TEXAS
Health and Human Services

HCPCS Special Bulletin

2019 Healthcare Common Procedure Coding System (HCPCS) Special Bulletin, No. 15

GENERAL INFORMATION

2019 HCPCS Implementation

On January 1, 2019, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2019 annual Healthcare Common Procedure Coding System (HCPCS) updates that are effective for dates of service on or after January 1, 2019.

This combined Special Bulletin includes the HCPCS updates for Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program. This bulletin is intended to notify providers of program and coding changes related to the 2019 updates for HCPCS and Current Procedural Terminology (CPT®).

Policy updates for a specific program or provider type are discussed in designated sections of the bulletin. ■

Rate Hearings and Expenditure Review

New and increased benefits that are adopted by Texas Medicaid must complete the rate hearing process to receive comments on new and increased Texas Medicaid reimbursement rates. The CSHCN Services Program reviews the adopted Texas Medicaid rates to determine whether the rates are fiscally feasible for the CSHCN Services Program.

All new, revised, and discontinued 2019 HCPCS procedure codes are effective for dates of service on or after January 1, 2019. The new procedure codes that are designated with asterisks (*) in the "Medicaid Allowable" and the "CSHCN Allowable" columns of the table located on page 36 of this bulletin must complete the rate hearing process, and expenditures must be approved before the rates are adopted by Texas Medicaid and the CSHCN Services Program. Providers will be notified in a future banner message or web article if a new procedure code will not be reimbursed because the expenditures were not approved.

Providers may refer to the following resources for more information about the public rate hearings and approval of expenditures:

- http://legacy-hhsc.hhsc.state.tx.us/rad/rate-packets.shtml
- http://www.sos.state.tx.us/texreg/index.shtml

■ ■ ■

Claims Filing

The new 2019 HCPCS procedure codes may be billed beginning January 1, 2019, and must be submitted within the initial 95-day filing deadline. Services provided before the rate hearing is completed and expenditures are approved will be denied with an explanation of benefits (EOB) 02008, "This procedure code has been approved as a benefit pending the approval of expenditures. Providers will be notified of the effective dates of service in a future notification if expenditures are approved."

Note: *In the rare instance that expenditures are not approved for a particular procedure code, that procedure code will not be made a benefit effective January 1, 2019.*

Once expenditures are approved, TMHP will automatically reprocess the affected claims. Providers are not required to appeal the claims unless they are denied for other reasons after the claims reprocessing is complete. When the affected claims are reprocessed, providers may receive additional payment, which will be reflected on Remittance and Status (R&S) Reports.

If the effective date of service changes for one or more of the new procedure codes, providers will be notified in a future article. The client cannot be billed for these services.

Important: To avoid fraudulent billing, providers must submit the procedure codes that are most appropriate for the services provided. ■

Code Updates Web Page

Providers are encouraged to refer to the TMHP Code Updates – HCPCS web page at www.tmhp.com/Pages/CodeUpdates/HCPCS_2019.aspx for reimbursement rates, quarterly HCPCS updates, and all other notifications about HCPCS procedure codes. ■

PRIOR AUTHORIZATION CHANGES

Authorization or Prior Authorization

For procedure codes that require authorization or prior authorization but are awaiting a rate hearing and approval of expenditures, providers must follow the established authorization or prior authorization processes as defined in the following:

- Current *Texas Medicaid Provider Procedures Manual*
- Current *Children with Special Health Care Needs (CSHCN) Services Program Provider Manual*
- Articles published on the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com

For services that require prior authorization or authorization, providers must obtain a timely authorization or prior authorization for the services that they provide. Services that are submitted without the proper authorization will be denied.

Important: Authorization or prior authorization is a condition for reimbursement; it is not a guarantee of payment.

Prior Authorization for Discontinued Procedure Codes That Do Not Need to be Updated by the Provider

Providers who have received prior authorization for any of the following 2019 Healthcare Common Procedure Coding System (HCPCS) discontinued procedure codes for dates of service that occur on, after, or encompass January 1, 2019, do not have to update prior authorization requests that were approved on or before December 31, 2018. TMHP will automatically update affected prior authorization requests with the corresponding new procedure code that replaces the discontinued procedure code(s) as follows:

TOS	Discontinued Procedure Code	Direct Replacement Procedure Code
1	C9028	J9229
1	C9032	J3398
1	C9466	J0517
1	C9493	J1301
1	Q2040	Q2042

TOS = Type of service

Important: For managed care clients, providers must contact the client's Texas Medicaid managed care organization (MCO) for direction concerning prior authorization requests.

New authorization requests submitted on or after January 1, 2019, must be submitted with the new procedure codes as applicable.

To submit claims for the procedures indicated in the above table, providers must use the procedure code that was payable at the time the service was rendered, as follows:

- Claims submitted with dates of service on or before December 31, 2018, must be submitted with the previous procedure codes that were payable on or before December 31, 2018, as authorized.
- Claims submitted with dates of service on or after January 1, 2019, must be submitted with the new 2019 HCPCS procedure codes, as applicable. The previously-approved authorizations will be automatically updated to the corresponding new procedure codes.

Prior Authorization for Discontinued Procedure Codes that Require the Provider to Update the Request

Providers who have received prior authorization for any of the following 2019 HCPCS discontinued procedure codes for dates of service that occur on, after, or encompass January 1, 2019, must contact the TMHP Prior Authorization Department to update the procedure codes that are prior authorized for those services:

TOS	Discontinued Procedure Code	Prior Authorization Requirements
2	64550	MCD, CSHCN
4	77058	MCD
I	77058	MCD
T	77058	MCD
4	77059	MCD
I	77059	MCD
T	77059	MCD
5	81211	MCD, CSHCN
5	81214	MCD, CSHCN
1	99090	MCD, CSHCN
W	D5281	CSHCN
W	D9940	CSHCN

TOS = Type of service, CSHCN = Prior authorization required for the CSHCN Services Program, MCD = Prior authorization required for Texas Medicaid.

For procedure codes that require prior authorization or authorization but are awaiting a rate hearing, providers must follow the established prior authorization process as defined in the applicable provider manual. Providers must obtain a timely prior authorization for services provided. Providers must not wait until the rate hearing process is complete to request authorization or prior authorization. In this situation, retroactive prior authorization requests are not granted; the requests are denied as late submissions. Providers are also responsible for meeting the initial 95-day claims filing deadline and for ensuring that the authorization or prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement.

Refer to: The *Texas Medicaid Provider Procedures Manual*, subsection 5.11, "Guidelines for Procedures Awaiting Rate Hearing," for information about HCPCS prior authorizations.

The "TMHP Telephone and Fax Communication" section in the current *Texas Medicaid Provider Procedures Manual, Appendix A: State, Federal, and TMHP Contact Information*, and section 1.1 "TMHP-CSHCN Services Program Contact Information" in the current *CSHCN Services Program Provider Manual*, for a list of Prior Authorization Department telephone numbers. ■

MEDICAID FEE-FOR-SERVICE AND MANAGED CARE PROVIDERS

Texas Medicaid HCPCS Updates

The 2019 Healthcare Common Procedure Coding System (HCPCS) updates including authorization or prior authorization updates for Texas Medicaid are included in the HCPCS tables in the "All Code Changes: Added, Discontinued, Replacement, and Revised" section of this bulletin beginning on page 53. The 2019 HCPCS deletions and replacements are effective January 1, 2019, for dates of service on or after January 1, 2019, for Texas Medicaid.

Refer to: The "General Information" section starting on page 2 in this bulletin for more information.

Authorization and Prior Authorization Update Reminder

Effective January 1, 2019, the 2019 HCPCS discontinued procedure codes are no longer reimbursed by Texas Medicaid. Unless otherwise indicated on page 4 of this bulletin, providers who have received authorization or prior authorization for dates of service that occur on, after, or encompass January 1, 2019, must submit a written request on the appropriate, completed Texas Medicaid prior authorization request form to update the HCPCS procedure codes authorized for those services.

Refer to: The "Prior Authorization Changes" section in this bulletin for information about obtaining authorization or prior authorization.

Texas Medicaid Benefit Changes

The following Texas Medicaid benefit changes have been made to support the 2019 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2019. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Note: *These changes apply to Texas Medicaid fee-for-service and Medicaid managed care claims and authorization requests that are submitted to TMHP for processing.*

The policy articles in this bulletin contain the following information:

- ***Discontinued:*** Discontinued procedure codes are no longer reimbursed after December 31, 2018.
- ***Added:*** Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS).
- ***Limitations:*** Additional benefit and limitation information for the added procedure codes.

Breast Cancer Gene 1 and 2 (BRCA) Testing

Added Procedure Codes				
81163	81164	81165	81166	81167
Discontinued Procedure Codes				
81211	81213	81214		

Limitations for added procedure codes: Procedure codes 81163, 81164, 81165, 81166, and 81167 require prior authorization, and may be reimbursed as follows:

- To independent lab/privately owned lab providers for services rendered in the independent laboratory setting.

BRCA comprehensive and/or BRCA large rearrangement gene mutation analysis testing is a benefit of Texas Medicaid for clients who meet the benchmarks. The prescribing provider is responsible for ordering the specific/appropriate (e.g., BRCA1 vs. BRCA2) BRCA test based on medical necessity of the testing criteria and genetic counseling result.

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

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

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

BRCA gene mutation analysis testing is limited to once per lifetime. Once a BRCA test has a positive result, additional BRCA testing services may be considered on a case-by-case basis with prior authorization and documentation to support medical necessity.

Refer to: The *Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook*, subsection 2.2.6, "Breast Cancer Gene 1 and 2 (BRCA) Testing," for additional information.

Clinician-Administered Drug – Blood Factor Products

Added Procedure Codes		
J7170	J7177	J7203
Discontinued Procedure Codes		
C9468	Q9995	

Limitations for added procedure codes: Procedure code J7170 replaces discontinued procedure code Q9995, and procedure code J7203 replaces discontinued procedure code C9468. Procedure codes J7170, J7177, and J7203 may be reimbursed as follows:

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

Refer to: *The Texas Medicaid Provider Procedures Manual*, *Clinician-Administered Drugs Handbook,* subsection 16, "Blood Factor Products," for additional information.

Clinician-Administered Drug – Burosumab-twza (Crysvita)

Added Procedure Code
J0584

Limitations for added procedure code: Procedure code J0584 requires prior authorization. Burosumab-twza (Crysvita) may be approved for 12 months per prior authorization request.

For initial therapy, the following criteria must be met:

- The client is one year of age or older.
- The client has a diagnosis of X-linked hypophosphatemia (XLH) (diagnosis code E8330 or E8331) that is supported by one of the following:
  - Confirmed phosphate regulating gene with homology to endopeptidases located on the X chromosome (PHEX-gene) mutation.
  - Serum fibroblast growth factor-23 (FGF23) level >30 pg/ml.
- The prescriber discontinues any oral phosphate or active vitamin D analog supplementation at least one week prior to starting burosumab-twza (Crysvita) therapy.
- The prescriber agrees to measure serum phosphate throughout therapy and withhold medication when serum phosphorus is above 5 mg/dl.

For renewal or continuation of therapy, the following criteria must be met:

- The client has previously received treatment with burosumab-twza (Crysvita).
- Documentation from the physician confirms one of the following:
  - The client has achieved a normal level of serum phosphate.

- The client has demonstrated a positive clinical response to burosumab-twza (Crysvita) (e.g., enhanced height velocity, improvement in skeletal deformity, reduction of fractures, reduction of generalized bone pain).
- The physician continues to monitor serum phosphate level.

Burosumab-twza (Crysvita) must be prescribed by a nephrologist or endocrinologist, or in consultation with a nephrologist or endocrinologist.

Burosumab-twza (Crysvita) is not a benefit for the following:

- Clients who currently use oral phosphates and active vitamin D analogs.
- Clients whose serum phosphorus is within or above the normal range for the client's age.
- Clients with severe renal impairment or end stage renal disease.

