

Diagnosis Codes							
C7951	C7952	C9110	C9112	C9192	C91Z2	C9292	C92Z2
C9512	C9592	D45					

Chromic phosphate P-32 suspension (procedure code A9564) may be reimbursed when submitted with diagnosis codes C782 and C786.

An appropriate modifier may be used when billing for services more than once per day, same provider.

Iodine i-131 iobenguane procedure code A9590 is a benefit for clients who are 12 years of age and older.

Iodine i-131 iobenguane is a radiopharmaceutical indicated for the treatment of adult and pediatric clients who are 12 years of age and older with iobenguane scan positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma who require systemic anticancer therapy. Iodine i-131 iobenguane should be handled with appropriate safety measures to minimize radiation exposure and should be administered by or under the control of physicians who are licensed and authorized to administer radiopharmaceuticals.

Procedure code A9590 is limited to the following diagnosis codes:

Diagnosis Codes						
C7410	C7411	C7412	C755	C7A1	C7A8	D447

9.2.79 Urethral Dilation

If urethral dilation (procedure code 53600, 53601, 53605, 53620, 53621, 53660, 53661, or 53665) is billed on the same date of service by the same provider as procedure code 52000, the charges will be combined and processed as procedure code 52281.

Urethral dilation will be denied when billed on the same date of service by the same provider as any other cystoscopy.

9.2.80 Ventilation Assist and Management for the Inpatient

Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 94002 and 94003. Procedure codes 94002 and 94003 may be reimbursed only when the client is in observation or inpatient status. Respiratory care billed in any other POS will be denied.

Use the ventilation assist and management subsequent code (procedure code 94003) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

When the use of a ventilator is required as part of a major surgery, initial ventilation assist and management will be denied. It should be billed as ventilation assist and management subsequent procedure code 94003.

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Procedure codes 94002 and 94003 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, arterial or venous punctures; interpretations of arterial blood gases; or pulmonary function tests and management of the hemodynamic functions of the patient).

Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing–first day (procedure coed 94002) when respiratory support must be established for a patient. It is a one-time charge per hospitalization that may be paid when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (procedure code 94003).

9.2.81 Wearable Cardiac Defibrillator (WCD)

A WCD (procedure codes 93292, 93745, and K0606) are a benefit of Texas Medicaid.

The rental of a WCD (procedure code K0606) is limited to once per month and must be submitted with modifier RR.

Modifier 25 may be used to identify a significant separately identifiable evaluation and management service performed (for example, different diagnosis) on the same day as the initial set up of a WCD by the same provider for the same client. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Procedure code 93292 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

Procedure codes 93000, 93005, 93010, 93040, 93041, and 93042 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

9.2.81.1 Prior Authorization for WCD

Prior authorization is required for the rental of WCD (procedure code K0606).

The WCD may be prior authorized for clients at high-risk of sudden cardiac arrest who meets one of the following criteria:

- Has completed electrophysiologic studies to determine the type of arrhythmia present and confirm that a wearable cardiac defibrillator is the best course of treatment.
- Is contraindicated for an implantable cardiac defibrillator (ICD) at the current time, such as with a systemic infection.
- Is waiting for ICD implantation.
- Is waiting for ICD implantation and is undergoing treatment for a systemic infection.
- Has had an ICD explantation due to pocket infection.
- Is waiting for heart transplantation.
- Has self-limiting arrhythmias from iatrogenic (drug loading with potentially pro-arrhythmic medications) or other causes.
- Has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy.
- Has had either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction (LVEF) less than or equal to 35 percent.
- Has received a documented diagnosis of any one of the following conditions:

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- Clinically inducible hemodynamically significant ventricular tachycardia (HSVT) or ventricular fibrillation (VF), where drug treatment has been ineffective, or the side effects of the medication used to treat the arrhythmia are intolerable.
- Inducible VT or VF despite endocardial ablation or surgical excision when drug therapy has failed.
- VF or syncopal ventricular tachycardia.
- Specific ST-T wave changes, borderline CPK-MB isoenzymes, and dangerous ventricular arrhythmias are exhibited in a postmyocardial infarction patient.
- VT caused by ischemic heart disease not associated with an acute myocardial infarction, and where drug therapy or surgical therapy has failed.
- Recurrent syncope of undetermined etiology in a patient with HSVT or VF induced by EPS in whom no effective or tolerated drug is available or appropriate. Symptoms must be linked to HSVT or VF.
- Recurrent syncope of undetermined etiology with positive EPS studies where ventricular arrhythmia is documented as the cause.
- Palliative treatment for VT or VF in clients awaiting heart transplant.

The WCD is contraindicated in clients with an active ICD and should not be used in clients who meet the following criteria:

- Have a vision or hearing problem that may interfere with the perception of alarms or messages from the WCD.
- Is taking medications that would interfere with responding to the alarms or message from the WCD by depressing buttons.
- Is unwilling or unable to wear the device continuously, except when bathing or showering.
- Is pregnant or breastfeeding.
- Is of childbearing age and is not attempting to prevent pregnancy.

The WCD is considered investigational and not medically necessary for all other indications, including but not limited to, the following:

- Clients with drug-refractory class IV congestive heart failure who is not candidates for heart transplantation.
- Clients who have a history of psychiatric disorders that interfere with the necessary care and follow-up.
- Clients in whom a reversible triggering factor for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities.
- Clients with terminal illnesses.

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form requesting the DME and/or supplies must be signed and dated by a physician familiar with the client before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

Note: *A physician assistant (PA), certified nurse practitioner (CNP), or clinical nurse specialist (CNS) is not allowed to sign the Title XIX form to lease a WCD.*

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The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department at 1-512-514-4209 or in writing to the following address:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977

When a WCD is not covered as a home health service, it may be considered for reimbursement through the CCP for clients who are 20 years of age and younger. All of the following criteria must be met for CCP reimbursement for a WCD:

- The client is eligible for CCP benefits.
- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed in the policy.
- Federal financial participation is available.
- The client's cardiac status would be compromised without the requested equipment.
- The requested equipment is safe in the home setting.

Note: *For clients who are 21 years of age or older, requests for a WCD that does not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Rental of an automatic external defibrillator, with integrated electrocardiogram analysis, garment type (procedure code K0606) may be prior authorized (initially for up to three months) with documentation supporting the medical necessity and appropriateness of the device.

The provider may be reimbursed only for the length of time the device is used even though the authorization for the rental may be for a longer period of time.

The rental of the device includes the monitor, electrode belt (four sensors or electrodes and three treatment pads), garment, two rechargeable batteries, a battery charger and modem.

The purchase of a replacement battery (procedure code K0607), the purchase of a garment (procedure code K0608), and electrodes (procedure code K0609) will be considered part of the rental.

Prior authorization extensions for WCDs beyond the initial three-month rental may be considered by the medical director when documentation supports continued medical necessity for the device. Providers must submit new documentation to support continued medical necessity for an extension of the rental to be considered.

