HEALTHCARE COMMON PROCEDURE CODING SYSTEM

HCPCS SPECIAL BULLETIN

2021 EDITION

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Contents

2021 HCPCS Implementation

On January 1, 2021, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2021 annual Healthcare Common Procedure Coding System (HCPCS) updates that are effective for dates of service on or after January 1, 2021.

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 2021 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.

Note: *Additions for ambulatory surgical center/hospital ambulatory surgical center (ASC/HASC) facilities are listed in the "2021 HCPCS Procedure Code Additions" table located on page 30 of this 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 2021 HCPCS procedure codes are effective for dates of service on or after January 1, 2021. The new procedure codes that are designated with "Requires rate hearing" or "Requires rate review" in the "Medicaid Allowable" and the "CSHCN Allowable" columns of the "2021 HCPCS Procedure Code Additions" table located on page 30 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 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:

rad.hhs.texas.gov/rate-packets

sos.state.tx.us/texreg/index.shtml

Claims Filing

The new 2021 HCPCS procedure codes may be billed beginning January 1, 2021, 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, 2021.*

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 Rate and Code Updates web page at **tmhp.com/resources/rate-and-code-updates** for reimbursement rates, quarterly HCPCS updates, and all other articles about HCPCS procedure codes. ■

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 **tmhp.com**

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

For services that require prior authorization or authorization, providers must obtain a timely authorization or prior authorization for the services 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 the following 2021 Healthcare Common Procedure Coding System (HCPCS) discontinued procedure code for dates of service that occur on, after, or encompass January 1, 2021, do not have to update prior authorization requests that were approved on or before December 31, 2020. TMHP will automatically update affected prior authorization requests with the corresponding new procedure code that replaces the discontinued procedure code as follows:

Type of Service	Discontinued Procedure Code	Direct Replacement Procedure Code
2	C9749	30468

New authorization requests submitted on or after January 1, 2021, 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, 2020, must be submitted with the previous procedure codes that were payable on or before December 31, 2020, as authorized.

- Claims submitted with dates of service on or after January 1, 2021, must be submitted with the new 2021 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 2021 HCPCS discontinued procedure codes for dates of service that occur on, after, or encompass January 1, 2021, must contact the TMHP Prior Authorization Department to update the procedure codes that are prior authorized for those services:

Type of Service	Discontinued Procedure Code	Prior Authorization Requirements
2	19324	CSHCN
F	19324	CSHCN
2	19366	CSHCN
8	19366	CSHCN
2	61870	Medicaid and CSHCN
8	61870	Medicaid and CSHCN

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 1.1.1 "CSHCN Services Program Telephone and Fax Communication" in the current CSHCN Services Program Provider Manual, for Prior Authorization Department telephone numbers. ■

Texas Medicaid HCPCS Updates

The 2021 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 30. The 2021 HCPCS deletions and replacements are effective January 1, 2021, for dates of service on or after January 1, 2021, for Texas Medicaid.

Refer to: The "General Information" section starting on page 3 in this bulletin for more information.

Authorization and Prior Authorization Update Reminder

Effective January 1, 2021, the 2021 HCPCS discontinued procedure codes are no longer reimbursed by Texas Medicaid. Unless otherwise indicated in the "Prior Authorization for Discontinued Procedure Codes That Do Not Need to be Updated by the Provider" section on page 5 of this bulletin, providers who have received authorization or prior authorization for dates of service that occur on, after, or encompass January 1, 2021, 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 2021 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2021. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **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, 2020.
- 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.

Allergy Testing

Discontinued Procedure Code									
95071									

Refer to: *The Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.5.2, "Allergy Testing" for additional information.

Clinician-Administered Drug – Antisense Oligonucleotides

Added Procedure Code									
C9071									

Limitations for added procedure code

Procedure code C9071 requires prior authorization and may be reimbursed as follows:

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

Additional criteria will be published in a future article.

Clinician-Administered Drug – Chimeric Antigen Receptor (CAR) T-Cell Therapy

Added Procedure Code									
C9073									

Limitations for added procedure code

Procedure code C9073 requires prior authorization and may be reimbursed as follows:

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

Procedure code C9073 may be reimbursed for clients who are 18 years of age and older.

Brexucabtagene autoleucel (Tecartus) (procedure code C9073) must be prescribed by an oncologist or in consultation with an oncologist, and treatment must take place at a certified healthcare facility.

Additional criteria will be published in a future article.