Clinician-Administered Drug – Hematopoietic Injections

Added Procedure Code
J0887

Limitations for added procedure code: Procedure code J0887 is limited to diagnosis codes D631 and N186, and may be reimbursed as follows:

- To PA, NP, CNS, physician, and nephrology (hemodialysis, renal dialysis) providers for services rendered in the office setting.
- To hospital, nephrology (hemodialysis, renal dialysis), and renal dialysis facility providers for services rendered in the outpatient hospital setting.

Epoetin beta may be considered for reimbursement when the dose is titrated consistent with prevailing, evidence-based, clinical guidelines as published by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative, including appropriate monitoring of the rise and fall of the hemoglobin or hematocrit levels.

Providers must maintain medical records in their offices that document regular monitoring of hemoglobin or hematocrit levels and explain the rationale for the dosing of epoetin beta.

Procedure code J0887 is limited to one injection every 2 calendar weeks, any provider.

Refer to: The *Texas Medicaid Provider Procedures Manual, Clinician-Administered Drugs Handbook*, subsection 24, "Hematopoietic Injections," for additional information.

Clinician-Administered Drug – Ibalizumab-uiyk (Trogarzo)

Added Procedure Code
J1746

Limitations for added procedure code: Procedure code J1746 requires prior authorization. Ibalizumab-uiyk (Trogarzo) may be approved for 12 months per prior authorization request.

For initial therapy, the following criteria must be met:

- The client is 18 years of age or older.
- The client has a documented diagnosis of multi-drug-resistant human immunodeficiency virus (diagnosis code B20) from the prescriber and meets the following criteria:
  - The client has received antiretroviral treatment for at least 6 months and is failing or has recently failed therapy.
  - The client has documented resistance, measured by resistance testing, to at least one antiretroviral (ARV) medication from each of the following 3 classes of ARV:
    - Nucleoside reverse transcriptase inhibitors (NRTI).
    - Non-Nucleoside reverse transcriptase inhibitors (NNRTI)
    - Protease inhibitor (PI)
- The client has documented ribonucleic acid (RNA) viral load greater than 1,000 copies/mL.
- Physician uses Trogarzo concomitantly with another antiretroviral medication to which the client's virus is susceptible.

For renewal or continuation of therapy, the following criteria must be met:

- The client has previously received treatment with ibalizumab.
- Documentation from the physician confirms the client has achieved a clinical viral response defined as one of the following:
  - Decrease in viral load
  - Sustained viral load reduction
- The physician continues ibalizumab therapy with another antiretroviral

Ibalizumab-uiyk (Trogarzo) must be prescribed by a physician, in consultation with an infectious disease physician or a physician who specializes in the treatment of human immunodeficiency virus (HIV) infection.

Trogarzo is not a benefit for clients who fail to demonstrate heavily treated multi-drug resistance.

Clinician-Administered Drug – Inotuzumab ozogamicin (Besponsa)

Added Procedure Code
J9229
Discontinued Procedure Code
C9028

Limitations for added procedure code: Procedure code J9229 replaces discontinued procedure code C9028. Procedure code J9229 is a benefit for clients who are 18 years of age and older with prior authorization, and may be reimbursed as follows:

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

Refer to: The *Texas Medicaid Provider Procedures Manual, Clinician-Administered Drugs Handbook*, subsection 28, "Inotuzumab ozogamicin (Besponsa)," for additional information.

Clinician-Administered Drugs – Mepsevii (Vestronidase alfa-vjbk)

Added Procedure Code
J3397

Limitations for added procedure code: Procedure code J3397 requires prior authorization. Mepsevii (Vestronidase alfa-vjbk) may be approved for 12 months per prior authorization request.

For initial therapy, the following criteria must be met:

- Documentation of clinical signs and symptoms of Mucopolysaccharidosis VII (MPS VII) (e.g. skeletal deformities, enlarged liver and/or spleen, airway obstruction or pulmonary problems, joint limitations, etc.)
- Diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome), diagnosis code E7629, or diagnosis code E763 supported by elevated urine glycosaminoglycans excretion at a minimum of 3-fold over the mean normal for age at screening, and one of the following:
  - Beta-glucuronidase enzyme deficiency in peripheral blood based on leukocytes or cultured fibroblasts
  - Mutation in the glucuronidase beta (GUSB) gene, confirmed by molecular genetic testing

For renewal or continuation of therapy, the following criteria must be met:

- Client has previously received treatment with vestronidase alfa-vjbk without an adverse reaction.
- Documentation from the physician confirms the client has experienced an improvement in clinical response compared to pretreatment baseline (e.g., stability in skeletal deformities, reduction in liver and/or spleen volume, stable or improved pulmonary function, improved endurance and functional capacity, etc.)

Clinician-Administered Drug – Monoclonal Antibodies – Asthma and Chronic Idiopathic Urticaria

Added Procedure Code
J0517
Discontinued Procedure Code
C9466

Limitations for added procedure code: Procedure code J0517 replaces discontinued procedure code C9466. Procedure code J0517 requires prior authorization and may be reimbursed as follows:

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

Procedure code J0517 may be reimbursed for clients who are 12 years of age and older.

Procedure codes J0517, J2182, J2357, and J2786 may not be billed in any combination for the same date of service by any provider.

Refer to: The *Texas Medicaid Provider Procedures Manual, Clinician-Administered Drugs Handbook*, subsection 35, "Monoclonal Antibodies—Asthma and Chronic Idiopathic Urticaria," for additional information about benralizumab.

Clinician-Administered Drug – Voretigene Neparvovec-Rzyl (Luxturna)

Added Procedure Code
J3398
Discontinued Procedure Code
C9032

Limitations for added procedure code: Procedure code J3398 replaces discontinued procedure code C9032. Procedure code J3398 requires prior authorization and may be reimbursed as follows:

- To ophthalmologist and durable medical equipment (DME) pharmacy providers for services rendered in the office and outpatient hospital settings.

Procedure code J3398 may be reimbursed for clients who are 1 through 65 years of age.

Procedure code J3398 is limited to one dose per eye, per lifetime.

Refer to: The *Texas Medicaid Provider Procedures Manual*, *Clinician-Administered Drugs Handbook,* subsection 42, "Voretigene neparvovec-rzyl (Luxturna)," for additional information.

Computed Tomography and Magnetic Resonance Imaging (MRI)

Added Procedure Codes			
77046	77047	77048	77049
Discontinued Procedure Codes			
77058	77059		

Limitations for added procedure codes: Procedure codes 77046, 77047, 77048, and 77049 may be reimbursed as follows:

- The total component may be reimbursed:
  - To physician, radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To hospital, radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the outpatient hospital setting.
- The professional component may be reimbursed:
  - To physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office and outpatient hospital settings.
  - To physician providers for services rendered in the inpatient hospital setting.
- The technical component may be reimbursed:
  - To physician, radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the outpatient hospital setting

Authorization is required for MRI procedures.

Refer to: The *Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook*, subsection 3.2.2, "Computed Tomography and Magnetic Resonance Imaging," for additional information.

Development Screening and Testing and Aphasia Assessment

Added Procedure Codes	
96112	96113
Discontinued Procedure Code	
96111	

Limitations for added procedure codes: Procedure codes 96112 and 96113 are a benefit for clients who are birth through 20 years of age, and may be reimbursed as follows:

- To PA, NP, CNS, physician, and psychologist providers for services rendered in the office, home, and outpatient hospital settings.

Procedure codes 96112 and 96113, which consist of an extended evaluation, require the use of a standardized norm-referenced tool.

Procedure codes 96112 and 96113 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Developmental testing is not a benefit when completed for the purposes of entering day care, Head Start, or a school setting, unless completed during an acute care visit in a clinic setting.

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

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.25.2, "Developmental Testing," for additional information.

Doctor of Dentistry Services as a Limited Physician

Added Procedure Codes									
10004	10005	10006	10007	10008	10009	10010	10011	10012	11102
11103	11104	11105	11106	11107					
Discontinued Procedure Codes									
10022	11100	11101	20005	41500					

Limitations for added procedure codes: Procedure codes 10004, 10006, 10008, 10010, and 10012 may be reimbursed as follows:

- To PA, NP, CNS, physician, and dentist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Procedure codes 10005, 10007, 10009, and 10011 may be reimbursed as follows:

- To PA, NP, CNS, physician, and dentist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.
- To ambulatory surgical center providers for services rendered in the outpatient hospital setting.

Procedure codes 11102, 11104, and 11106 may be reimbursed as follows:

- To PA, NP, CNS, physician, dentist, and podiatrist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.
- To ambulatory surgical center providers for services rendered in the outpatient hospital setting.

Procedure codes 11103, 11105, and 11107 may be reimbursed as follows:

- To PA, NP, CNS, physician, dentist, and podiatrist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.3, "Doctor of Dentistry Practicing as a Limited Physician," for additional information.

Genetic Testing for Colorectal Cancer

Added Procedure Codes	
81233	81237

Limitations for added procedure codes: Procedure codes 81233 and 81237 require prior authorization and may be reimbursed as follows:

- To independent laboratory providers for services rendered in the laboratory setting.

Diagnosis code Z800 is acceptable as a diagnosis for procedure codes 81233 and 81237.

Procedure codes 81233 and 81237 are limited to once per lifetime.

Refer to: The *Texas Medicaid Provider Procedures Manual*, *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.15.3, "Genetic Testing for Colorectal Cancer," for additional information.

Hearing Devices

Added Procedure Codes								
V5171	V5172	V5181	V5211	V5212	V5213	V5214	V5215	V5221
Discontinued Procedure Codes								
V5170	V5180	V5210	V5220					

Limitations for added procedure codes: The above procedure codes are a benefit for clients who are birth through 20 years of age, and may be reimbursed as follows:

- To physician, audiologist, and hearing aid providers for services rendered in the office, home, nursing home (skilled nursing facility, intermediate care facility, or extended care facility), and "other location" settings.

Procedure codes V5171, V5172, and V5181 must be billed with the appropriate modifier LT or RT to be considered for reimbursement.

One hearing aid device per ear may be reimbursed every 5 rolling years from the month it is dispensed.

Refer to: The *Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook*, subsection 2.2.4, "Hearing Aid Devices and Accessories (Nonimplantable)," for additional information.

Inpatient Behavioral Health

Added Procedure Codes					
96130	96131	96132	96133	96136	96137
Discontinued Procedure Codes					
96101	96118				

Limitations for added procedure codes: Procedure codes 96130, 96131, 96132, 96133, 96136, and 96137 may be reimbursed as follows:

- To physician and psychologist providers for services rendered in the inpatient hospital setting.

Procedure codes 96130, 96131, 96132, 96133, 96136, and 96137 are limited to the diagnosis codes listed in Appendix A on page page 56 of this document.

Add-on procedure codes (96131, 96133, and 96137) must be billed in conjunction with the corresponding primary procedure code (96130, 96132, or 96136).

Psychological testing (procedure codes 96130, 96131, 96136, and 96137) and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are limited to a total of 4 hours per day and 8 hours per calendar year, per client, for any provider.

The reimbursement for procedure codes 96130, 96131, 96132, 96133, 96136, and 96137 includes the face-to-face testing and the scoring and interpretation of the results. The number of units in the claim must reflect the time spent face-to-face performing testing with the client plus the time spent scoring and interpreting the results in one hour increments.

Procedure codes 96130, 96131, 96132, 96133, 96136, and 96137 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137) will be denied as part of another service when performed on the same date of service as neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137).

Procedure codes 96130, 96131, 96132, 96133, 96136, and 96137 may be reimbursed on the same date of service as a psychiatric diagnostic evaluation (procedure codes 90791 and 90792).

Refer to: The *Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook*, subsections 4.2.3, "Delegated Services," 4.2.7, "Psychological, Neurobehavioral, and Neuropsychological Testing," 4.3.1, "Services Requiring Prior Authorization," and 4.5, "Twelve Hour System Limitation," for additional information.