To facilitate the determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the device and is subject to retrospective review. The physician must maintain documentation of medical necessity in the client's medical record. The requesting DME provider may be asked for additional information to clarify or complete a request for the WCD.

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

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9.2.82 Wound Care Management

Wound care management includes the care of acute and chronic wounds, which include, but are not limited to, open ulcers (venous pressure or diabetic ulcers), fistulas, or erosion of skin related to cancer. Acute and chronic wounds are defined as the following:

- Acute wounds: Wounds taking less than or up to 30 days for complete healing
- Chronic wounds: Wounds taking more than 30 days for complete healing

Wound care includes the following:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue
- Maintenance of a clean, moist bed of granulation tissue
- Necessary treatment to resolve any infection that may be present
- Education of the client or their caregiver on how to clean and properly dress their wound

For clients with an ulcer, wound care may include the following:

- Frequent repositioning of a client who has a pressure ulcer
- Off-loading pressure and good glucose control for a client who has a diabetic ulcer
- Establishment of adequate circulation for a client who has an arterial ulcer
- Use of a compression system for clients who have a venous ulcer

Wound care management includes first- and second-line therapies. First-line wound care is used for acute wounds. If the wound does not improve with first-line treatment, adjunctive second-line therapy may be used. Measurable signs of improved healing can be used as outcome measures in a wound care treatment plan and include the following:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue

Wound care must be performed by a licensed health professional who is qualified to safely and effectively provide the medically necessary care. Providers are expected to exercise their clinical judgment to render the most appropriate care in accordance with their scope of practice as designated by their regulatory and governing boards. Education of the client or their caregiver during wound care interventions is a standard of care. Clients or their caregivers should be able to explain why each intervention is being performed for their specific type of wound.

All wound care services require documentation of the wound, and a comprehensive treatment plan is required to be maintained in the client's medical record as outlined in the documentation requirements section. Providers will document progress with each client encounter and use the measurable signs of healing to determine the degree of improvement.

The following services are not a benefit of Texas Medicaid:

- Infrared therapy
- Ultraviolet therapy
- Topical hyperbaric oxygen therapy
- Low-energy ultrasound wound cleanser (MIST therapy)

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- Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
- Electrical stimulation and electromagnetic therapy

9.2.82.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Cleansing, antibiotics, and pressure off-loading
- Compression
- Debridement
- Dressing
- Whirlpool for burns

9.2.82.1.1 Cleansing, Antibiotics, and Pressure Off-loading

Wound cleansing helps to create an optimal healing environment and decreases the potential for infection by loosening and removing cellular debris and residual topical agents from previous dressings.

Wound cleansing agents may include normal saline, commercial wound cleansers, providone iodine, hydrogen peroxide, or sodium hydrochlorite. Cleansing solutions and methods vary based on effectiveness and individual client needs.

Systemic or topical antibiotics may be used to prevent or treat wound infections and to aid in the healing of wounds.

Pressure off-loading devices, such as pillows, boots, mattresses, and protectors, may also be used as part of first-line wound care therapy to prevent or relieve pressure on the wound.

Procedure code 29445 may be reimbursed for pressure off-loading performed as part of wound care management.

9.2.82.1.2 Compression

Compression performed as a part of wound care management is a benefit and may be reimbursed when billed with procedure code 29580 or 29581.

9.2.82.1.3 Debridement

Wound debridement includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the client on the date of service.

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion rossr
- Mechanical debridement

The following procedure codes may be reimbursed for wound debridement:

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Procedure Codes									
11000	11001	11042	11043	11044	11045	11046	11047	97597	97598
97602									

Professional services for selective wound debridement (procedure codes 97597 and 97598) may be reimbursed to a licensed physical therapist, when it is determined to be within the provider's scope of practice, and the service is prescribed by a Medicaid-enrolled supervising physician or qualified non-physician provider.

Procedure codes 16020, 16025, and 16030 may be reimbursed for debridement of partial-thickness burns.

Prior authorization is not required for debridement of partial-thickness burns (procedure codes 16020, 16025, or 16030).

Prior authorization is required for wound debridement procedure codes 11042, 11043, and 11044. A request for prior authorization must be submitted to TMHP with the Special Medical Prior Authorization (SMPA) Request Form before the procedure is performed. Providers must retain a copy of the signed and dated form in the client's medical record at the provider's place of business. The requesting provider may be asked for additional information to clarify or complete a request for the equipment/supply requested.

Requests for prior authorization for wound debridement procedure codes 11042, 11043, and 11044 must include the following documentation:

- Location of the wound
- Characteristics of the wound, which include all of the following:
  - Dimensions (diameter and depth)
  - Drainage (amount and type)
  - Related signs and symptoms (swelling, pain, inflammation)
  - Presence of necrotic tissue/slough

When submitting an initial prior authorization request, the treating provider (registered nurse, physician, physical therapist) must submit a signed and dated wound care treatment plan or letter of medical necessity that includes all the following documentation:

- Planned interventions for the problem identified
- Treatment goals
- Expected outcomes

The treatment plan or letter of medical necessity is considered current when it is signed and dated within 30 calendar days prior to or on the date the procedure is performed. Otherwise, a new treatment plan must be submitted.

Retroactive authorization requests for wound debridement performed on an urgent or emergent basis (procedure code 11042, 11043, or 11044) will be denied if not submitted within 14 calendar days, beginning the day after the procedure is performed.

For wound debridement retroactive authorization to be considered, the treatment plan or letter of medical necessity must be signed and dated within 14 calendar days beginning the day after the procedure is performed. If the treatment plan is not signed and dated within the 14-calendar-day period, the request will be denied.

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For procedure codes 11043 and 11044, at least one of the following conditions must be present and documented:

- Stage III or IV wounds
- Venous or arterial insufficiency ulcers
- Dehisced wounds or wounds with exposed hardware or bone
- Neuropathic ulcers
- Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment

Wound debridement procedure codes 11042, 11043, and 11044 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates
- Acne surgery
- Destruction of warts
- Burn debridement

Prior authorization requests must be submitted by the provider within 30 calendar days prior to, or on the date the procedure is performed. If the prior authorization request is not submitted within 30 calendar days prior to, or on the date the procedure is performed, the request will be denied. The SMPA Request Form must be signed by the requesting provider on or within 30 days prior to the requested start of service. All dates of service prior to the prescribing providers signature date will be denied.

The physician's signature on the SMPA Request Form is considered current when signed and dated within 30 calendar days prior to, or on the date the procedure is performed. If the physician's signature is not signed and dated within the 30-calendar-day period prior to or on the date the procedure is performed, the request will be denied.

Prior authorization requests for procedure codes 11042, 11043, and 11044 will be considered for three calendar months, beginning on the requested procedure date.

Retroactive authorization is required for wound debridement procedure codes 11042, 11043, and 11044 that are performed on an urgent or emergent basis. The provider must submit a request for retroactive authorization within 14 calendar days, beginning the day after the procedure is performed.