Refer to: *The Texas Medicaid Provider Procedures Manual, Outpatient Drug Services Handbook*, subsection 7.17, "Chimeric Antigen Receptor (CAR) T-Cell Therapy" for additional information.

Clinician-Administered Drug – Esketamine (Spravato)

Added Procedure Code									
S0013									

Limitations for added procedure code

Procedure code S0013 requires prior authorization and 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 durable medical equipment (DME) pharmacy providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Procedure code S0013 may be reimbursed for clients who are 18 years of age and older.

Unlisted procedure code J3490 will no longer be used to submit claims for esketamine (Spravato).

Refer to: *The Texas Medicaid Provider Procedures Manual, Outpatient Drug Services Handbook,* subsection 7.28, "Esketamine (Spravato)" for additional information.

Clinician-Administered Drug – Inebilizumab-cdon (Uplizna)

Added Procedure Code									
J1823									

Limitations for added procedure code

Procedure code J1823 requires prior authorization and may be reimbursed for clients who are 18 years of age and older 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.

Additional criteria will be published in a future article.

Clinician-Administered Drug – Injections-Immune Globulins

Added Procedure Code									
C9072									

Limitations for added procedure code

Procedure code C9072 may be reimbursed as follows:

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

Refer to: *The Texas Medicaid Provider Procedures Manual, Outpatient Drug Services Handbook,* subsection 7.39, "Immune Globulin" for additional information.

Computed Tomography and Magnetic Resonance Imaging

Added Procedure Code									
71271									

Limitations for added procedure code

Procedure code 71271 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.
  - To physician providers for services rendered in the inpatient hospital setting.
- 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.

Authorization is required for computed tomography 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.

Diagnostic and Therapeutic Breast Procedures

Discontinued Procedure Codes									
19324	19366								

Refer to: *The Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.42.3, "Breast Reconstruction" for additional information.

Evoked Response Tests and Neuromuscular Procedures

Added Procedure Codes									
92650	92651	92652	92653						

Discontinued Procedure Codes									
92585	92586								

Limitations for added procedure codes

Procedure codes 92650 and 92651 may be reimbursed as follows:

- To physician, audiologist, 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 codes 92652 and 92653 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.

Procedure codes 92650, 92651, 92652, and 92653 are each limited to once per date of service, any provider.

Evoked potential tests may be reimbursed up to four services per rolling year, any combination of services by any provider.

Refer to: *The Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.27.3, "Evoked Potential Testing" for additional information.

Gynecological and Reproductive Health Services

Discontinued Procedure Codes									
58293	99201								

Refer to: *The Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook, subsection 2.2.1, "Family Planning Annual Exams," and* subsection 6.13, "Hysterectomy Services," for additional information.

Neurostimulators and Neuromuscular Stimulators

Discontinued Procedure Code									
61870									

Refer to: *The Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.43.9, "Intracranial Neurostimulators" for additional information.

Obstetric Services

Discontinued Procedure Code									
99201									

Refer to: *The Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook,* subsection 4.1.14, "Antenatal and Postnatal Care Visits" for additional information.

Otology and Audiometry Services

Added Procedure Codes									
92650	92651	92652	92653						

Discontinued Procedure Codes									
92585	92586								

Limitations for added procedure codes

Procedure codes 92650 and 92651 may be reimbursed as follows:

- To physician, audiologist, 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 codes 92652 and 92653 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.

Procedure codes 92650, 92651, 92652, and 92653 are benefits for clients of any age when performed to identify and diagnose hearing loss and for newborns when performed for the purpose of a newborn hearing screening.

Procedure codes 92650, 92651, 92652, and 92653 may be reimbursed once per day, same provider, same client, assuming testing is done in both ears. For testing performed only in one ear, providers must use modifier 52.

Refer to: *The Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook,* subsection 2.2.3, "Audiology and Audiometry Evaluation and Diagnostic Services" for additional information.

Pathology and Laboratory Services – Drug Testing and Therapeutic Drug Assays

Added Procedure Codes									
80143	80151	80161	80167	80179	80181	80189	80193	80204	80210

Limitations for added procedure codes

Procedure codes 80143, 80151, 80161, 80167, 80179, 80181, 80189, 80193, 80204, and 80210 may be reimbursed as follows:

- To physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), physician, and certified nurse midwife (CNM) 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 Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook,* subsection 2.2.8, "Drug Testing and Therapeutic Drug Assays" for additional information.