Neurostimulators and Neuromuscular Stimulators

Added Procedure Codes				
95836	95976	95977	95983	95984
Discontinued Procedure Codes				
64550	95974	95975	95978	95979

Limitations for added procedure codes: Procedure code 95836 may be reimbursed as follows:

- To physician providers for services rendered in the inpatient hospital and outpatient hospital settings.

Procedure code 95836 may be reported only once for each 30 day period.

Procedure codes 95976, 95977, 95983, and 95984 may be reimbursed as follows:

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

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.44.16, "Electronic Analysis for Neurostimulators," for additional information.

Outpatient Mental Health Services

Added Procedure Codes						
96121	96130	96131	96132	96133	96136	96137
Discontinued Procedure Codes						
96101	96118					

Limitations for added procedure codes: Procedure code 96121 may be reimbursed as follows:

- To physician and psychologist providers for services rendered in the office, home, and nursing home (skilled nursing facility, intermediate care facility, or extended care facility) settings.
- To physician, psychologist, and hospital providers for services rendered in the outpatient hospital setting.

Procedure codes 96130, 96132, 96136, and 96137 may be reimbursed as follows:

- To physician, psychologist, and FQHC providers for services rendered in the office, home, and nursing home (skilled nursing facility, intermediate care facility, or extended care facility) settings.
- To physician, psychologist, FQHC, and hospital providers for services rendered in the outpatient hospital setting.

Procedure code 96131 and 96133 may be reimbursed as follows:

- To physician and psychologist providers for services rendered in the office, home, and nursing home (skilled nursing facility, intermediate care facility, or extended care facility) settings.
- To physician, psychologist, and hospital providers for services rendered in the outpatient hospital setting.

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are limited to the diagnosis codes listed in Appendix A on page page 56 of this document.

Add-on procedure codes (96121, 96131, 96133, and 96137) must be billed in conjunction with the corresponding primary procedure code (96116, 96130, 96132, or 96136).

Psychological testing (procedure codes 96130, 96131, 96136, and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are limited to a total of 4 hours per day and 8 hours per calendar year, per client, for any provider. Additional hours require prior authorization when medically necessary.

The reimbursement for procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 includes the face-to-face testing and the scoring and interpretation of the results. The number of units in the claim must reflect the time spent face-to-face performing testing with the client plus the time spent scoring and interpreting the results in one hour increments.

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137), neurobehavioral testing (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) will not be reimbursed on the same date of service when performed by the same provider.

Procedure codes 96130, 96131, 96132, 96133, 96136, and 96137 may be reimbursed on the same date of service as a psychiatric diagnostic evaluation (procedure codes 90791 and 90792).

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 will be denied as part of another procedure on the same day when billed in addition to procedure code 90870, by any provider.

Refer to: The *Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook*, subsections 4.2.3, "Delegated Services," 4.2.7, "Psychological, Neurobehavioral, and Neuropsychological Testing," 4.3.1, "Services Requiring Prior Authorization," and 4.5, "Twelve Hour System Limitation," and Clinics and Other Outpatient Facility Services Handbook, subsection 4.1.2, "Services, Benefits, Limitations, and Prior Authorization," for additional information.

Pathology and Laboratory Services – Urinalysis/Chemistry

Added Procedure Codes	
82642	83722

Limitations for added procedure codes: Procedure codes 82642 and 83722 may be reimbursed as follows:

- To PA, NP, CNS, physician, certified nurse midwife (CNM), nephrology (hemodialysis, renal dialysis), and renal dialysis facility providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.
- To independent laboratory providers for services rendered in the laboratory setting.

Procedure codes 82642 and 83722 are limited to one per day without a modifier and one per day with a modifier when billed by the same provider.

Refer to: The *Texas Medicaid Provider Procedures Manual*, *Radiology and Laboratory Services Handbook,* subsection 2.2.16, "Urinalysis and Chemistry," for additional information.

Renal Dialysis Services

Added Procedure Code
E0447

Limitations for added procedure code: Procedure code E0447 is considered part of the facility's composite rate, which includes all necessary equipment, supplies, and services for the client receiving dialysis in the home or in a facility.

Refer to: The *Texas Medicaid Provider Procedures Manual, Clinics and Other Outpatient Facility Services Handbook*, subsection 6.2.2, "Renal Dialysis Facilities-Method I Composite Rate," for additional information.

Screening Brief Intervention and Referral to Treatment (SBIRT)

Added Procedure Code	
G2011	
Discontinued Procedure Codes	
96101	96118

Limitations for added procedure code: Procedure code G2011 is a benefit for clients who are 10 years of age and older, and may be reimbursed as follows:

- To PA, NP, CNS, licensed professional counselor, licensed clinical social worker, physician, psychologist, CNM, and medical supplier (DME) providers for services rendered in the office, home, and "other location" settings.

- To PA, NP, CNS, licensed professional counselor, licensed clinical social worker, physician, psychologist, CNM, medical supplier (DME), and hospital providers for services rendered in the outpatient hospital setting.

Procedure code G2011 will be denied if billed for the same date of service as the following procedure codes:

Procedure Codes								
90865	90870	96130	96131	96132	96133	96136	96137	99408

Clients may have a maximum of up to four combined screening and brief intervention sessions per rolling year.

Refer to: The *Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Services Handbook*, subsection 7, "Screening, Brief Intervention, and Referral to Treatment (SBIRT)," for additional information.

Telemonitoring Services

Added Procedure Codes	
99453	99454
Discontinued Procedure Code	
99090	

Limitations for added procedure codes: Procedure codes 99453 and 99454 require prior authorization and may be reimbursed as follows:

- To home health agency providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Note: *When a service is a benefit of both Medicare and Medicaid, the claim must be filed to Medicare first. Providers should not file a claim with Medicaid until Medicare has dispositioned the claim.*

The initial setup and installation (procedure code 99453) of the equipment in the client's home is limited to once per episode of care, even if monitoring parameters are added after initial setup and installation. A claim for a subsequent set up and installation will not be reimbursed unless there is a documented new episode of care or unless the provider submits documentation of extenuating circumstances that require another installation of telemonitoring equipment.

Procedure code 99454 will be limited to once per calendar month for the length of the prior authorization period.

Hospital providers must submit revenue code 780 with procedure code 99453 or 99454.

Refer to: The *Texas Medicaid Provider Procedures Manual, Telecommunication Services Handbook*, subsections 3.4.1, "Facility Services," and 3.5.1, "Prior Authorization of Telemonitoring Services," for additional information.

Vision Services - Nonsurgical

Added Procedure Codes	
92273	92274
Discontinued Procedure Code	
92275	

Limitations for added procedure codes: Procedure codes 92273 and 92274 may be reimbursed as follows:

- The medical component may be reimbursed to PA, NP, CNS, physician, optometrist, and federally qualified health center (FQHC) providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.
- The professional interpretation component may be reimbursed to PA, NP, CNS, physician, and optometrist providers for services rendered in the inpatient and outpatient hospital settings.
- The technical component may be reimbursed to PA, NP, CNS, physician, and optometrist providers for services rendered in the office setting.

Procedure codes S0620 and S0621 will be denied if billed with the same date of service as the medical component of procedure code 92273 or 92274.

Procedure codes 92273 and 92274 may be reimbursed once per day and twice per calendar year by any provider.

Refer to: The *Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook*, subsection 4.3.5.11, "Other Specialized Vision Services," for additional information.

Wound Care Management

Discontinued Procedure Code
Q4131

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.78.1.4, "Dressings and Metabolically Active Skin Equivalents," for additional information. ■

Ambulatory Surgical Center/Hospital Ambulatory Surgical Center

(ASC/HASC) Code Additions
Additions for ambulatory surgical center/hospital ambulatory surgical center (ASC/HASC) facilities are listed in the "All Code Changes: Added, Discontinued, Replacement, and Revised" table located on page 53 of this bulletin.

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

HOME HEALTH AND COMPREHENSIVE CARE PROGRAM (CCP) PROVIDERS

Home Health Services Benefit Changes

The following Texas Medicaid Home Health services benefit changes have been made to support the 2019 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2019. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Respiratory Equipment and Supplies – Home Health

Added Procedure Codes	
E0447	E0467

Limitations for added procedure codes: Procedure codes E0447 and E0467 require prior authorization and may be reimbursed as follows:

- To home health DME and medical supplier (DME) providers for services rendered in the home setting.

Procedure code E0447 is limited to one per calendar month.

Procedure code E0447 is denied if billed in the same month by any provider as procedure code E0424, E0431, E0433, E0434, E0439, E1390, or K0738.

Procedure code E0467 is limited to one rental per calendar month, and is not intended for use as a continuous positive airway pressure (CPAP) or respiratory assist device (RAD); however, a home ventilator may be considered when medically necessary. A home ventilator requested with CPAP or RAD settings must be submitted on the Texas Medicaid Prior Authorization Request for CPAP or RAD (Bi-level PAP) form with a letter of medical necessity explaining why a CPAP or RAD is not medically appropriate for the client.

The following procedure codes are denied if billed in the same month by any provider as procedure code E0467:

Procedure Codes									
A4216	A4217	A4481	A4483	A4605	A4611	A4612	A4613	A4618	A4619
A4624	A4628	A7000	A7002	A7003	A7004	A7005	A7006	A7007	A7012
A7013	A7014	A7015	A7017	A7025	A7026	A7027	A7028	A7029	A7030
A7031	A7032	A7033	A7034	A7035	A7036	A7037	A7038	A7039	A7046
A7525	E0424	E0431	E0433	E0434	E0439	E0441	E0442	E0443	E0444
E0465	E0466	E0470	E0471	E0472	E0482	E0483	E0561	E0562	E0565
E0570	E0585	E0600	E0601	E1372	E1390	K0738			

Refer to: The *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*, subsection 2.2.22.11, "Oxygen Therapy," for additional information. ■

TEXAS HEALTH STEPS DENTAL PROVIDERS

Texas Health Steps Dental Services Benefit Changes

The following Texas Health Steps dental services benefit changes have been made to support the 2019 Healthcare Common Procedure Coding System (HCPCS) and Current Dental Terminology (CDT) updates and are effective for dates of service on or after January 1, 2019. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Texas Health Steps (THSteps) Preventive Dental Services

Added Procedure Codes			
D1516	D1517	D1526	D1527
Discontinued Procedure Codes			
D1515	D1525		

Limitations for added procedure codes: Procedure codes D1516, D1517, D1526, and D1527 may be reimbursed as follows, for clients who are 1 through 20 years of age:

- To federally qualified health center (FQHC), Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office and outpatient hospital settings.
- To Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the inpatient hospital setting.

Space maintainers are limited to one per tooth identification number (TID), per lifetime, per client.

Procedure codes D1516 and D1526 are restricted to TIDs 3, 14, A, B, I, and J.

Procedure codes D1517 and D1527 are restricted to TIDs 19, 30, K, L, S, and T.

Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device.

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook*, subsection 4.2.2.2, "Preventive Services," for additional information.

Texas Health Steps (THSteps) Therapeutic Dental Services

Added Procedure Code	
D9944	
Discontinued Procedure Codes	
D5281	D9940

Limitations for added procedure code: Procedure code D9944 may be reimbursed as follows, for clients who are 16 through 20 years of age:

- To federally qualified health center (FQHC), Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office and outpatient hospital settings.
- To Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the inpatient hospital setting.

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook*, subsection 4.2.21, "Adjunctive General Services," for additional information. ■

STATE FUNDED FAMILY PLANNING PROGRAM (FPP) PROVIDERS

Family Planning Program Services Benefit Changes

The 2019 Healthcare Common Procedure Coding System (HCPCS) updates including added procedure codes for the Family Planning Program are included in the HCPCS tables in the "All Code Changes: Added, Discontinued, Replacement, and Revised" section of this bulletin beginning on page 53. ■

HEALTHY TEXAS WOMEN (HTW) PROGRAM PROVIDERS

Healthy Texas Women Program Services Benefit Changes

The following HTW benefit changes have been made to support the 2019 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2019. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Healthy Texas Women

Added Procedure Codes			
77046	77047	77048	77049
Discontinued Procedure Codes			
10022	77058	77059	

Limitations for added procedure codes: Procedure codes 77046, 77047, 77048, and 77049 may be reimbursed as follows:

- The total component may be reimbursed:
  - To physician, radiation therapy center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To hospital, radiation therapy center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the outpatient hospital setting.
- The professional component may be reimbursed:
  - To physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office and outpatient hospital settings.
- The technical component may be reimbursed:
  - To physician, radiation therapy center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To radiation therapy center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the outpatient hospital setting.