For wound debridement retroactive authorization requests, the physician's signature on the SMPA Request Form is considered current when signed and dated within 14 calendar days, beginning the day after the procedure is performed. Requests with the physician's signature not signed and dated within the 14-calendar-day period will be denied.

Prior authorization requests for subsequent debridement will be considered on a case-by-case basis with documentation of medical necessity. These requests will be reviewed by the Medical Director.

The wound debridement procedure code submitted on the prior authorization or retroactive authorization request must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

9.2.82.1.4 Dressings and Metabolically Active Skin Equivalents

Wound dressings may include wet and dry dressings.

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All dressings applied to the wound during a wound debridement procedure are considered part of the service for wound debridement.

9.2.82.1.5 Whirlpool for Burns

Whirlpool is a benefit when used as first-line wound care therapy for the treatment of burn wounds.

9.2.82.2 Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic Stage III or IV wounds and may be covered only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second line wound care measures as indicated by the client's medial condition.

Second-line wound care therapy includes the following:

- Whirlpool
- Irrigation, including pulsatile jet irrigation
- Application of metabolically active skin equivalents/skin substitutes

9.2.82.2.1 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage III or IV wounds when other forms of treatment have failed. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

9.2.82.2.2 Negative Pressure Wound Therapy (NPWT)

Negative pressure wound therapy (NPWT) procedure codes 97605, 97606, 97607, and 97608 are a benefit of Texas Medicaid for clients who are 18 years of age or older.

NPWT may be provided utilizing durable medical equipment (DME), or nondurable medical equipment to treat acute and chronic wounds that include diabetic foot ulcers, venous leg ulcers, pressure ulcer wounds, non-healing surgical wounds, non-adhering skin grafts. NPWT may consist of using a traditional computerized electric vacuum pump, or a disposable single use mechanical device which includes the collection canister and the hydrocolloid dressing with the integrated nozzle and tubing.

NPWT may promote tissue granulation and wound healing by providing a warm moist wound bed while removing excessive secretions or bacterial material from the wound and should be considered only when other treatments are not effective.

Procedure codes 97605 and 97606 include management of the exudate collection system, topical application, wound assessment, and instructions for ongoing care services.

DME and supplies are not included for procedure codes 97605 and 97606 and may be reimbursed separately.

Procedure codes 97607 and 97608 include management of the exudate collection system, topical application, wound assessment, instructions for ongoing care services, and the disposable device.

The disposable device is included with procedure codes 97607 and 97608 and is not separately reimbursed.

NWPT is contraindicated for any of the following wound types and conditions:

- Necrotic tissue with eschar present
- Untreated osteomyelitis
- Fistulas
- Wounds containing malignancy

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- Exposed vasculature, nerves, anastomotic site, or organs
- Actively bleeding wounds

Prior authorization is not required for the initial 90 days of NPWT. A maximum of 36 NPWT treatments will be allowed in any 90-day period per rolling year, which will begin on the first day of the first NPWT treatment.

Prior authorization is required for more than 36 NPWT treatments within or after the initial 90 days and will be considered on a case-by-case basis with documentation of medical necessity. A request submitted to TMHP may be considered for services beyond the initial 90 days for an additional 30-day treatment period. These requests will be reviewed by the medical director.

Claims for procedure codes 97605, 97606, 97607, and 97608 must include the authorization number on the claim at the time of claim submission.

9.2.82.2.3 Skin Substitutes and Surgical Wound Preparation

The application of skin substitutes is a benefit for the treatment of chronic Stage 3 or 4 wounds that have failed to respond to standard wound care treatment after 30 days. A failed response is defined as a wound that has increased in size or depth, or has not changed in baseline size or depth, and shows no measurable signs of healing improvements after 30 days of appropriate wound-care measures.

Use of the appropriate specific skin substitute product(s) for the episode of each documented wound is expected. Compliance with the Food and Drug Administration (FDA) assessments and submitted guidelines for the specific skin substitute product(s) used is expected. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental and/or investigational. All wound care services require documentation of the wound, and a comprehensive treatment plan is required to be maintained in the client's medical record.

The following procedure codes may be reimbursed for the application of skin substitute grafts:

Procedure Codes									
15271	15272	15273	15274	15275	15276	15277	15278		

Approved skin substitute products used in wound care services that are provided in an office-based setting will be considered for separate reimbursement when submitted with an appropriate application procedure code from the table above.

The approved skin substitute product(s) must have a published average sales price, must be FDA cleared/approved or be designated as 361 HCT/P exempt, and should be used in accordance with each product's individualized labeling and application guidelines. The approved list of skin substitute products are reviewed and updated biannually. Providers should refer to the Center for Medicare & Medicaid Services (CMS) Medicare Part B Drug Average Sales Price web page at www.cms.gov for updates to the list of approved skin substitute products.

All skin substitute products used in wound care services that are provided in a facility setting are considered part of the application services (procedure codes listed in the table above) and are not separately reimbursed.

Surgical Wound Preparation

Appropriate surgical wound preparation is expected at least once at the initiation of care, prior to placement of the skin substitute graft. Repeated use of surgical preparation services in conjunction with skin substitute application codes will be considered not reasonable or necessary and will not be reimbursed.

The following procedure codes may be reimbursed for surgical wound preparation:

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Procedure Codes							
15002	15003	15004	15005	15040	15050	15271	15272
15273	15274	15275	15276	15277	15278	G0681	G0682
G0683	G0684						

Note: *Procedure code 15005 is not a benefit for ambulatory surgical center providers.*

Limitations

The treatment of any chronic skin wound will typically last no more than 12 weeks.

Skin substitute applications and grafts are limited to 10 per episode of care in a 12-week period, per rolling year beginning on the first day of the first skin substitute application. If more than one specific product is used or a product change occurs during the 12-week period of care, the expectation remains that the cumulative number of applications will not exceed 10.

More than 10 skin substitute applications in a 12-week period will be considered on a case-by-case basis with documentation of medical necessity. These requests will be reviewed by the Medical Director.

Re-Treatment of Healed, Stage 3, or Stage 4 Chronic Wounds

Retreating healed skin wounds showing greater than 75 percent in size reduction and smaller than 0.5 square cm is not considered medically reasonable or necessary and will not be reimbursed.

Retreating a venous stasis ulcer or diabetic neuropathic foot ulcer with any skin substitute product(s) within one year of previous treatment is considered treatment failure. This unsuccessful treatment does not meet reasonable and necessary criteria for re-treatment and will not be reimbursed.

Unsuccessful treatment is defined as an increase in size or depth of an ulcer, or no change in baseline size or depth and no sign of improvement or indication that improvement is likely (such as granulation, epithelialization, or progress towards closing) for a period of 4 weeks past the start of therapy.

Contraindications

Skin substitute grafts are contraindicated for the following:

- Clients with known hypersensitivity to any component of the specific skin substitute graft (e.g., allergy to avian, bovine, porcine, or equine products).
- Skin substitute grafts will not be considered reasonable and necessary for clients with inadequate control of underlying conditions or exacerbating factors, such as the following:
- Clients with uncontrolled diabetes
- Clients with active infection
- Clients with active Charcot arthropathy of the ulcer extremity
- Clients with vasculitis
- Clients who continue smoking tobacco and have not received smoking cessation guidance from their physician

9.2.82.3 Specialized Wound Care Education

Specialized wound care education with prior authorization may be reimbursed when provided by a wound care services provider.