Pathology and Laboratory Services – Urinalysis/Chemistry

Added Procedure Codes									
82077	82681								

Limitations for added procedure codes

Procedure codes 82077 and 82681 may be reimbursed as follows:

- To PA, NP, CNS, physician, 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.

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

Physician Evaluation and Management Services

Added Procedure Code									
99417									

Discontinued Procedure Code									
99201									

Limitations for added procedure code

Procedure code 99417 may be reimbursed as follows:

- To PA, NP, CNS, physician, dentist, CNM, registered nurse (RN), and family planning clinic providers for services rendered in the office setting.
- To PA, NP, CNS, physician, dentist, CNM, and RN providers for services rendered in the outpatient hospital setting.

Procedure code 99417 is only used when an office or other outpatient evaluation and management service has been selected using time alone as the basis, and the minimum time required to report the highest level (procedure code 99205 or 99215) has been exceeded by 15 minutes.

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

Refer to: *The Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook Handbook*, subsection 9.2.56.5, "Prolonged Physician Services" for additional information.

Pulmonary Function Studies

Added Procedure Code									
94619									

Discontinued Procedure Codes									
94250	94400								

Limitations for added procedure code

Procedure code 94619 may be reimbursed as follows:

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

Refer to: *The Texas Medicaid Provider Procedures Manual, Inpatient and Outpatient Hospital Services Handbook,* subsection 4.2.20.3, "Pulmonary Function Studies" for additional information.

Rabies Postexposure Treatment

Added Procedure Code									
90377									

Limitations for added procedure code

Procedure code 90377 may be reimbursed as follows:

- To PA, NP, CNS, physician, and rural health clinic (freestanding/independent and hospital-based) providers for services rendered in the office and "other location" settings.
- To PA, NP, CNS, physician, and rural health clinic (freestanding/independent) providers for services rendered in the home setting.
- To PA, NP, CNS, physician, hospital, and rural health clinic (freestanding/independent and hospital-based) providers for services rendered in the outpatient hospital setting.

Reimbursement for postexposure rabies vaccine is limited to one per client per day, by any provider.

Refer to: *The Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.37, "Postexposure Prophylaxis for Rabies" for additional information.

Rhinoplasty

Added Procedure Code									
30468									

Discontinued Procedure Code									
C9749									

Limitations for added procedure code

Procedure code 30468 may be reimbursed as follows:

- To physician 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.

Stereotactic Radiosurgery

Added Procedure Code									
76145									

Limitations for added procedure code

Procedure code 76145 requires prior authorization and may be reimbursed as follows:

- To physician and radiation therapy center providers for services rendered in the office setting.
- To radiation therapy center 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 9.2.60.2.1, "Prior Authorization for Stereotactic Radiosurgery" for additional information.

Telehealth Services (Non-Physician Delivered Services)

Discontinued Procedure Code									
99201									

Refer to: *The Texas Medicaid Provider Procedures Manual, Telecommunication Services Handbook,* subsection 3.4.1, "Distant Site" for additional information.

Telemedicine Services (Physician-Delivered Services)

Added Procedure Code									
99417									

Discontinued Procedure Code									
99201									

Limitations for added procedure code

Procedure code 99417, when billed with modifier 95, may be reimbursed for telemedicine distant-site providers.

Refer to: *The Texas Medicaid Provider Procedures Manual, Telecommunication Services Handbook,* subsection 3.3.1, "Distant Site" for additional information.

Tuberculosis Services

Discontinued Procedure Code									
99201									

Refer to: *The Texas Medicaid Provider Procedures Manual, Clinics and Other Outpatient Facility Services Handbook Handbook,* subsection 8.2.1, "TB-Related Clinic Services" for additional information.

Vision Services–Nonsurgical

Added Procedure Code									
92229									

Limitations for added procedure code

Procedure code 92229 may be reimbursed as follows:

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

Procedure code 92229 is limited to one service per day and two services 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.

CCP Services Benefit Changes

The following Texas Medicaid CCP services benefit changes have been made to support the 2021 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2021. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **800-925-9126**.