Refer to: The *Texas Medicaid Provider Procedures Manual, Women's Health Services Handbook*, subsection 2.3, "Services, Benefits, Limitations, and Prior Authorization," for additional information. ■

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM PROVIDERS

CSHCN Services Program Updates

The 2019 Healthcare Common Procedure Coding System (HCPCS) updates including authorization and prior authorization updates for the CSHCN Services Program are included in the HCPCS tables in the "All Code Changes: Added, Discontinued, Replacement, and Revised" section of this bulletin beginning on page 53. The 2019 HCPCS deletions and replacements are effective January 1, 2019, for dates of service on or after January 1, 2019, for the CSHCN Services Program. Providers may refer to the "General Information" section for more information.

Important: New and increased benefits that are adopted by Texas Medicaid must complete the rate hearing process to receive comments on new and increased Texas Medicaid reimbursement rates. The CSHCN Services Program reviews the adopted Texas Medicaid rates to determine whether the rates are fiscally feasible for the CSHCN Services Program.

The new procedure codes that are designated with asterisks (*) in the "CSHCN Allowable" columns of the table located on page 53 of this bulletin must complete the rate hearing process, and expenditures must be approved by the CSHCN Services Program before the rates are adopted. Providers will be notified in a future banner message or web article if a new procedure code will not be reimbursed because the expenditures were not approved.

Authorization and Prior Authorization Update Reminder

Effective January 1, 2019, the 2019 HCPCS discontinued procedure codes are no longer reimbursed by the CSHCN Services Program. Unless otherwise indicated on page 4 of this bulletin, providers who have received authorizations or prior authorizations for dates of service that occur on, after, or encompass January 1, 2019, must submit a written request on the appropriate, completed CSHCN Services Program authorization or prior authorization request form to update the HCPCS procedure codes authorized for those services.

Refer to: The "Prior Authorization Changes," section in this bulletin, for information about obtaining authorization or prior authorization.

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

CSHCN Services Program Benefit Changes

The following CSHCN Services Program benefit changes have been made to support the 2019 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2019. For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

The policy articles below contain the following information:

- ***Discontinued:*** Discontinued procedure codes are no longer reimbursed after December 31, 2018.
- ***Added:*** Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS).
- ***Limitations:*** Additional benefit and limitation information for the added procedure codes.

Note: *For the purposes of this section for CSHCN Services Program benefit changes, "advanced practice registered nurse (APRN)" includes nurse practitioner (NP) and clinical nurse specialist (CNS) providers only.*

Behavioral Health Services

Added Procedure Codes						
96121	96130	96131	96132	96133	96136	96137
Discontinued Procedure Codes						
96101	96118					

Limitations for added procedure codes: Procedure code 96121 may be reimbursed as follows:

- To physician and psychologist providers for services rendered in the office and home settings.
- To physician, psychologist, and hospital providers for services rendered in the inpatient hospital and outpatient hospital settings.

Procedure codes 96130, 96132, and 96136 may be reimbursed as follows:

- To physician, psychologist, and federally qualified health center (FQHC) providers for services rendered in the office and home settings.
- To physician and psychologist providers for services rendered in the inpatient hospital setting.
- To physician, psychologist, FQHC, and hospital providers for services rendered in the outpatient hospital setting.

Procedure code 96131, 96133, and 96137 may be reimbursed as follows:

- To physician and psychologist providers for services rendered in the office, home, and inpatient hospital settings.

- To physician, psychologist, and hospital providers for services rendered in the outpatient hospital setting.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137), neurobehavioral status exams (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) are limited to a total of four hours per day and eight hours per calendar year, per client, for any provider.

Testing procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 count toward the 30 per calendar year limitation.

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Psychological testing (procedure codes 96130, 96131, 96136, and 96137), neurobehavioral testing (procedure codes 96116 and 96121), and neuropsychological testing (procedure codes 96132, 96133, 96136, and 96137) will not be reimbursed on the same date of service when performed by the same provider.

Procedure codes 96130, 96131, 96132, 96133, 96136, and 96137 may be reimbursed on the same date of service as a psychiatric diagnostic evaluation (procedure codes 90791 and 90792).

Refer to: The *CSHCN Services Program Provider Manual*, subsections 19.2.4, "Behavioral Health Services," 24.4.1.2, "Hospital-Based Outpatient Behavioral Health Services," 29.2, "Benefits, Limitations, and Authorization Requirements," and 31.2.34, "Psychological Testing" for additional information.

Dental - Preventive Services

Added Procedure Codes			
D1516	D1517	D1526	D1527
Discontinued Procedure Codes			
D1515	D1525		

Limitations for added procedure codes: Procedure codes D1516, D1517, D1526, and D1527 may be reimbursed as follows, for clients who are 1 year of age and older:

- To dentist and FQHC providers for services rendered in the office and outpatient hospital settings.
- To dentist providers for services rendered in the inpatient hospital setting.

Space maintainers are limited to one per tooth identification number (TID), per lifetime, per client.

Procedure codes D1516 and D1526 are restricted to TIDs 3, 14, A, B, I, and J.

Procedure codes D1517 and D1527 are restricted to TIDs 19, 30, K, L, S, and T.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 14.2.5.5, "Space Maintainers," for additional information.

Dental – Therapeutic Services

Added Procedure Code	
D9944	
Discontinued Procedure Codes	
D5281	D9940

Limitations for added procedure code: Procedure code D9944 requires prior authorization and may be reimbursed to dentist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 14.2.6.9, "Adjunctive General Services," for additional information.

Doctor of Dentistry Services as a Limited Physician

Added Procedure Codes					
11102	11103	11104	11105	11106	11107
Discontinued Procedure Codes					
11100	11101	20005	41500		

Limitations for added procedure codes: Procedure codes 11102, 11104, and 11106 may be reimbursed as follows:

- To physician, dentist, and podiatrist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.
- To ambulatory surgical center providers for services rendered in the outpatient hospital setting.

Procedure codes 11103 and 11105 may be reimbursed as follows:

- To physician, dentist, and podiatrist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Procedure code 11107 may be reimbursed as follows:

- To physician assistant (PA), APRN, physician, dentist, and podiatrist providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 14.2.8, "Doctor of Dentistry Services as a Limited Physician," for additional information.

Genetic Testing for Colorectal Cancer

Added Procedure Code
81233

Limitations for added procedure code: Procedure code 81233 requires prior authorization and may be reimbursed as follows:

- To independent laboratory providers for services rendered in the laboratory setting.

Procedure code 81233 is limited to once per lifetime.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 25.2.5.3, "Genetic Testing for Colorectal Cancer," for additional information.

Genetic Testing for Hereditary Breast and Ovarian Cancers

Added Procedure Codes				
81163	81164	81165	81166	81167
Discontinued Procedure Codes				
81211	81213	81214		

Limitations for added procedure codes: Procedure codes 81163, 81164, 81165, 81166, and 81167 are a benefit for clients who are 18 years of age and older with prior authorization, and may be reimbursed as follows:

- To independent lab and privately owned lab providers for services rendered in the independent laboratory setting.

Genetic testing for hereditary breast and ovarian cancers is limited to once per lifetime.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 25.2.5.4, "Genetic Testing for Hereditary Breast and Ovarian Cancers," for additional information.

Hearing Services

Added Procedure Codes								
V5171	V5172	V5181	V5211	V5212	V5213	V5214	V5215	V5221
Discontinued Procedure Codes								
V5170	V5180	V5210	V5220					

Limitations for added procedure codes: The above procedure codes may be reimbursed as follows:

- To physician, audiologist, and hearing aid providers for services rendered in the office, home, and "other location" settings.

Procedure codes V5171, V5172, and V5181 must be billed with the appropriate modifier, LT or RT, to be considered for reimbursement.

Hearing aid devices may be reimbursed once every five rolling years.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 20.2.4, "Hearing Aid Devices and Accessories," for additional information.

Medications – Blood Factor Products

Added Procedure Codes	
J7170	J7203
Discontinued Procedure Codes	
C9468	Q9995

Limitations for added procedure codes: Procedure code J7170 replaces discontinued procedure code Q9995, and may be reimbursed as follows:

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

Procedure code J7170 is limited to the following diagnosis codes: D66, D67, D680, D682, and D689.

Procedure code J7203 replaces discontinued procedure code C9468. Procedure code J7203 is limited to diagnosis code D67, and may be reimbursed as follows:

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

Refer to: The *CSHCN Services Program Provider Manual,* subsection 31.2.9, "Blood Factor Products," for additional information.

Neurostimulators and Neuromuscular Stimulators

Added Procedure Codes				
95836	95976	95977	95983	95984
Discontinued Procedure Codes				
64550	95974	95975	95978	95979

Limitations for added procedure codes: Procedure code 95836 may be reimbursed as follows:

- To physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Procedure code 95836 may be reported only once for each 30 day period.

Procedure codes 95976, 95977, 95983, and 95984 may be reimbursed as follows:

- To physician providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Refer to: The CSHCN Services Program Provider Manual, subsection 27.2.9, "Electronic Analysis for Implantable Neurostimulators," for additional information.

Pathology and Laboratory Services – Urinalysis/Chemistry

Added Procedure Codes	
82642	83722

Limitations for added procedure codes: Procedure codes 82642 and 83722 may be reimbursed as follows:

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

Refer to: The *CSHCN Services Program Provider Manual*, subsection 25.2.14, "Urinalysis and Chemistry," for additional information.

Preventive Care Medical Checkups and Developmental Testing

Added Procedure Codes	
96112	96113
Discontinued Procedure Code	
96111	

Limitations for added procedure codes: Procedure codes 96112 and 96113 are a benefit for clients who are birth through 20 years of age, and may be reimbursed as follows:

- To PA, APRN, physician, and psychologist providers for services rendered in the office, home, and outpatient hospital settings.

Procedure codes 96112 and 96113, which consist of an extended evaluation, require the use of a standardized tool. Procedure codes 96112 and 96113 are also a benefit when performed outside of a preventive care medical checkup.

Procedure codes 96112 and 96113 are included in the system limitation of 12 hours of behavioral health services per day, per provider.

Refer to: The CSHCN Services Program Provider Manual, subsection 31.2.18.9.6, "Developmental Testing," for additional information.

Radiology – Magnetic Resonance Imaging (MRI)

Added Procedure Codes			
77046	77047	77048	77049
Discontinued Procedure Codes			
77058	77059		

Limitations for added procedure codes: Procedure codes 77046, 77047, 77048, and 77049 may be reimbursed as follows:

- The professional component may be reimbursed to physician providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.
- The technical component may be reimbursed to physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.

The total component of procedure codes 77046 and 77048 may be reimbursed as follows:

- To physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
- To hospital, radiation treatment center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the outpatient hospital setting.

The total component of procedure codes 77047 and 77049 may be reimbursed as follows:

- To physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Authorization is not required for up to four MRI procedures per rolling year.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 16.2.7, "Magnetic Resonance Imaging (MRI)," for additional information.

Renal Dialysis Services

Added Procedure Code
E0447

Limitations for added procedure code: Procedure code E0447 is considered part of the facility's composite rate, which includes all necessary equipment, supplies, and services for the client receiving dialysis where in the home or in a facility.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 35.3.1, "In-Facility Services and Method I Home Dialysis Services," for additional information.

Respiratory Services

Added Procedure Codes	
E0447	E0467

Limitations for added procedure codes: Procedure codes E0447 and E0467 require prior authorization and may be reimbursed as follows:

- To home health DME and medical supplier (DME) providers for services rendered in the home setting.