In addition to the education included in the standard of care, specialized wound care education can be provided by a wound care services provider (with modifier U1) for additional reimbursement. These client interactions are denoted by the addition of the modifier U1 to the Healthcare Common Procedure

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Coding System (HCPCS) procedure code or other applicable HCPCS code billed for the wound care procedure performed. When the modifier U1 is used, documentation (client chart records) should be filed with the claim.

To evaluate progress and determine the degree of improvement, the wound care provider performing the specialized education must document in the client's chart each client encounter including the education provided and a description of the client's wound using measurable signs of healing.

The documentation must include:

- A record of teaching specific to the knowledge and skills necessary for independent care of the client's wound provided to the client or their caregiver.
- An affirmative statement that the client or their caregiver has received the education.

9.2.82.3.1 Limitations of Wound Care Education

Specialized wound care education is limited to the following:

- Two claims with a wound care procedure code submitted with modifier U1 per wound occurrence in an office setting or facility
- Four claims with modifier U1 per wound occurrence in an ambulatory surgical center

Each wound occurrence is defined as a three-month rolling time period. Additional prior authorization requests for more than the limitation number of claims submitted for wound occurrence will be considered on a case-by-case basis with documentation of medical necessity. These requests will go to a clinical review for consideration.

9.2.82.3.2 Reimbursement

Specialized wound care education will be limited to four wound care education services per 90 days by the same provider for services rendered in the ambulatory surgical center and may be reimbursed with the following procedure codes with modifier U1:

Procedure Codes						
11000	11042	11043	11044	15002	15004	15040
15050	15271	15273	15275	15277	16020	16025
16030	29445	29580	29581			

Specialized wound care education will be limited to two wound care education services per 90 days by the same provider for services rendered in the office, home, or facility setting and may be reimbursed with the following procedure codes with modifier U1:

Procedure Codes						
97597	97598	97602	97605	97606	97607	97608

9.2.82.4 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, which includes but is not limited to the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
- Wound location

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- Wound measurements, which includes length, width, and depth, any tunneling and/or undermining
- Wound color, drainage (type and amount), and odor, if present
- The prescribed wound care regimen, which includes frequency, duration, and supplies needed
- Treatment for infection, if present
- All previous wound care therapy regimens, if appropriate
- The client's use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

Wound care services providers must document the specialized education covered and the client's progress in the client's wound care education treatment plan with each billed encounter using the U1 modifier.

The measurable signs of healing described will be used as outcome measures to determine the degree of improvement as a result of such education.

9.2.82.4.1 Skin Substitutes

Documentation maintained in the client's medical record must support the need for skin substitute applications and the product used.

Documentation for all wound care treatments involving the application of skin substitute products must include, but is not limited to, the following:

- Wound treatments are accompanied by the appropriate adjunctive measures, and identify the specific adjunctive therapies being provided to the client as part of the wound treatment regimen.
- Clients who use tobacco must satisfy one of the following documentation requirements:
  - The client will have ceased smoking or have refrained from systemic tobacco intake for at least 4 weeks prior to beginning skin substitute applications and during the conservative wound care.
  - Smoking history, cessation counseling on the effects of smoking on surgical outcomes, treatment for smoking cessation (if applicable), and the outcome of counseling must be recorded in the client's medical record.
- Adequate circulation/oxygenation to support tissue growth/wound healing must be present as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30 millimeters of mercury [mmHg]).
- The wound has a skin deficit at least 1.0 square centimeter in size.
- For diabetic foot ulcers, the client's medical record reflects a diagnosis of Type 1 or Type 2 diabetes.
- Partial or full thickness ulcers must have a clean granular base without tendon and or muscle involvement, bone exposure, or sinus tracts.
- Documentation of the wound's response to the treatment is required at least every 30 days for each treatment episode. The documentation requirements must include measurements of the initial wound, measurements at the completion of appropriate wound care every 30 days, and measurements immediately prior to placement and with each subsequent placement of the skin substitute.

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- Wound care services that include the use of skin substitutes must be FDA cleared/approved or be designated as 361 HCT/P exempt and should be used in accordance with each product's individualized labeling and application guidelines. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental, investigational, or both.

9.2.82.5 Exclusions

The following services are not a benefit of Texas Medicaid:

- Separately billed, repeated use of a skin substitute product after 12 weeks for a single wound or episode
- Skin substitute grafting for partial thickness loss with the retention of epithelial appendages is not covered, as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting

9.3 Collaborative Care Model (CoCM)

The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions (mental health or substance use) in primary care settings. The model integrates the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.

CoCM services are benefits for persons of all ages who are enrolled in Texas Medicaid and who have a mental health or substance use condition to include a pre-existing or suspected mental health or substance use condition, when provided by a physician, physician assistant, nurse practitioner, clinic or group practices, federally qualified health center (FQHC), or rural health clinic (RHC) (henceforth, referred to as the Primary Care Provider).

Prior to delivering CoCM services, the primary care provider must attest in the Provider Enrollment and Management System (PEMS) that their practice location has an established CoCM program as described in this section. To ensure continued adherence to the CoCM core principles and the specific functional requirements of the model, the primary care provider must also re-attest in PEMS at the time of enrollment revalidation.

CoCM services must be provided under the direction of the primary care provider and are benefits when provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility or other locations.

An episode of care of CoCM services begins when the person receiving services is referred by the primary care provider to the BHCM for CoCM services and ends after 12 calendar months (initial calendar month plus 11 subsequent calendar months) of services or earlier if treatment goals are met. A new episode of care must be initiated when either:

- The person receiving services is referred to a behavioral health provider for ongoing treatment of the behavioral health condition.
- There is a break in services, which is defined as no CoCM services provided for six consecutive calendar months.

CoCM services are individually delivered, time-based, monthly services that include outreach and engagement, completing an initial assessment, developing an individualized and person-centered plan of care, monitoring and tracking a person's progress using a registry, providing brief interventions and other focused treatments, and conducting weekly caseload reviews with the psychiatric consultant. For more information on registry requirements refer to The Advancing Integrated Mental Health Solutions (AIMS) Center, University of Washington, Psychiatry and Behavioral Sciences Division of Population Health.

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Initial CoCM services (procedure code 99492) are those BHCM activities provided to the person receiving services in the first calendar month of services. Initial CoCM services, using procedure code 99492, must include the following elements and be documented in the electronic medical record (EMR) or electronic health record (EHR) for reimbursement:

- Conducting outreach to and engagement of the person needing services, directed by the primary care provider
- Completing an initial assessment to include administration of a validated rating scale
- Developing a person-centered plan of care that is reviewed and modified, as needed, by the psychiatric consultant
- Monitoring progress and updating the person-centered plan of care, as needed
- Entering information into the registry and tracking follow-up activities and progress through the registry with appropriate documentation
- Participating in weekly caseload consultation meetings with the psychiatric consultant
- Providing evidenced-based brief interventions, such as motivational interviewing or other focused strategies

Subsequent CoCM services (procedure code 99493) are those BHCM activities provided to the person receiving services in the months following the first calendar month of services.