Clinician-Directed Care Coordination Services – CCP

Discontinued Procedure Code									
99201									

Limitations

Procedure code 99358 may no longer be billed with the following procedure codes:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215

Refer to: *The Texas Medicaid Provider Procedures Manual, Children's Services Handbook,* subsection 2.5.1.1.6, "Non-Face-to-Face Prolonged Services" for additional information. ■

Texas Health Steps Dental Services Benefit Changes

The following Texas Health Steps dental services benefit changes have been made to support the 2021 Healthcare Common Procedure Coding System (HCPCS) and Current Dental Terminology (CDT) updates and are effective for dates of service on or after January 1, 2021. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **800-925-9126**.

Texas Health Steps Therapeutic Dental Services

Added Procedure Codes									
D7961	D7962								

Discontinued Procedure Code									
D7960									

Limitations for added procedure codes

Procedure code D7961 is a benefit for clients who are 12 through 20 years of age and may be reimbursed as follows:

- 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.

Procedure code D7962 is a benefit for clients who are 1 through 20 years of age and may be reimbursed as follows:

- To 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.

Procedure codes D7961 and D7962 require prior authorization. Additional criteria will be published in a future article.

Refer to: *The Texas Medicaid Provider Procedures Manual, Children's Services Handbook,* subsection 4.2.20, "Oral and Maxillofacial Surgery Services" for additional information. ■

STATE FUNDED FAMILY PLANNING PROGRAM (FPP) PROVIDERS

Family Planning Program Services Benefit Changes

The 2021 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 30. ■

Healthy Texas Women Program Services Benefit Changes

The following HTW benefit changes have been made to support the 2021 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2021. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **800-925-9126**.

Healthy Texas Women (HTW)

Added Procedure Codes									
81513	81514	82681	99417	J0693					

Discontinued Procedure Code									
99201									

Limitations for added procedure codes

Procedure codes 81513, 81514, and 82681 may be reimbursed as follows:

- To physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse midwife (CNM), registered nurse (RN), physician, 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 code 99417 may be reimbursed as follows:

- To PA, NP, CNS, physician, dentist, CNM, RN, and family planning clinic providers for services rendered in the office setting.
- To PA, NP, CNS, physician, dentist, CNM, and RN providers for services rendered in the outpatient hospital setting.

Procedure code J0693 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.

The following procedure codes are only a benefit of HTW Plus:

Added Procedure Codes									
93241	93242	93243	93244	93245	93246	93247	93248	94619	

Procedure codes 93241 and 93245 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 codes 93242, 93243, 93246, and 93247 may be reimbursed as follows:

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

Procedure codes 93244 and 93248 may be reimbursed as follows:

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

Procedure code 94619 may be reimbursed as follows:

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

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

CSHCN Services Program Updates

The 2021 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 30. The 2021 HCPCS deletions and replacements are effective January 1, 2021, for dates of service on or after January 1, 2021, 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 "Requires rate review" in the "CSHCN Allowable" column of the "2021 HCPCS Procedure Code Additions" table located on page 30 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 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, 2021, the 2021 HCPCS discontinued procedure codes are no longer reimbursed by the CSHCN Services Program. Unless otherwise indicated in the "Prior Authorization for Discontinued Procedure Codes That Do Not Need to be Updated by the Provider" section on page 5 of this bulletin, providers who have received authorizations or prior authorizations for dates of service that occur on, after, or encompass January 1, 2021, 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 **800-568-2413**.

CSHCN Services Program Benefit Changes

The following CSHCN Services Program benefit changes have been made to support the 2021 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2021. For more information, call the TMHP-CSHCN Services Program Contact Center at **800-568-2413**.

The policy articles below contain the following information:

- Discontinued: Discontinued procedure codes are no longer reimbursed after December 31, 2020.
- 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.*

Dental – Therapeutic Services

Added Procedure Codes									
D7961	D7962								

Discontinued Procedure Code									
D7960									

Limitations for added procedure codes

Procedure code D7961 is a benefit for clients who are 12 through 20 years of age and may be reimbursed as follows:

- To dentist, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Procedure code D7962 may be reimbursed as follows:

- To dentist, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

Procedure codes D7961 and D7962 require prior authorization.

Refer to: *The CSHCN Services Program Provider Manual*, subsection 14.2.6.8, "Oral and Maxillofacial Surgery," for additional information.

Diagnostic and Surgical/Reconstructive Breast Therapies and Corrective Procedures

Discontinued Procedure Codes									
19324	19366								

Refer to: *The CSHCN Services Program Provider Manual,* subsection 31.2.39.2.4, "Breast Reconstruction," for additional information.