Procedure code E0447 is limited to one per calendar month, and may be prior authorized for clients who own their own oxygen systems.

Procedure code E0467 is limited to one rental per calendar month, and may be prior authorized for a rental of an initial period of three months for clients who require assisted mechanical ventilation. Following the initial rental period of three months, additional requests may be considered for six month intervals at a time with prior authorization, documentation of medical necessity, and documentation of client compliance and effectiveness. A new prior authorization form must be submitted for each request.

Refer to: The CSHCN Services Program Provider Manual, subsections 36.2.6, "Oxygen Therapy," and 36.2.12, "Home Ventilators (any type) with or without Invasive Interface," for additional information.

Telemonitoring Services

Added Procedure Codes	
99453	99454
Discontinued Procedure Code	
99090	

Limitations for added procedure codes: Procedure codes 99453 and 99454 require prior authorization and may be reimbursed as follows:

- To home health agency providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

The initial setup and installation (procedure code 99453) of the equipment in the client's home is limited to once per episode of care, even if monitoring parameters are added after initial setup and installation. A claim for a subsequent set up and installation will not be reimbursed unless there is a documented new episode of care.

Procedure code 99454 will be limited to once per calendar month for the length of the prior authorization period.

Hospital providers must submit revenue code 780 with procedure code 99453 or 99454.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 38.2.4, "Telemonitoring Services," for additional information.

Vision Services Nonsurgical

Added Procedure Codes	
92273	92274
Discontinued Procedure Code	
92275	

Limitations for added procedure codes: Procedure codes 92273 and 92274 may be reimbursed as follows:

- The medical component may be reimbursed to physician, optometrist, and FQHC providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.
- The professional component may be reimbursed to PA, APRN, physician, and optometrist providers for services rendered in the inpatient and outpatient hospital settings.
- The technical component may be reimbursed to PA, APRN, physician, and optometrist providers for services rendered in the office setting.

Procedure codes S0620 and S0621 are denied if billed with the same date of service as the medical component of procedure code 92273 or 92274.

Procedure codes 92273 and 92274 may be reimbursed once per day and twice per calendar year by any provider.

Refer to: The *CSHCN Services Program Provider Manual*, subsection 40.2.3.7, "Ocular Viewing and Diagnostic Testing Procedures," for additional information.

Wound Care Management Services

Discontinued Procedure Code
Q4131

Refer to: The *CSHCN Services Program Provider Manual*, subsection 31.2.42.2.1, "Metabolically Active Skin Equivalents/Skin Substitutes," for additional information. ■

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

2019 HCPCS Procedure Code Additions

The following is a list of new Healthcare Common Procedure Coding System (HCPCS) procedure codes:

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
2	10004	*	*	NC	NC		MCD
2	10005	*	*	NC	NC		MCD
F	10005	*	*	NC	NC		MCD
2	10006	*	*	NC	NC		MCD
2	10007	*	*	NC	NC		MCD
F	10007	*	*	NC	NC		MCD
2	10008	*	*	NC	NC		MCD
2	10009	*	*	NC	NC		MCD
F	10009	*	*	NC	NC		MCD
2	10010	*	*	NC	NC		MCD
2	10011	*	*	NC	NC		MCD
F	10011	*	*	NC	NC		MCD
2	10012	*	*	NC	NC		MCD
2	11102	*	*	NC	NC		MCD, CSHCN
F	11102	*	*	NC	NC		MCD, CSHCN
2	11103	*	*	NC	NC		MCD, CSHCN

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
2	11104	*	*	NC	NC		MCD, CSHCN
F	11104	*	*	NC	NC		MCD, CSHCN
2	11105	*	*	NC	NC		MCD, CSHCN
2	11106	*	*	NC	NC		MCD, CSHCN
F	11106	*	*	NC	NC		MCD, CSHCN
2	11107	*	*	NC	NC		MCD, CSHCN
2	20932	*	*	NC	NC		
8	20932	*	*	NC	NC		
8	20932	*	*	NC	NC		
2	20933	*	*	NC	NC		
8	20933	*	*	NC	NC		
8	20933	*	*	NC	NC		
2	20934	*	*	NC	NC		
2	27369	*	*	NC	NC		
2	33274	NC	NC	NC	NC		
F	33274	NC	NC	NC	NC		
2	33275	NC	NC	NC	NC		
F	33275	NC	NC	NC	NC		
2	33285	*	*	NC	NC		
F	33285	*	*	NC	NC		
2	33286	*	*	NC	NC		
F	33286	*	*	NC	NC		
2	33289	NC	NC	NC	NC		
2	33440	*	*	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
8	33440	*	*	NC	NC		
8	33440	*	*	NC	NC		
2	33866	*	*	NC	NC		
2	36572	*	*	NC	NC		
F	36572	*	*	NC	NC		
2	36573	*	*	NC	NC		
F	36573	*	*	NC	NC		
2	38531	*	*	NC	NC		
2	43762	*	*	NC	NC		
F	43762	*	*	NC	NC		
2	43763	*	*	NC	NC		
F	43763	*	*	NC	NC		
2	50436	*	*	NC	NC		
F	50436	*	*	NC	NC		
2	50437	*	*	NC	NC		
F	50437	*	*	NC	NC		
2	53854	*	*	NC	NC		
F	53854	*	*	NC	NC		
4	76391	*	*	NC	NC		
I	76391	*	*	NC	NC		
T	76391	*	*	NC	NC		
4	76978	*	*	NC	NC		
I	76978	*	*	NC	NC		
T	76978	*	*	NC	NC		
4	76979	*	*	NC	NC		
I	76979	*	*	NC	NC		
T	76979	*	*	NC	NC		
4	76981	*	*	NC	NC		
I	76981	*	*	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
T	76981	*	*	NC	NC		
4	76982	*	*	NC	NC		
I	76982	*	*	NC	NC		
T	76982	*	*	NC	NC		
4	76983	*	*	NC	NC		
I	76983	*	*	NC	NC		
T	76983	*	*	NC	NC		
4	77046	*	*	*	*		MCD, CSHCN, HTW
I	77046	*	*	*	*		MCD, CSHCN, HTW
T	77046	*	*	*	*		MCD, CSHCN, HTW
4	77047	*	*	*	*		MCD, CSHCN, HTW
I	77047	*	*	*	*		MCD, CSHCN, HTW
T	77047	*	*	*	*		MCD, CSHCN, HTW
4	77048	*	*	*	*		MCD, CSHCN, HTW
I	77048	*	*	*	*		MCD, CSHCN, HTW

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
T	77048	*	*	*	*		MCD, CSHCN, HTW
4	77049	*	*	*	*		MCD, CSHCN, HTW
I	77049	*	*	*	*		MCD, CSHCN, HTW
T	77049	*	*	*	*		MCD, CSHCN, HTW
5	81163	*	*	NC	NC	MCD, CSHCN	MCD
5	81164	*	*	NC	NC	MCD, CSHCN	MCD
5	81165	*	*	NC	NC	MCD, CSHCN	MCD
5	81166	*	*	NC	NC	MCD, CSHCN	MCD
5	81167	*	*	NC	NC	MCD, CSHCN	MCD
5	81171	NC	NC	NC	NC		
5	81172	NC	NC	NC	NC		
5	81173	NC	NC	NC	NC		
5	81174	NC	NC	NC	NC		
5	81177	NC	NC	NC	NC		
5	81178	NC	NC	NC	NC		
5	81179	NC	NC	NC	NC		
5	81180	NC	NC	NC	NC		
5	81181	NC	NC	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
5	81182	NC	NC	NC	NC		
5	81183	NC	NC	NC	NC		
5	81184	NC	NC	NC	NC		
5	81185	NC	NC	NC	NC		
5	81186	NC	NC	NC	NC		
5	81187	NC	NC	NC	NC		
5	81188	NC	NC	NC	NC		
5	81189	NC	NC	NC	NC		
5	81190	NC	NC	NC	NC		
5	81204	NC	NC	NC	NC		
5	81233	*	*	NC	NC	MCD, CSHCN	MCD, CSHCN
5	81234	NC	NC	NC	NC		
5	81236	NC	NC	NC	NC		
5	81237	*	NC	NC	NC	MCD	MCD
5	81239	NC	NC	NC	NC		
5	81271	NC	NC	NC	NC		
5	81274	NC	NC	NC	NC		
5	81284	NC	NC	NC	NC		
5	81285	NC	NC	NC	NC		
5	81286	NC	NC	NC	NC		
5	81289	NC	NC	NC	NC		
5	81305	NC	NC	NC	NC		
5	81306	NC	NC	NC	NC		
5	81312	NC	NC	NC	NC		
5	81320	NC	NC	NC	NC		
5	81329	NC	NC	NC	NC		
5	81333	NC	NC	NC	NC		
5	81336	NC	NC	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
5	81337	NC	NC	NC	NC		
5	81343	NC	NC	NC	NC		
5	81344	NC	NC	NC	NC		
5	81345	NC	NC	NC	NC		
5	81443	NC	NC	NC	NC		
5	81518	NC	NC	NC	NC		
5	81596	NC	NC	NC	NC		
5	82642	*	*	NC	NC		MCD, CSHCN
5	83722	*	*	NC	NC		MCD, CSHCN
1	90689	NC	NC	NC	NC		
S	90689	NC	NC	NC	NC		
1	92273	*	*	NC	NC		MCD, CSHCN
I	92273	*	*	NC	NC		MCD, CSHCN
T	92273	*	*	NC	NC		MCD, CSHCN
1	92274	*	*	NC	NC		MCD, CSHCN
I	92274	*	*	NC	NC		MCD, CSHCN
T	92274	*	*	NC	NC		MCD, CSHCN
5	93264	NC	NC	NC	NC		
5	95836	*	*	NC	NC		MCD, CSHCN
5	95976	*	*	NC	NC		MCD, CSHCN

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
5	95977	*	*	NC	NC		MCD, CSHCN
5	95983	*	*	NC	NC		MCD, CSHCN
5	95984	*	*	NC	NC		MCD, CSHCN
1	96112	*	*	NC	NC		MCD, CSHCN
1	96113	*	*	NC	NC		MCD, CSHCN
1	96121	*	*	NC	NC		MCD, CSHCN
1	96130	*	*	NC	NC		MCD, CSHCN
1	96131	*	*	NC	NC		MCD, CSHCN
1	96132	*	*	NC	NC		MCD, CSHCN
1	96133	*	*	NC	NC		MCD, CSHCN
1	96136	*	*	NC	NC		MCD, CSHCN
1	96137	*	*	NC	NC		MCD, CSHCN
1	96138	NC	NC	NC	NC		
1	96139	NC	NC	NC	NC		
1	96146	NC	NC	NC	NC		
1	97151	Info	Info	Info	Info		
1	97152	Info	Info	Info	Info		
1	97153	Info	Info	Info	Info		
1	97154	Info	Info	Info	Info		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
1	97155	Info	Info	Info	Info		
1	97156	Info	Info	Info	Info		
1	97157	Info	Info	Info	Info		
1	97158	Info	Info	Info	Info		
1	99451	NC	NC	NC	NC		
1	99452	Info	Info	Info	Info		
1	99453	*	*	NC	NC	MCD, CSHCN	MCD, CSHCN
1	99454	*	*	NC	NC	MCD, CSHCN	MCD, CSHCN
1	99457	NC	NC	NC	NC		
1	99491	NC	NC	NC	NC		
9	A4563	NC	NC	NC	NC		
9	A5514	NC	NC	NC	NC		
9	A6460	NC	NC	NC	NC		
9	A6461	NC	NC	NC	NC		
9	A9513	NC	NC	NC	NC		
9	A9589	*	NC	NC	NC		
9	B4105	NC	NC	NC	NC		
J	C1823	NC	NC	NC	NC		
4	C8937	NC	NC	NC	NC		
1	C9035	*	NC	NC	NC		
1	C9036	*	NC	NC	NC	MCD	
1	C9037	NC	NC	NC	NC		
1	C9038	NC	NC	NC	NC		
1	C9039	*	*	NC	NC		
9	C9407	*	NC	NC	NC		
9	C9408	NC	NC	NC	NC		
2	C9751	*	*	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
2	C9752	*	*	NC	NC		
2	C9753	*	*	NC	NC		
2	C9754	*	*	NC	NC		
2	C9755	*	*	NC	NC		
W	D0412	NC	NC	NC	NC		
W	D1516	*	*	NC	NC		MCD, CSHCN
W	D1517	*	*	NC	NC		MCD, CSHCN
W	D1526	*	*	NC	NC		MCD, CSHCN
W	D1527	*	*	NC	NC		MCD, CSHCN
W	D5282	NC	NC	NC	NC		
W	D5283	NC	NC	NC	NC		
W	D5876	NC	NC	NC	NC		
W	D9130	NC	NC	NC	NC		
W	D9613	NC	NC	NC	NC		
W	D9944	*	*	NC	NC	CSHCN	MCD, CSHCN
W	D9945	NC	NC	NC	NC		
W	D9946	NC	NC	NC	NC		
W	D9961	NC	NC	NC	NC		
W	D9990	NC	NC	NC	NC		
9	E0447	*	*	NC	NC	MCD, CSHCN	MCD, CSHCN
L	E0467	*	*	NC	NC	MCD, CSHCN	MCD, CSHCN
1	G0068	Info	Info	Info	Info		
1	G0069	Info	Info	Info	Info		