Initial or subsequent CoCM services (procedure code G2214) are those BHCM activities provided to the person receiving services in the first calendar month or subsequent calendar months of services.

Procedure codes 99493 and G2214 must include the following elements and be documented in the EMR or EHR for reimbursement:

- Tracking follow-up activities and progress of the person receiving services through the registry with appropriate documentation
- Participating in weekly caseload consultation meetings with the psychiatric consultant
- Collaborating with and coordinating of the person's care and treatment with the primary care provider or other treating behavioral health providers
- Reviewing progress and recommendations from the psychiatric consultant for changes in treatment to include modifications to the medication regimen
- Providing evidenced-based brief interventions
- Monitoring clinical outcomes using a validated rating scale
- Planning for relapse prevention as the person receiving services prepares for discharge from services

9.3.1 CoCM Team Member Qualifications and Responsibilities

The primary care provider must be a physician (including specialists, such as a cardiologist or oncologist), physician assistant, or nurse practitioner that has an established CoCM program.

The primary care provider must:

- Direct the BHCM and other clinical staff.
- Oversee the care of the person receiving services to include prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
- Remain actively involved in the care and treatment of the person receiving services through continuous oversight, management, collaboration, and reassessment.
- Comply with all applicable licensure board rules.

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The BHCM must be credentialed as a Qualified Mental Health Professional-Community Services (QMHP-CS), as defined in Title 1 Texas Administrative Code (TAC) §353.1415. The BHCM works under the oversight and direction of the primary care provider and, in consultation with the psychiatric consultant, provides care management services, including:

- Completing an initial assessment
- Administrating a validated rating scale
- Developing a person-centered plan of care
- Providing evidenced-based brief interventions
- Collaborating with the primary care provider
- Maintaining the registry

The BHCM must:

- Be available to provide CoCM services in person when needed.
- Maintain a continuous relationship with the person receiving CoCM services.
- Be able to engage the person receiving CoCM services outside of regular office hours, as needed, to perform CoCM duties.

Note: *BHCM activities may be provided in person or by synchronous audio-visual or audio only (telephone) technology, if clinically appropriate, safe, and agreed to by the person receiving CoCM services. Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience*

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine and telehealth.

The psychiatric consultant must be a medical professional who is trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant must engage, at a minimum, in weekly caseload reviews with the BHCM that may be conducted in person or by synchronous audio-visual or audio only (telephone) technology. Caseload reviews typically focus on persons who are new to CoCM services or who are not improving as expected under their current person-centered plan of care. The psychiatric consultant advises and makes recommendations, either directly to the primary care provider or through the BHCM, regarding psychiatric and other medical care to include:

- Psychiatric and other medical diagnoses
- Treatment strategies to include appropriate therapies, medication management, and medical management of complications associated with treatment of psychiatric disorders
- Referral for specialty services

The psychiatric consultant typically does not meet with the person receiving services but must be able to do so either in person or by synchronous audio-visual technology if clinically indicated. The psychiatric consultant must also facilitate referrals to a behavioral health provider when clinically appropriate.

9.3.2 Prior Authorization Requirements

Prior authorization is not required for the first six calendar months (initial month and five subsequent months) of CoCM services.

Prior authorization is required for an additional six calendar months (beyond the first six calendar months) of CoCM services.

Note: *Prior authorization is a condition of reimbursement, not a guarantee of payment.*

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Prior authorization requests are considered on a case-by-case basis with documentation supporting medical necessity for an additional six calendar months of CoCM services. Requests must be received prior to the last day of the sixth calendar month of services. The documentation must demonstrate the person receiving services continues to meet eligibility criteria, as outlined in the section above, and include the following:

- The current person-centered recovery plan that includes goals and objectives
- Progress made relative to the goals and objectives outlined in the person-centered recovery plan

Requests must be submitted by the primary care provider to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The form must be signed and dated within 30 calendar days prior to the start of an additional six calendar months of CoCM services, and must include the following information:

- Identifying information for the person receiving services
- Provider information
- Service and procedure code information
- Expected dates of service
- Diagnosis or diagnoses
- Medical necessity information

Note: *A nurse practitioner and physician assistant may sign all documentation related to the provision of CoCM services on behalf of the physician when the physician delegates this authority to the nurse practitioner or physician assistant.*

Primary care providers are required to adhere to prior authorization requirements.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department through 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 EMR or 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 person'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 the 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, responsible adults of persons receiving services, and persons receiving services may sign prior authorization forms and supporting documentation using electronic or wet signatures.

To complete the prior authorization process by paper, the provider must fax or mail the completed prior authorization request form to the TMHP Prior Authorization Department and retain a copy of the signed and dated prior authorization form in the client's medical record.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated prior authorization form in the person's medical record.

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 services requested. The physician must maintain documentation of medical necessity in the person's medical record.

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The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services.

9.3.3 Documentation Requirements

Prior to receiving CoCM services, the primary care provider must obtain verbal or written consent from the person being referred for CoCM services to consult with the psychiatric consultant and other relevant specialists. A new consent is not required for each subsequent calendar month of services or annually unless the person receiving services changes primary care providers. If the person receiving services changes primary care providers, then a new verbal or written consent must be obtained and documented by the new primary care provider prior to the provision of CoCM services. Informed consent must be documented in the EMR or EHR.

Primary care providers must use a registry that is used jointly with the EMR or EHR of the practice to track clinical outcomes.

All elements for the procedure code being billed (99492, 99493 or G2214), as described in this section must be documented in the registry for reimbursement. In addition, documentation must also include the following:

- The initial assessment and any subsequent assessments
- The validated rating scale, or scales, used to include results
- All versions of the individualized, person-centered plan of care.
- The person-centered plan of care must:
  - Identify the goals of treatment
  - Indicate progress of the person receiving services towards their goals
  - Include any modifications to care and treatment.

All services outlined in this section are subject to retrospective review to ensure that the documentation in the person's medical record supports the medical necessity of the services provided.

9.3.4 Claims Reimbursement

CoCM services are time-based and reported as the total amount of time the BHCM spends engaging in clinical activities over the course of a calendar month.

Only the primary care provider may submit claims for CoCM services. The BHCM and psychiatric consultant are reimbursed by the primary care provider through a contract, employment, or other arrangement. If a contract or other arrangement is pursued, it must be as a billing agent, such as billing service or accounting firm, that furnishes statements and receives payments in the name of the provider; a facility under which the service is provided; or a foundation plan or similar organization under which the organization submits the claim, in accordance with 42 CFR 447.10.