Evoked Response Tests and Neuromuscular Procedures

Added Procedure Codes									
92650	92651	92652	92653						

Discontinued Procedure Codes									
92585	92586								

Limitations for added procedure codes

Procedure codes 92650, 92651, 92652, and 92653 may be reimbursed as follows:

- To physician, audiologist, 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 codes 92650, 92651, 92652, and 92653 are each limited to once per date of service, any provider.

Evoked potential tests may be reimbursed up to four services per rolling year, any combination of services by any provider.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 31.2.19.3, "Evoked Potential Procedures," for additional information.

Hearing Services

Added Procedure Codes									
92650	92651	92652	92653						

Discontinued Procedure Codes									
92585	92586								

Limitations for added procedure codes

Procedure codes 92650, 92651, 92652, and 92653 may be reimbursed as follows:

- To physician, audiologist, 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 codes 92650, 92651, 92652, and 92653 may be reimbursed once per day, same provider, same client, assuming testing is done in both ears. For testing performed only in one ear, providers must use modifier 52.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 20.2.3, "Hearing Testing, Examination, and Evaluation Services," for additional information.

Immune Globulins

Added Procedure Code									
C9072									

Limitations for added procedure code

Procedure code C9072 is a benefit for clients who are 12 years of age and older, and may be reimbursed as follows:

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

Refer to: *The CSHCN Services Program Provider Manual,* subsection 31.2.25.14, "Immune Globulins," for additional information.

Neurostimulators and Neuromuscular Stimulators

Discontinued Procedure Code									
61870									

Refer to: *The CSHCN Services Program Provider Manual,* subsection 27.2.2, "Intracranial Neurostimulation (ICN)," for additional information.

Pathology and Laboratory Services – Drug Testing and Therapeutic Drug Assays

Added Procedure Codes									
80143	80151	80161	80167	80179	80181	80189	80193	80204	80210

Limitations for added procedure codes

Procedure codes 80143, 80151, 80161, 80167, 80179, 80181, 80189, 80193, 80204, and 80210 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 25.2.5.1, "Drug Testing and Therapeutic Drug Assays," for additional information.

Pathology and Laboratory Services – Urinalysis/Chemistry

Added Procedure Codes									
82077	82681								

Limitations for added procedure codes

Procedure codes 82077 and 82681 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.

Physician Evaluation and Management Services

Added Procedure Code									
99417									

Discontinued Procedure Code									
99201									

Limitations for added procedure code

Procedure code 99417 may be reimbursed as follows:

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

Procedure code 99417 is only used when an office or other outpatient evaluation and management service has been selected using time alone as the basis, and the minimum time required to report the highest level (procedure code 99205 or 99215) has been exceeded by 15 minutes.

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

Refer to: *The CSHCN Services Program Provider Manual,* subsection 31.2.18.6, "Prolonged Physician Services," for additional information.

Rabies Postexposure Treatment

Added Procedure Code									
90377									

Limitations for added procedure code

Procedure code 90377 may be reimbursed as follows:

- To physician assistant (PA), APRN, and physician providers for services rendered in the office, home, and "other location" settings.
- To PA, APRN, physician, and hospital providers for services rendered in the outpatient hospital setting.

Reimbursement for postexposure rabies vaccine is limited to one per client, per day, by any provider.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 31.2.24.14, "Rabies Postexposure Prophylaxis," for additional information.

Telemedicine Services

Added Procedure Code									
99417									

Discontinued Procedure Code									
99201									

Limitations for added procedure code

Procedure code 99417, when billed with modifier 95, may be reimbursed for telemedicine distant-site providers.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 38.2.2.1, "Distant Site," for additional information.

Vision Services – Nonsurgical

Added Procedure Code									
92229									

Limitations for added procedure code

Procedure code 92229 may be reimbursed as follows:

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

Procedure code 92229 is limited to two services 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. ■

2021 HCPCS Procedure Code Additions

The table below lists the new Healthcare Common Procedure Coding System (HCPCS) procedure codes. If a program name (i.e., Medicaid, CSHCN, HTW) appears in the Benefit Changes column, see that program's section of this bulletin for more information.