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1	G0070	Info	Info	Info	Info		
1	G0071	Info	Info	Info	Info		
1	G0076	Info	Info	Info	Info		
1	G0077	Info	Info	Info	Info		
1	G0078	Info	Info	Info	Info		
1	G0079	Info	Info	Info	Info		
1	G0080	Info	Info	Info	Info		
1	G0081	Info	Info	Info	Info		
1	G0082	Info	Info	Info	Info		
1	G0083	Info	Info	Info	Info		
1	G0084	Info	Info	Info	Info		
1	G0085	Info	Info	Info	Info		
1	G0086	Info	Info	Info	Info		
1	G0087	Info	Info	Info	Info		
1	G2000	Info	NC	Info	Info		
1	G2010	NC	NC	NC	NC		
1	G2011	*	NC	NC	NC		MCD
1	G2012	NC	NC	NC	NC		
1	G9978	Info	Info	Info	Info		
1	G9979	Info	Info	Info	Info		
1	G9980	Info	Info	Info	Info		
1	G9981	Info	Info	Info	Info		
1	G9982	Info	Info	Info	Info		
1	G9983	Info	Info	Info	Info		
1	G9984	Info	Info	Info	Info		
1	G9985	Info	Info	Info	Info		
1	G9986	Info	Info	Info	Info		
1	G9987	Info	Info	Info	Info		
1	J0185	*	*	NC	NC		

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1	J0517	*	*	NC	NC	MCD, CSHCN	MCD
1	J0567	*	*	NC	NC		
1	J0584	*	NC	NC	NC	MCD	MCD
1	J0599	*	*	NC	NC		
1	J0841	NC	NC	NC	NC		
1	J0887	*	*	NC	NC		MCD
1	J1095	NC	NC	NC	NC		
1	J1301	*	NC	NC	NC	MCD	
1	J1454	*	NC	NC	NC		
1	J1628	*	*	NC	NC		
1	J1746	*	NC	NC	NC	MCD	MCD
1	J2062	*	NC	NC	NC		
1	J2186	*	*	NC	NC		
1	J2787	NC	NC	NC	NC		
1	J2797	NC	NC	NC	NC		
1	J3245	NC	NC	NC	NC		
1	J3304	*	*	NC	NC		
1	J3316	*	*	NC	NC		
1	J3397	*	NC	NC	NC	MCD	MCD
1	J3398	*	NC	NC	NC	MCD	MCD
1	J3591	NC	NC	NC	NC		
1	J7170	*	*	NC	NC		MCD, CSHCN
1	J7177	*	*	NC	NC		MCD
1	J7203	*	*	NC	NC		MCD, CSHCN
1	J7318	*	*	NC	NC		
1	J7329	*	*	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
1	J9044	*	*	NC	NC		
1	J9057	*	NC	NC	NC		
1	J9153	*	*	NC	NC		
1	J9173	*	*	NC	NC		
1	J9229	*	*	NC	NC	MCD, CSHCN	MCD
1	J9311	*	*	NC	NC		
1	J9312	*	*	NC	NC		
9	L8608	NC	NC	NC	NC		
9	L8698	NC	NC	NC	NC		
J	L8701	NC	NC	NC	NC		
L	L8701	NC	NC	NC	NC		
J	L8702	NC	NC	NC	NC		
L	L8702	NC	NC	NC	NC		
1	M1000	Info	Info	Info	Info		
1	M1001	Info	Info	Info	Info		
1	M1002	Info	Info	Info	Info		
1	M1003	Info	Info	Info	Info		
1	M1004	Info	Info	Info	Info		
1	M1005	Info	Info	Info	Info		
1	M1006	Info	Info	Info	Info		
1	M1007	Info	Info	Info	Info		
1	M1008	Info	Info	Info	Info		
1	M1009	Info	Info	Info	Info		
1	M1010	Info	Info	Info	Info		
1	M1011	Info	Info	Info	Info		
1	M1012	Info	Info	Info	Info		
1	M1013	Info	Info	Info	Info		
1	M1014	Info	Info	Info	Info		

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

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

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
1	M1015	Info	Info	Info	Info		
1	M1016	Info	Info	Info	Info		
1	M1017	Info	Info	Info	Info		
1	M1018	Info	Info	Info	Info		
1	M1019	Info	Info	Info	Info		
1	M1020	Info	Info	Info	Info		
1	M1021	Info	Info	Info	Info		
1	M1022	Info	Info	Info	Info		
1	M1023	Info	Info	Info	Info		
1	M1024	Info	Info	Info	Info		
1	M1025	Info	Info	Info	Info		
1	M1026	Info	Info	Info	Info		
1	M1027	Info	Info	Info	Info		
1	M1028	Info	Info	Info	Info		
1	M1029	Info	Info	Info	Info		
1	M1030	Info	Info	Info	Info		
1	M1031	Info	Info	Info	Info		
1	M1032	Info	Info	Info	Info		
1	M1033	Info	Info	Info	Info		
1	M1034	Info	Info	Info	Info		
1	M1035	Info	Info	Info	Info		
1	M1036	Info	Info	Info	Info		
1	M1037	Info	Info	Info	Info		
1	M1038	Info	Info	Info	Info		
1	M1039	Info	Info	Info	Info		
1	M1040	Info	Info	Info	Info		
1	M1041	Info	Info	Info	Info		
1	M1042	Info	Info	Info	Info		
1	M1043	Info	Info	Info	Info		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
1	M1044	Info	Info	Info	Info		
1	M1045	Info	Info	Info	Info		
1	M1046	Info	Info	Info	Info		
1	M1047	Info	Info	Info	Info		
1	M1048	Info	Info	Info	Info		
1	M1049	Info	Info	Info	Info		
1	M1050	Info	Info	Info	Info		
1	M1051	Info	Info	Info	Info		
1	M1052	Info	Info	Info	Info		
1	M1053	Info	Info	Info	Info		
1	M1054	Info	Info	Info	Info		
1	M1055	Info	Info	Info	Info		
1	M1056	Info	Info	Info	Info		
1	M1057	Info	Info	Info	Info		
1	M1058	Info	Info	Info	Info		
1	M1059	Info	Info	Info	Info		
1	M1060	Info	Info	Info	Info		
1	M1061	Info	Info	Info	Info		
1	M1062	Info	Info	Info	Info		
1	M1063	Info	Info	Info	Info		
1	M1064	Info	Info	NC	NC		
S	M1064	Info	Info	NC	NC		
1	M1065	Info	Info	NC	NC		
S	M1065	Info	Info	NC	NC		
1	M1066	Info	Info	NC	NC		
S	M1066	Info	Info	NC	NC		
1	M1067	Info	Info	Info	Info		
1	M1068	Info	Info	Info	Info		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
1	M1069	Info	Info	Info	Info		
1	M1070	Info	Info	Info	Info		
1	M1071	Info	Info	Info	Info		
1	Q2042	*	NC	NC	NC	MCD	
9	Q4183	NC	NC	NC	NC		
9	Q4184	NC	NC	NC	NC		
9	Q4185	NC	NC	NC	NC		
9	Q4186	NC	NC	NC	NC		
9	Q4187	NC	NC	NC	NC		
9	Q4188	NC	NC	NC	NC		
9	Q4189	NC	NC	NC	NC		
9	Q4190	NC	NC	NC	NC		
9	Q4191	NC	NC	NC	NC		
9	Q4192	NC	NC	NC	NC		
9	Q4193	NC	NC	NC	NC		
9	Q4194	NC	NC	NC	NC		
9	Q4195	NC	NC	NC	NC		
9	Q4196	NC	NC	NC	NC		
9	Q4197	NC	NC	NC	NC		
9	Q4198	NC	NC	NC	NC		
9	Q4200	NC	NC	NC	NC		
9	Q4201	NC	NC	NC	NC		
9	Q4202	NC	NC	NC	NC		
9	Q4203	NC	NC	NC	NC		
9	Q4204	NC	NC	NC	NC		
1	Q5107	NC	NC	NC	NC		
1	Q5108	*	*	NC	NC		
1	Q5109	NC	NC	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	FPP Allowable	Auth Req	Benefit Changes
1	Q5110	*	*	NC	NC		
1	Q5111	NC	NC	NC	NC		
9	T4545	NC	NC	NC	NC		
R	V5171	*	*	NC	NC		MCD, CSHCN
R	V5172	*	*	NC	NC		MCD, CSHCN
R	V5181	*	*	NC	NC		MCD, CSHCN
R	V5211	*	*	NC	NC		MCD, CSHCN
R	V5212	*	*	NC	NC		MCD, CSHCN
R	V5213	*	*	NC	NC		MCD, CSHCN
R	V5214	*	*	NC	NC		MCD, CSHCN
R	V5215	*	*	NC	NC		MCD, CSHCN
R	V5221	*	*	NC	NC		MCD, CSHCN

TOS=type of service, Auth Req=Authorization Requirements

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

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

Note: *All new, revised, and discontinued 2019 HCPCS procedure codes are effective for dates of service on or after January 1, 2019. The new procedure codes that are indicated with an asterisk (*) in the above table are pending a rate hearing and approval of expenditures. Providers will be notified in a future notification if a new procedure code is not approved for reimbursement. Providers can refer to the section in this bulletin titled "Rate Hearings and Expenditure Review" for more information about benefits that are pending approval of expenditures.*

The following new procedure codes are used for reporting purposes and are informational only:

Medical Procedure Codes									
0521T	0522T	0528T	0529T	0533T	0534T	0535T	0536T		
Surgical Procedure Codes									
0510T	0511T	0514T	0515T	0516T	0517T	0518T	0519T	0520T	0525T
0526T	0527T	0530T	0531T	0532T					
Radiological Procedure Codes									
0505T	0506T	0507T	0508T	0509T	0512T	0513T	0523T	0524T	0541T
0542T									
Laboratory Procedure Codes									
0012M	0013M	0024U	0025U	0026U	0027U	0028U	0029U	0030U	0031U
0032U	0033U	0034U	0035U	0036U	0037U	0038U	0039U	0040U	0041U
0042U	0043U	0044U	0045U	0046U	0047U	0048U	0049U	0050U	0051U
0052U	0053U	0054U	0055U	0056U	0057U	0058U	0059U	0060U	0061U
0062U	0063U	0064U	0065U	0066U	0067U	0068U	0069U	0070U	0071U
0072U	0073U	0074U	0075U	0076U	0077U	0078U	0079U	0537T	0538T
0539T	0540T								

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

Discontinued Procedure Codes

The 2019 HCPCS discontinued procedure codes are no longer reimbursed after December 31, 2018. The following is a list of procedure codes that have been discontinued:

Procedure Codes									
10022	11100	11101	20005	27370	31595	33282	33284	41500	43760
46762	50395	61332	61480	61610	61612	63615	64508	64550	66220
76001	77058	77059	78270	78271	78272	81211	81213	81214	92275
95974	95975	95978	95979	96101	96102	96103	96111	96118	96119
96120	99090	C8904	C8907	C9014	C9015	C9016	C9024	C9028	C9029
C9030	C9031	C9032	C9033	C9275	C9463	C9464	C9465	C9466	C9467
C9468	C9469	C9492	C9493	C9497	C9741	C9744	C9748	C9750	D1515
D1525	D5281	D9940	G9534	G9535	G9536	G9538	G9686	J0833	J9310
K0903	Q2040	Q4131	Q4172	Q5102	Q9993	Q9994	Q9995	V5170	V5180
V5210	V5220								

The following informational reporting procedure codes have been discontinued:

Procedure Codes									
0001M	0020U	0028U	0159T	0188T	0189T	0190T	0195T	0196T	0337T
0346T	0359T	0360T	0361T	0363T	0364T	0365T	0366T	0367T	0368T
0369T	0370T	0371T	0372T	0374T	0387T	0388T	0389T	0390T	0391T
0406T	0407T								

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413. ■

Replacement Procedure Codes

Effective for dates of service on or after January 1, 2019, the following discontinued procedure codes will be replaced by the corresponding replacement procedure codes:

Replacement Codes	Discontinued Codes	Medicaid Rate	CSHCN Rate
0525T	C9750	Info	Info
33289	C9741	NC	NC
53854	C9748	0-20 yrs: $493.70 21-999 yrs: $470.19	0-20 yrs: $493.70 21-999 yrs: $470.19
76978	C9744	*	*
76979	C9744	*	*
77046	C8904	*	*
77047	C8907	*	*
A9513	C9031	NC	NC
A9589	C9275	$816.20	NC
B4105	Q9994	NC	NC
C8937	0159T	NC	NC
J0185	C9463	$4.26	**
J0517	C9466	$170.13	$170.13
J0567	C9014	$91.80	**
J0599	C9015	$9.59	$10.10
J1301	C9493	$18.46	NC
J1454	C9033	$547.74	NC
J1628	C9029	$103.62	$104.01
J2062	C9497	*	NC
J2797	C9464	NC	NC
J3304	Q9993	$19.13	$19.13

* = Texas Medicaid rate hearing required, **CSHCN rate review required, NC = Procedure code not a benefit, Info = Procedure code is informational only

Replacement Codes	Discontinued Codes	Medicaid Rate	CSHCN Rate
J3316	C9016	$2,720.00	$2,864.00
J3398	C9032	$2,833.33	NC
J7170	Q9995	$44.28	**
J7203	C9468	$4.30	**
J7318	C9465	$994.50	$994.50
J9057	C9030	$4,510.80	NC
J9153	C9024	$211.36	$211.36
J9173	C9492	$84.12	$83.49
J9229	C9028	$1,870.00	$1,870.00
J9311	C9467	$46.38	$46.38
Q2042	Q2040	$475,000.00	NC

* = Texas Medicaid rate hearing required, **CSHCN rate review required, NC = Procedure code not a benefit, Info = Procedure code is informational only

Procedure Code Description Changes

Providers may refer to the following Centers for Medicare & Medicaid Services (CMS) web page to identify procedure code description changes that are effective for dates of service on or after January 1, 2019:
https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

Providers must contact the appropriate copyright holder to obtain procedure code descriptions.

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413. ■

Modifiers

The following table lists new, revised, and discontinued modifiers:

New Modifiers			
CO	CQ	ER	G0
Revised Modifier			
96			

New modifiers are effective for dates of service on or after January 1, 2019. Providers may contact the appropriate copyright holder to obtain modifier descriptions. ■

APPENDIX A

Diagnosis Codes For Procedure Codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137

Procedure codes 96121, 96130, 96131, 96132, 96133, 96136, and 96137 are limited to the following diagnosis codes:

Diagnosis Codes						
A8100	A8101	A8109	A8181	A8183	B1001	B1009
B451	D8681	E7500	E7501	E7502	E7509	E7510
E7511	E7519	E7523	E7525	E7526	E7529	E754
F0150	F0151	F0280	F0281	F0390	F0391	F04
F05	F060	F061	F062	F0630	F0631	F0632
F0633	F0634	F064	F068	F070	F0781	F0789
F09	F1010	F1011	F10120	F10121	F10129	F1014
F10150	F10151	F10159	F10180	F10181	F10182	F10188
F1019	F1020	F1021	F10220	F10221	F10229	F10230
F10231	F10232	F10239	F1024	F10250	F10251	F10259
F1026	F1027	F10280	F10281	F10282	F10288	F1029
F10920	F10921	F10929	F1094	F10950	F10951	F10959
F1096	F1097	F10980	F10981	F10982	F10988	F1099
F1110	F1111	F11120	F11121	F11122	F11129	F1114
F11150	F11151	F11159	F11181	F11182	F11188	F1119
F1120	F1121	F11220	F11221	F11222	F11229	F1123
F1124	F11250	F11251	F11259	F11281	F11282	F11288
F1129	F11920	F11921	F11922	F11929	F1193	F1194
F11950	F11951	F11959	F11981	F11982	F11988	F1199
F1210	F1211	F12120	F12121	F12122	F12129	F12150
F12151	F12159	F12180	F12188	F1219	F1220	F1221
F12220	F12221	F12222	F12229	F1223	F12250	F12251
F12259	F12280	F12288	F1229	F1290	F12920	F12921
F12922	F12929	F1293	F12950	F12951	F12959	F12980
F12988	F1299	F1310	F1311	F13120	F13121	F13129
F1314	F13150	F13151	F13159	F13180	F13181	F13182
F13188	F1320	F1321	F13220	F13221	F13229	F13230
F13231	F13232	F13239	F1324	F13250	F13251	F13259
F1326	F1327	F13280	F13281	F13282	F13288	F13920
F13921	F13929	F13930	F13931	F13932	F13939	F1394

Diagnosis Codes						
F13950	F13951	F13959	F1396	F1397	F13980	F13981
F13982	F13988	F1399	F1410	F1411	F14120	F14121
F14122	F14129	F1414	F14150	F14151	F14159	F14180
F14181	F14182	F14188	F1419	F1420	F1421	F14220
F14221	F14222	F14229	F1423	F1424	F14250	F14251
F14259	F14280	F14281	F14282	F14288	F1429	F14920
F14921	F14922	F14929	F1494	F14950	F14951	F14959
F14980	F14981	F14982	F14988	F1499	F1510	F1511
F15120	F15121	F15122	F15129	F1514	F15150	F15151
F15159	F15180	F15181	F15182	F15188	F1519	F1520
F1521	F15220	F15221	F15222	F15229	F1523	F1524
F15250	F15251	F15259	F15280	F15281	F15282	F15288
F1529	F15920	F15921	F15922	F15929	F1593	F1594
F15950	F15951	F15959	F15980	F15981	F15982	F15988
F1599	F1610	F1611	F16120	F16121	F16122	F16129
F1614	F16150	F16151	F16159	F16180	F16183	F16188
F1619	F1620	F1621	F16220	F16221	F16229	F1624
F16250	F16251	F16259	F16280	F16283	F16288	F1629
F16920	F16921	F16929	F1694	F16950	F16951	F16959
F16980	F16983	F16988	F1699	F1810	F1811	F18120
F18121	F18129	F1814	F18150	F18151	F18159	F1817
F18180	F18188	F1819	F1820	F1821	F18220	F18221
F18229	F1824	F18250	F18251	F18259	F1827	F18280
F18288	F1829	F1890	F18920	F18921	F18929	F1894
F18950	F18951	F18959	F1897	F18980	F18988	F1899
F1910	F1911	F19120	F19121	F19122	F19129	F1914
F19150	F19151	F19159	F1916	F1917	F19180	F19181
F19182	F19188	F1919	F1920	F1921	F19220	F19221
F19222	F19229	F19230	F19231	F19232	F19239	F1924
F19250	F19251	F19259	F1926	F1927	F19280	F19281
F19282	F19288	F1929	F19920	F19921	F19922	F19929
F19930	F19931	F19932	F19939	F1994	F19950	F19951
F19959	F1996	F1997	F19980	F19981	F19982	F19988
F1999	F200	F201	F202	F203	F205	F2081
F2089	F209	F21	F22	F23	F24	F250
F251	F258	F259	F28	F29	F3010	F3011
F3012	F3013	F302	F303	F304	F308	F309
F310	F3110	F3111	F3112	F3113	F312	F3130

Diagnosis Codes						
F3131	F3132	F314	F315	F3160	F3161	F3162
F3163	F3164	F3170	F3171	F3172	F3173	F3174
F3175	F3176	F3177	F3178	F3181	F3189	F319
F320	F321	F322	F323	F324	F325	F3281
F3289	F329	F330	F331	F332	F333	F3341
F3342	F338	F339	F340	F341	F3481	F3489
F349	F39	F4001	F4002	F4010	F4011	F40210
F40218	F40220	F40228	F40230	F40231	F40232	F40233
F40240	F40241	F40242	F40243	F40248	F40290	F40291
F40298	F408	F409	F410	F411	F413	F418
F419	F422	F423	F424	F428	F429	F430
F4310	F4311	F4312	F4320	F4321	F4322	F4323
F4324	F4325	F4329	F438	F439	F440	F441
F442	F444	F445	F446	F447	F4481	F4489
F449	F450	F451	F4520	F4521	F4522	F4529
F4541	F4542	F458	F459	F481	F482	F488
F489	F5000	F5001	F5002	F502	F5081	F5082
F5089	F509	F5101	F5102	F5103	F5104	F5105
F5109	F5111	F5112	F5113	F5119	F513	F514
F515	F518	F519	F520	F521	F5221	F5222
F5231	F5232	F524	F525	F526	F528	F529
F530	F531	F54	F550	F551	F552	F553
F554	F558	F600	F601	F602	F603	F604
F605	F606	F607	F6081	F6089	F609	F630
F631	F632	F633	F6381	F6389	F639	F640
F641	F642	F648	F649	F650	F651	F652
F653	F654	F6551	F6552	F6581	F6589	F659
F66	F6810	F6811	F6812	F6813	F688	F68A
F69	F70	F71	F72	F73	F78	F79
F800	F801	F802	F804	F8082	F8089	F809
F810	F812	F8181	F819	F82	F840	F842
F843	F845	F848	F849	F88	F89	F900
F901	F902	F908	F909	F910	F911	F912
F913	F918	F919	F930	F938	F939	F940
F941	F942	F948	F949	F950	F951	F952
F958	F959	F980	F981	F9821	F9829	F983
F984	F985	F988	F989	G000	G001	G002
G003	G008	G009	G01	G02	G030	G031

Diagnosis Codes						
G032	G038	G039	G0400	G0401	G0402	G042
G0430	G0431	G0432	G0439	G0481	G0489	G0490
G0491	G053	G054	G060	G061	G062	G07
G210	G300	G301	G308	G309	G3101	G3109
G311	G312	G3181	G3182	G3183	G3184	G3185
G3189	G319	G3289	G35	G40001	G40009	G40011
G40019	G40101	G40109	G40111	G40119	G40201	G40209
G40211	G40219	G40301	G40309	G40311	G40319	G40501
G40509	G40801	G40802	G40803	G40804	G40811	G40812
G40813	G40814	G40821	G40822	G40823	G40824	G4089
G40901	G40909	G40911	G40919	G40A01	G40A09	G40A11
G40A19	G40B01	G40B09	G40B11	G40B19	G44209	G450
G451	G452	G454	G458	G459	G468	G4720
G4721	G4722	G4723	G4724	G4725	G4726	G4727
G4729	G910	G911	G912	G92	G930	G931
G9340	G9341	G9349	G937	G9381	G9389	G939
G94	H93291	H93292	H93293	H93A1	H93A2	H93A3
H93A9	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	I6300
I63011	I63012	I63013	I63019	I6302	I63031	I63032
I63033	I63039	I6309	I6310	I63111	I63112	I63113
I63119	I6312	I63131	I63132	I63133	I63139	I6319
I6320	I63211	I63212	I63213	I63219	I6322	I63231
I63232	I63233	I63239	I6329	I6330	I63311	I63312
I63313	I63319	I63321	I63322	I63323	I63329	I63331
I63332	I63333	I63339	I63341	I63342	I63343	I63349
I6339	I6340	I63411	I63412	I63413	I63419	I63421
I63422	I63423	I63429	I63431	I63432	I63433	I63439
I63441	I63442	I63443	I63449	I6349	I6350	I63511
I63512	I63513	I63519	I63521	I63522	I63523	I63529
I63531	I63532	I63533	I63539	I63541	I63542	I63543
I63549	I6359	I6381	I6389	I6501	I6502	I6503
I6509	I651	I6521	I6522	I6523	I6529	I658
I659	I6601	I6602	I6603	I6609	I6611	I6612
I6613	I6619	I6621	I6622	I6623	I6629	I663