To be reimbursed for CoCM services, the primary care provider must meet the following core components:

- Provide active treatment and care management for an identified population
- Use a registry to monitor treatment and outcomes, and to conduct psychiatric caseload reviews

The primary care provider must use procedure codes 99492, 99493, 99494, or G2214 to bill for monthly CoCM services in all settings. The primary care provider must also use the place of service code for the location where services would normally be provided for in-person care and treatment.

CoCM services begin after the referral is made by the primary care provider and the BHCM starts engaging in reimbursable clinical activities, as described in this section.

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The primary care provider must use procedure code 99492 for the first 70 minutes accrued during the initial calendar month of BHCM activities, in consultation with the psychiatric consultant.

The primary care provider must use procedure code 99493 for the first 60 minutes accrued during each subsequent calendar month of BHCM activities, in consultation with the psychiatric consultant.

The primary care provider must use add-on procedure code 99494 for each additional 30 minutes accrued during the initial calendar month or subsequent calendar months of BHCM activities, in consultation with the psychiatric consultant. The add-on procedure code must be billed with the appropriate primary procedure code 99492 or 99493.

The primary care provider must use procedure code G2214 for no more than 30 minutes accrued during an initial calendar month or subsequent calendar months of BHCM activities, in consultation with the psychiatric consultant.

The primary care provider may not bill both procedure codes 99492 and G2214 during the initial calendar month of services or procedure codes 99493 and G2214 during any subsequent calendar month of services for the same person, same provider. See the CoCM procedure codes table for information about time thresholds.

The primary care provider must use the appropriate evaluation and management (E/M) code for the initial presenting visit with the person.

All required elements of the procedure codes, as described in this section, must be performed and documented, and time thresholds met, to be reimbursed for services.

The BHCM may provide other outpatient mental health services, if eligible for reimbursement, in the same calendar month as CoCM services but those services are separate and distinct from CoCM services and do not count toward the time thresholds for CoCM services. Therefore, the BHCM must report separately those other mental health services that are delivered in the same calendar month as CoCM services.

The psychiatric consultant may provide E/M services and other outpatient mental health services, if eligible for reimbursement, in the same calendar month as CoCM consultation services but those services are separate and distinct from CoCM services and do not count toward the time thresholds for CoCM services. Therefore, the psychiatric consultant must report separately E/M or other mental health services that are delivered in the same calendar month as CoCM services.

Refer to: The "Behavioral Health and Case Management Services Handbook" in the *Behavioral Health and Case Management Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about outpatient mental health services, and Section 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about physician evaluation and management (E/M) services.

FQHCs and RHCs should submit claims using the CoCM standard procedure codes only, which will be reimbursed at the fee-for-service rate outside the FQHC or RHC encounter rate.

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The following procedure codes may be reimbursed for CoCM services based on the time thresholds listed:

Procedure Code	Additional Information
99492	Billable at 36 minutes. Time threshold is 36 to 85 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during the initial calendar month of an episode of care. Limited to one per initial calendar month, same person, same provider. May not be billed in subsequent months of services.
99493	Billable at 31 minutes. Time threshold is 31 to 75 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during subsequent calendar months of an episode of care. Limited to one per subsequent calendar month, same person, same provider. May not be billed in the initial calendar month of services.
99494	Billable at 16 minutes, beyond total time, to 30 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during any calendar month (initial or subsequent) of an episode of care. Limited to two per calendar month (initial or subsequent), same person, same provider. Add-on code must be billed with primary procedure code 99492 or 99493. May not be submitted with procedure code G2214.
G2214	Billable at 16 minutes. Time threshold is 16 to 30 minutes. Administrative and clerical duties do not count towards the time threshold. May only be billed by the primary care provider during any calendar month (initial or subsequent) of an episode of care. Limited to one per calendar month (initial or subsequent), same person, same provider. The primary care provider may not bill both procedure codes 99492 and G2214 during the initial calendar month of services or procedure codes 99493 and G2214 during any subsequent calendar month of services for the same person, same provider.

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Procedure code 99492 is limited to one occurrence or unit in the initial calendar month of CoCM services, same person, same provider during an episode of care. Procedure code 99492 will be denied if billed during any subsequent calendar month of CoCM services.

Procedure code 99493 is limited to one occurrence or unit per calendar month for all subsequent calendar months of CoCM services, same client, same provider during an episode of care. Procedure code 99493 will be denied if billed during the initial calendar month of CoCM services.

Procedure code 99494 is limited to two occurrences or units per calendar month (initial or subsequent) of CoCM services, same person, same provider during an episode of care. Procedure code 99494 will be denied if billed without primary procedure code 99492 or 99493 for the same person, same provider.

Procedure code G2214 is limited to one occurrence or unit per calendar month (initial or subsequent) of CoCM services, same person, same provider during an episode of care.

Procedure codes 99492, 99493, and G2214 will be denied if billed in the same calendar month of CoCM services, same person, same provider.

9.3.5 Exclusions

Administrative and clerical duties, except for entering information in the registry which is a required element of the procedure codes are not a covered benefit of Texas Medicaid.

9.4 Doctor of Dentistry Practicing as a Limited Physician

This section outlines the guidelines for the Doctor of Dentistry practicing as a limited physician. The THSteps dental program is not addressed in these guidelines.

Services by a dentist (DDS or DMD) are covered by Texas Medicaid in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1987 §4103 and Title 2 *Texas Human Resources Code* §32.054, if the services are furnished within the dentist's scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

Dentist (DDS or DMD) who want to participate as a dentist-physician in Texas Medicaid must be separately enrolled as a Doctor of Dentistry practicing as a limited physician even if they are enrolled in the THSteps Dental Program.

Dual licensure (MD, DO, and DDS) is not required for a dentist to enroll as a limited physician. Medicare enrollment is required for a dentist to enroll as a limited physician.

9.4.1 Prior Authorization for General Dental Services Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients who are 21 years of age and older (who do not reside in an ICF-IID facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. *Mandatory prior authorization is required* and the dental diagnoses *must* be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a *general dentist* who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement.

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Examples of dental procedures that may be authorized for an *oral and maxillofacial surgeon* who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement maxillofacial surgeries to correct defects caused by accident or trauma.
- Surgical corrections of craniofacial dysostosis.

Note: *Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.*

9.4.1.1 Guidelines for Requesting Mandatory Prior Authorization

The limited physician dentist must request the mandatory prior authorization, and the request must include:

- A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition.
- Narrative describing the current medical problem, client status, and medical need for requested services.
- The client name and Medicaid number.
- The limited physician dentist's NPI.
- The name and address of the facility.
- CPT procedure codes.
- The history and physical.
- The limited physician dentist's signature.

Note: *The "limited physician" dentist who will perform the procedure(s) must submit the request for prior authorization.*

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12365-A Riata Trace Parkway
Austin, TX 78727-6418
Fax: 1-512-514-4213

9.4.2 Benefits and Limitations

Dental procedure codes and their corresponding CPT procedures may not be billed on the same date of service by any provider.

Cosmetic procedures are not a benefit of Texas Medicaid. Certain procedure codes, including, but not limited to, the procedure codes in the following table, may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury for the purpose of:

- Reconstructing tissues/body structures.
- Repairing damaged tissues.

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Procedure Codes									
11950	11951	11952	11954	11970	15780	15781	15786	15787	15788
15789	15838	15876	21089	21497	41820	41821	41828	61501	Q3031

9.4.2.1 Additional Payable Procedure Codes

The following procedure codes are a benefit when prior authorized and the dentist is qualified and licensed to perform the procedures:

Procedure Codes									
Surgery									
10004	10005	10006	10007	10008	10009	10010	10011	10012	10021
10060	10061	10120	10121	10140	10160	10180	11000	11001	11010
11011	11012	11042	11043	11044	11045	11046	11047	11102	11103
11104	11105	11106	11107	11200	11201	11305	11306	11307	11308
11310	11311	11312	11313	11420	11421	11422	11423	11424	11426
11440	11441	11442	11443	11444	11446	11620	11621	11622	11623
11624	11626	11640	11641	11642	11643	11644	11646	11900	11901
11950	11951	11952	11954	11960	11970	11971	12001	12002	12004
12005	12006	12007	12011	12013	12014	12015	12016	12017	12018
12020	12021	12031	12032	12034	12035	12036	12037	12051	12052
12053	12054	12055	12056	12057	13120	13121	13122	13131	13132
13133	13151	13152	13153	13160	14020	14021	14040	14041	14060
14061	14301	14302	15004	15005	15115	15116	15120	15121	15135
15136	15155	15156	15157	15240	15241	15260	15261	15275	15276
15277	15278	15574	15576	15620	15630	15730	15733	15740	15750
15756	15757	15758	15760	15769	15770	15780	15781	15782	15783
15786	15787	15788	15789	15792	15793	15820	15821	15822	15823
15838	15851	15852	15876	16020	16025	16030	17000	17003	17004
17106	17107	17108	17110	17111	17250	17270	17271	17272	17273
17274	17276	17280	17281	17282	17283	17284	17286	20100	20200
20205	20220	20240	20520	20525	20550	20551	20552	20600	20604
20605	20606	20615	20650	20660	20661	20670	20680	20690	20692
20693	20694	20696	20697	20900	20902	20910	20912	20920	20922
20955	20956	20957	20962	20969	20970	20972	20973	20999	21010
21011	21012	21013	21014	21015	21016	21025	21026	21029	21030
21031	21032	21034	21040	21044	21045	21046	21047	21048	21049
21050	21060	21070	21073	21076	21079	21080	21081	21082	21083
21085	21087	21088	21089	21100	21110	21116	21120	21121	21122
21123	21125	21127	21137	21138	21139	21141	21142	21143	21145
21146	21147	21150	21151	21154	21155	21159	21160	21172	21175
21179	21180	21181	21182	21183	21184	21188	21193	21194	21195
21196	21198	21199	21206	21208	21209	21210	21215	21230	21235

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Procedure Codes									
21240	21242	21243	21244	21245	21246	21247	21255	21256	21260
21261	21263	21267	21268	21270	21275	21280	21282	21295	21296
21299	21315	21320	21325	21330	21335	21336	21337	21338	21339
21340	21343	21344	21345	21346	21347	21348	21355	21356	21360
21365	21366	21385	21386	21387	21390	21395	21400	21401	21406
21407	21408	21421	21422	21423	21431	21432	21433	21435	21436
21440	21445	21450	21451	21452	21453	21454	21461	21462	21465
21470	21480	21485	21490	21497	21499	21501	21550	21552	21554
21555	21556	21558	21685	29800	29804	29999	30000	30020	30120
30124	30125	30150	30160	30200	30300	30310	30400	30410	30420
30430	30435	30450	30460	30462	30465	30520	30580	30600	30620
30630	30801	30802	30901	30903	30905	30906	30930	30999	31020
31030	31032	31080	31081	31084	31085	31086	31087	31225	31230
31600	31603	31605	31830	40490	40500	40510	40520	40525	40527
40530	40650	40652	40654	40700	40701	40702	40720	40761	40799
40800	40801	40804	40805	40806	40808	40810	40812	40814	40816
40818	40819	40820	40830	40831	40840	40842	40843	40844	40845
40899	41000	41005	41006	41007	41008	41009	41010	41015	41016
41017	41018	41100	41105	41108	41110	41112	41113	41114	41115
41116	41120	41130	41135	41140	41145	41150	41153	41155	41250
41251	41252	41510	41520	41599	41800	41805	41806	41820	41821
41822	41823	41825	41826	41827	41828	41830	41850	41870	41872
41874	41899	42000	42100	42104	42106	42107	42120	42140	42145
42160	42180	42182	42200	42205	42210	42215	42220	42225	42226
42227	42235	42260	42280	42281	42299	42300	42305	42310	42320
42330	42335	42340	42400	42405	42408	42409	42410	42415	42420
42425	42426	42440	42450	42500	42505	42507	42509	42510	42550
42600	42650	42660	42665	42699	42700	42720	42725	42800	42804
42806	42808	42809	42810	42815	42842	42844	42845	42890	42892
42894	42900	42950	42960	42961	42962	42970	42999	61501	61559
61575	61576	61580	61581	61584	61586	61590	61592	62147	64400
64600	64612	64722	64736	64738	64740	67900	67914	67915	67916
67917	67921	67922	67923	67924	67930	67935	67950	67961	92511
96360	96361	96369	96370	96372	96374				
Injections/Medications									
90284	J0121	J0162	J0168	J0169	J0280	J0290	J0295	J0330	J0360
J0475	J0525	J0558	J0561	J0670	J0690	J0692	J0694	J0696	J0697
J0698	J0702	J0720	J0744	J0780	J1010	J1100	J1165	J1171	J1200
J1364	J1459	J1555	J1557	J1559	J1561	J1566	J1568	J1569	J1572
J1576	J1580	J1630	J1631	J1720	J1790	J1800	J1885	J1920	J1921

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Procedure Codes									
J1938	J1941	J2010	J2060	J2175	J2249	J2291	J2305	J2360	J2371
J2372	J2401	J2402	J2410	J2540	J2550	J2560	J2690	J2700	J2765
J2800	J2865	J2919	J2970	J3000	J3010	J3260	J3301	J3303	J3360
J3373	J3410	J3430	J3480	J3485	J3490				
Pathology									
88305	88331	88332							

9.4.2.2 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement:

Procedure Codes									
70100	70110	70120	70130	70140	70150	70160	70190	70200	70250
70260	70300	70310	70320	70328	70332	70336	70350	70355	70370
70371	70380	70390	73100	70450	70460	70470	70480	70481	70482
70486	70487	70488	70490	70491	70492				

9.4.2.3 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§110.1 through 110.15, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.

The following anesthesia services are payable to dentists as physician services:

Procedure Codes									
00100	00102	00160	00162	00164	00170	00190	00192	00300	99100
99116	99135	99140							

9.5 Documentation Requirements

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

9.6 Claims Filing and Reimbursement

9.6.1 Claims Information

Claims for physician and doctor services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply them.