Diagnosis Codes						
I668	I669	I671	I672	I674	I675	I676
I677	I6781	I6782	I67850	I67858	I6789	I679
I680	I682	I688	I6900	I69010	I69011	I69012
I69013	I69014	I69015	I69018	I69019	I69020	I69021
I69022	I69023	I69028	I69031	I69032	I69033	I69034
I69039	I69041	I69042	I69043	I69044	I69049	I69051
I69052	I69053	I69054	I69059	I69061	I69062	I69063
I69064	I69065	I69069	I69090	I69091	I69092	I69093
I69098	I6910	I69110	I69111	I69112	I69113	I69114
I69115	I69118	I69119	I69120	I69121	I69122	I69123
I69128	I69131	I69132	I69133	I69134	I69139	I69141
I69142	I69143	I69144	I69149	I69151	I69152	I69153
I69154	I69159	I69161	I69162	I69163	I69164	I69165
I69169	I69190	I69191	I69192	I69193	I69198	I6920
I69210	I69211	I69212	I69213	I69214	I69215	I69218
I69219	I69220	I69221	I69222	I69223	I69228	I69231
I69232	I69233	I69234	I69239	I69241	I69242	I69243
I69244	I69249	I69251	I69252	I69253	I69254	I69259
I69261	I69262	I69263	I69264	I69265	I69269	I69290
I69291	I69292	I69293	I69298	I6930	I69310	I69311
I69312	I69313	I69314	I69315	I69318	I69319	I69320
I69321	I69322	I69323	I69328	I69331	I69332	I69333
I69334	I69339	I69341	I69342	I69343	I69344	I69349
I69351	I69352	I69353	I69354	I69359	I69361	I69362
I69363	I69364	I69365	I69369	I69390	I69391	I69392
I69393	I69398	I6980	I69810	I69811	I69812	I69813
I69814	I69815	I69818	I69819	I69820	I69821	I69822
I69823	I69828	I69831	I69832	I69833	I69834	I69839
I69841	I69842	I69843	I69844	I69849	I69851	I69852
I69853	I69854	I69859	I69861	I69862	I69863	I69864
I69865	I69869	I69890	I69891	I69892	I69893	I69898
I6990	I69910	I69911	I69912	I69913	I69914	I69915
I69918	I69919	I69920	I69921	I69922	I69923	I69928
I69931	I69932	I69933	I69934	I69939	I69941	I69942
I69943	I69944	I69949	I69951	I69952	I69953	I69954
I69959	I69961	I69962	I69963	I69964	I69965	I69969
I69990	I69991	I69992	I69993	I69998	O906	P102
P103	P520	P521	P5221	P5222	P523	P525

Diagnosis Codes						
P84	P90	P9160	P9161	P9162	P9163	R0901
R0902	R413	R41840	R41841	R41842	R41843	R41844
R4189	R450	R453	R454	R457	R45850	R45851
R4586	R4587	R4589	R5600	R5601	R569	S060X0A
S060X0D	S060X0S	S060X1A	S060X1D	S060X1S	S060X9A	S060X9D
S060X9S	S06306A	S06306D	S06306S	S06310A	S06310D	S06310S
S06311A	S06311D	S06311S	S06312A	S06312D	S06312S	S06313A
S06313D	S06313S	S06314A	S06314D	S06314S	S06315A	S06315D
S06315S	S06316A	S06316D	S06316S	S06319A	S06319D	S06319S
S06320A	S06320D	S06320S	S06321A	S06321D	S06321S	S06322A
S06322D	S06322S	S06323A	S06323D	S06323S	S06324A	S06324D
S06324S	S06325A	S06325D	S06325S	S06326A	S06326D	S06326S
S06329A	S06329D	S06329S	S06330A	S06330D	S06330S	S06331A
S06331D	S06331S	S06332A	S06332D	S06332S	S06333A	S06333D
S06333S	S06334A	S06334D	S06334S	S06335A	S06335D	S06335S
S06336A	S06336D	S06336S	S06339A	S06339D	S06339S	S06340A
S06340D	S06340S	S06341A	S06341D	S06341S	S06342A	S06342D
S06342S	S06343A	S06343D	S06343S	S06344A	S06344D	S06344S
S06345A	S06345D	S06345S	S06346A	S06346D	S06346S	S06349A
S06349D	S06349S	S06350A	S06350D	S06350S	S06351A	S06351D
S06351S	S06352A	S06352D	S06352S	S06353A	S06353D	S06353S
S06354A	S06354D	S06354S	S06355A	S06355D	S06355S	S06356A
S06356D	S06356S	S06359A	S06359D	S06359S	S06360A	S06360D
S06360S	S06361A	S06361D	S06361S	S06362A	S06362D	S06362S
S06363A	S06363D	S06363S	S06364A	S06364D	S06364S	S06365A
S06365D	S06365S	S06366A	S06366D	S06366S	S06369A	S06369D
S06369S	S06370A	S06370D	S06370S	S06371A	S06371D	S06371S
S06372A	S06372D	S06372S	S06373A	S06373D	S06373S	S06374A
S06374D	S06374S	S06375A	S06375D	S06375S	S06376A	S06376D
S06376S	S06379A	S06379D	S06379S	S06380A	S06380D	S06380S
S06381A	S06381D	S06381S	S06382A	S06382D	S06382S	S06383A
S06383D	S06383S	S06384A	S06384D	S06384S	S06385A	S06385D
S06385S	S06386A	S06386D	S06386S	S06389A	S06389D	S06389S
S064X0A	S064X0D	S064X0S	S064X1A	S064X1D	S064X1S	S064X2A
S064X2D	S064X2S	S064X3A	S064X3D	S064X3S	S064X4A	S064X4D
S064X4S	S064X5A	S064X5D	S064X5S	S064X6A	S064X6D	S064X6S
S064X9A	S064X9D	S064X9S	S065X0A	S065X0D	S065X0S	S065X1A
S065X1D	S065X1S	S065X2A	S065X2D	S065X2S	S065X3A	S065X3D

Diagnosis Codes						
S065X3S	S065X4A	S065X4D	S065X4S	S065X5A	S065X5D	S065X5S
S065X6A	S065X6D	S065X6S	S065X7A	S065X8A	S065X9A	S065X9D
S065X9S	S066X0A	S066X0D	S066X0S	S066X1A	S066X1D	S066X1S
S066X2A	S066X2D	S066X2S	S066X3A	S066X3D	S066X3S	S066X4A
S066X4D	S066X4S	S066X5A	S066X5D	S066X5S	S066X6A	S066X6D
S066X6S	S066X9A	S066X9D	S066X9S	S06890A	S06890D	S06890S
S06891A	S06891D	S06891S	S06892A	S06892D	S06892S	S06893A
S06893D	S06893S	S06894A	S06894D	S06894S	S06895A	S06895D
S06895S	S06896A	S06896D	S06896S	S06897A	S06899A	S06899D
S06899S	S069X0A	S069X0D	S069X0S	S069X1A	S069X1D	S069X1S
S069X2A	S069X2D	S069X2S	S069X3A	S069X3D	S069X3S	S069X4A
S069X4D	S069X4S	S069X5A	S069X5D	S069X5S	S069X6A	S069X6D
S069X6S	S069X9A	S069X9D	S069X9S	T5801XA	T5801XD	T5801XS
T5802XA	T5802XD	T5802XS	T5803XA	T5803XD	T5803XS	T5804XA
T5804XD	T5804XS	T5811XA	T5811XD	T5811XS	T5812XA	T5812XD
T5812XS	T5813XA	T5813XD	T5813XS	T5814XA	T5814XD	T5814XS
T582X1A	T582X1D	T582X1S	T582X2A	T582X2D	T582X2S	T582X3A
T582X3D	T582X3S	T582X4A	T582X4D	T582X4S	T588X1A	T588X1D
T588X1S	T588X2A	T588X2D	T588X2S	T588X3A	T588X3D	T588X3S
T588X4A	T588X4D	T588X4S	T5891XA	T5891XD	T5891XS	T5892XA
T5892XD	T5892XS	T5893XA	T5893XD	T5893XS	T5894XA	T5894XD
T5894XS	T71111A	T71111D	T71111S	T71112A	T71112D	T71112S
T71113A	T71113D	T71113S	T71114A	T71114D	T71114S	T71121A
T71121D	T71121S	T71122A	T71122D	T71122S	T71123A	T71123D
T71123S	T71124A	T71124D	T71124S	T71131A	T71131D	T71131S
T71132A	T71132D	T71132S	T71133A	T71133D	T71133S	T71134A
T71134D	T71134S	T71141A	T71141D	T71141S	T71143A	T71143D
T71143S	T71144A	T71144D	T71144S	T71151A	T71151D	T71151S
T71152A	T71152D	T71152S	T71153A	T71153D	T71153S	T71154A
T71154D	T71154S	T71161A	T71161D	T71161S	T71162A	T71162D
T71162S	T71163A	T71163D	T71163S	T71164A	T71164D	T71164S
T71191A	T71191D	T71191S	T71192A	T71192D	T71192S	T71193A
T71193D	T71193S	T71194A	T71194D	T71194S	T7120XA	T7120XD
T7120XS	T7121XA	T7121XD	T7121XS	T71221A	T71221D	T71221S
T71222A	T71222D	T71222S	T71223A	T71223D	T71223S	T71224A
T71224D	T71224S	T71231A	T71231D	T71231S	T71232A	T71232D
T71232S	T71233A	T71233D	T71233S	T71234A	T71234D	T71234S
T7129XA	T7129XD	T7129XS	T719XXA	T719XXD	T719XXS	T7401XA

Diagnosis Codes						
T7401XD	T7401XS	T7402XA	T7402XD	T7402XS	T7411XA	T7411XD
T7411XS	T7412XA	T7412XD	T7412XS	T7421XA	T7421XD	T7421XS
T7422XA	T7422XD	T7422XS	T7431XA	T7431XD	T7431XS	T7432XA
T7432XD	T7432XS	T7451XA	T7451XD	T7451XS	T7452XA	T7452XD
T7452XS	T7461XA	T7461XD	T7461XS	T7462XA	T7462XD	T7462XS
T751XXA	T751XXD	T751XXS	T7601XA	T7601XD	T7601XS	T7602XA
T7602XD	T7602XS	T7611XA	T7611XD	T7611XS	T7612XA	T7612XD
T7612XS	T7621XA	T7621XD	T7621XS	T7622XA	T7622XD	T7622XS
T7631XA	T7631XD	T7631XS	T7632XA	T7632XD	T7632XS	T7651XA
T7651XD	T7651XS	T7652XA	T7652XD	T7652XS	T7661XA	T7661XD
T7661XS	T7662XA	T7662XD	T7662XS	Z608	Z634	Z644
Z658	Z72810	Z72811	Z736	Z73810	Z73811	Z73812
Z73819	Z781	Z818	Z8651	Z8659	Z87820	Z87890
Z9183						