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

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Physicians who submit a claim using the physician's own NPI for services provided by an NP, CNS, PA, or CNM must submit one of the following modifiers on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit:

- SA – Services were provided by an NP or CNS
- U7 – Services were provided by a physician assistant
- SB – Services were provided by a CNM

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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.6.2 National Drug Codes (NDC)

Refer to: Subsection 6.3.4, "National Drug Code (NDC)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

9.6.3 Reimbursement

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with 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.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an NP, CNS, PA, or CNM if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. The 92 percent reimbursement rate will not apply to laboratory services, X-ray services, and injections provided by an NP, CNS, PA, or CNM.

Texas Medicaid implemented mandated rate reductions for certain services. The 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.

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

Reimbursement for these services will be 60 percent of the Texas Medicaid rate for the service furnished in the physician's office. The following table identifies the services applicable to the 60-percent limitation when furnished in outpatient hospital settings:

Procedure Codes									
99202	99203	99204	99205	99211	99212	99213	99214	99215	99281
99282	99283								

These procedures are designated with note code "1" in the current physician fee schedule, which is available at www.tmhp.com. The following list shows the services excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs).

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- Surgical services that are covered ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC) services.
- Anesthesiology and radiology services.
- Prenatal services when billed with modifier TH and the appropriate E/M procedure code to the highest level of specificity.
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Serious jeopardy to the client's health.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.

Because of TEFRA, Texas Medicaid reimbursement for a payable nonemergency office service that is performed in the outpatient department of a hospital is limited to 60 percent of Texas Medicaid rate for that service. If the condition qualifies as an emergency or if the client is critically ill or critically injured, the 60 percent professional service reimbursement limit does not apply.

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.

Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about conditions that are excluded from the 60-percent limitation.

Subsection 9.2.7, "Anesthesia" in this handbook for information on anesthesia services that are reimbursed according to relative value units (RVUs).

9.6.3.1 Affordable Care Act of 2010 (ACA) Rate Increase for Primary Care Services

To qualify for the Affordable Care Act of 2010 (ACA) rate increase for primary care services, a physician must have a specialty designated of general internal medicine, family practice, or pediatrics and must attest to one of the following:

- The provider has a certification recognized by the American Board of Allergy and Immunology (ABAI), American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or American Osteopathic Association (AOA) and meets the requirements as required by federal and state regulation to receive the increased payment.
- The provider does not have a certification recognized by the ABAI, ABMS, ABPS, or AOA, but at least 60 percent of the provider's Medicaid billings for the previous calendar year (or for the previous calendar month if the provider has been enrolled in Medicaid for less than one year) were for the evaluation and management (E/M) and vaccine administration procedure codes as published in the final federal and state regulations and the provider meets the requirement to receive payment.

  Note: *New providers with no history of Medicaid billings can attest that 60 percent of their Medicaid billing will be for primary care services.*

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Providers can attest using the Texas Medicaid Attestation for ACA Primary Care Services Rate Increases form. ABAI-certified allergists must indicate "ABAI-allergy" in the "List subspecialties" field of the attestation form.

Important: *By signing the form, providers attest that they qualify for the rate increase, and that the increase will be applied to paid claims for primary care services on or after the effective date. Payment of the rate increase may be subject to retrospective review and recoupment if it is determined at a later time that the provider did not qualify for the ACA primary care services rate increase. Federal regulations require states to conduct an annual audit of provider attestations.*

Non-physician practitioners who are under the supervision of a provider who has self-attested, are not required to submit a separate provider attestation form. Increased payment may be available to the supervising physician when the following conditions are met:

- The non-physician practitioner renders services under the personal supervision of a provider who has self-attested to meeting the requirements.
- Services are billed under the qualifying provider's provider identification number.

10 Physician Assistant

10.1 Enrollment

To enroll in Texas Medicaid, a PA must be licensed and recognized as a PA by the Texas Physician Assistant Board. Texas Medicaid accepts a signed letter of certification from the Texas Physician Assistant Board as acceptable documentation of appropriate licensure and certification for enrollment. The PA must identify their supervising physician in the appropriate field of the enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days.

Enrollment as an individual provider is optional. PAs currently treating clients and billing under the supervising physician's NPI may continue this billing arrangement.

All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

PAs may enroll as providers of THSteps medical checkups.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about enrolling as a THSteps provider.

PAs may be included as primary care providers in the provider network for Medicaid and CHIP programs (both fee-for-service and managed care), regardless of whether the physician supervising the PA is enrolled in Medicaid or in the provider network.

10.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law

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- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

Services provided to Medicaid clients must be documented in the client's medical record to include the following:

- Services provided
- Date of service
- Pertinent information about the client's condition supporting the need for service
- The individual practitioner of the service

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own NPI for services provided by a PA must submit modifier U7 on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and claims must be received within 95 days from the date of service.

Note: *Payment to providers for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.*

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

Section 9, "Physician" in this handbook.

Section 4, "THSteps Medical" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 9.3, "Collaborative Care Model (CoCM)" in this handbook for information about CoCM services.

10.2.1 Prior Authorization

Services performed by a PA are subject to the same prior authorization guidelines as services performed by other provider types.

10.3 Documentation Requirements

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

10.4 Claims Filing and Reimbursement

10.4.1 Claims Information

Claims for PA services must include modifier U7 on the claim details to indicate that the client was treated by a PA.

PA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

10.4.2 Reimbursement

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Note: *PA providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps NPI as the billing provider.*

PAs who bill Medicaid directly for services they perform must use their individual NPI. If the services were performed by the PA but billed by a physician or physician group, the billing provider is the physician or physician group. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a PA if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, or injections provided by a PA.

Providers can refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Texas Medicaid implemented mandated rate reductions for certain services. The 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.

Refer to: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on how to obtain electronic fee schedules from the TMHP website.

11 Claims Resources

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

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Resource	Location
Family Planning Claim Form Examples	Section 10, "Claim Form Examples" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* (*Vol. 2, Provider Handbooks*)
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*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

12 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.

13 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
Abortion Certification Statements Form
Attestation Form for the Collaborative Care Model (CoCM) in Texas Medicaid
DME Certification and Receipt Form
Hospital Report (Newborn Child or Children) (Form 7484)
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
Medicaid Certificate of Medical Necessity for Reduction Mammaplasty
Non-emergency Ambulance Exception Form
Non-emergency Ambulance Prior Authorization Request
Obstetric Ultrasound Prior Authorization Request Instructions
Obstetric Ultrasound Prior Authorization Request
Special Medical Prior Authorization (SMPA) Request Form
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
THSteps Dental Mandatory Prior Authorization Request Form
Criteria for Dental Therapy Under General Anesthesia

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14 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
Anesthesia
Certified Nurse-Midwife (CNM)
Certified Registered Nurse Anesthetist (CRNA)
Chiropractic Services
Dental (Doctor of Dentistry)
Dialysis Training
Genetics
Radiation Therapy
Surgery

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