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	30468	0-20 yrs: $394.77 21-999 yrs: $375.97	0-20 yrs: $394.77 21-999 yrs: $375.97	Not a benefit	Not a benefit	Not a benefit	CSHCN	Medicaid
F	30468	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid
2	32408	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	32408	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	33741	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
8	33741	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	33745	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
8	33745	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	33746	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
8	33746	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	33995	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
8	33995	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	33997	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
8	33997	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	55880	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	55880	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	57465	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	69705	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	69705	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	69706	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	69706	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
4	71271	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
I	71271	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
T	71271	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
6	76145	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
5	80143	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80151	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80161	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80167	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80179	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80181	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80189	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
5	80193	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80204	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	80210	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	81168	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81191	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81192	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81193	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81194	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81278	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
5	81279	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81338	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81339	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81347	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81348	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81351	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
5	81352	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
5	81353	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
5	81357	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81360	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81419	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81513	Requires rate hearing	Requires rate review	Requires rate hearing	Requires rate hearing	Requires rate hearing		HTW
5	81514	Requires rate hearing	Requires rate review	Requires rate hearing	Requires rate hearing	Requires rate hearing		HTW
5	81529	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81546	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81554	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	82077	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	82681	Requires rate hearing	Requires rate review	Requires rate hearing	Requires rate hearing	Requires rate hearing		Medicaid, CSHCN, HTW
1	90377	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	92229	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92517	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	92518	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	92519	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	92650	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	92651	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	92652	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	92653	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	93241	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW
T	93242	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW
T	93243	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW
I	93244	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
5	93245	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW
T	93246	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW
T	93247	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW
I	93248	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		HTW
5	94619	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		Medicaid, HTW
I	94619	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		Medicaid, HTW
T	94619	Requires rate hearing	Requires rate review	Not a benefit	Requires rate hearing	Not a benefit		Medicaid, HTW
1	99417	Requires rate hearing	Requires rate review	Requires rate hearing	Requires rate hearing	Requires rate hearing		Medicaid, CSHCN, HTW
1	99439	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	A9591	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C1052	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C1062	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
J	C1825	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
9	C9068	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	C9069	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	C9070	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	C9071	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
1	C9072	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	C9073	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
2	C9770	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	C9770	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C9771	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	C9771	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C9772	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	C9772	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C9773	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
F	C9773	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C9774	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	C9774	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C9775	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	C9775	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0604	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0605	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0701	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0702	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0703	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0704	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0705	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0706	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0707	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0708	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0709	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
W	D1321	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D1355	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D2928	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D3471	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D3472	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D3473	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D3501	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D3502	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D3503	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5995	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5996	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D6191	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D6192	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D7961	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit	Medicaid, CSHCN	Medicaid, CSHCN
W	D7962	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit	Medicaid, CSHCN	Medicaid, CSHCN
W	D7993	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D7994	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	G0088	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G0089	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G0090	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2173	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2174	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2175	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2176	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2177	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2178	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2179	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2180	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2181	Informational only	Informational only	Informational only	Informational only	Informational only		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	G2182	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2183	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2184	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2185	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2186	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2187	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2188	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2189	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2190	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2191	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2192	Informational only	Informational only	Informational only	Informational only	Informational only		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	G2193	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2194	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2195	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2196	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2197	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2198	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2199	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2200	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2201	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2202	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2203	Informational only	Informational only	Informational only	Informational only	Informational only		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	G2204	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2205	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2206	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2207	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2208	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2209	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2210	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2211	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2212	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2213	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2214	Informational only	Informational only	Informational only	Informational only	Informational only		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	G2215	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2216	Informational only	Informational only	Informational only	Informational only	Informational only		
1	G2250	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G2251	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G2252	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J0693	Requires rate hearing	Requires rate review	Requires rate hearing	Requires rate hearing	Requires rate hearing		HTW
1	J1823	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit	Medicaid, CSHCN	Medicaid
1	J7212	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J7352	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J9144	$45.19	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	J9223	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	J9281	$320.64	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	J9316	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	J9317	$30.02	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	M1145	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1146	Informational only	Informational only	Informational only	Informational only	Informational only		
1	M1147	Informational only	Informational only	Informational only	Informational only	Informational only		
1	M1148	Informational only	Informational only	Informational only	Informational only	Informational only		
1	M1149	Informational only	Informational only	Informational only	Informational only	Informational only		
1	Q5122	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	S0013	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
5	U0005	Requires rate hearing	Requires rate review	Requires rate hearing	Requires rate hearing	Requires rate hearing		

Note: *All new, revised, and discontinued 2021 HCPCS procedure codes are effective for dates of service on or after January 1, 2021. The new procedure codes that are indicated with "Requires rate hearing" or "Requires rate review" in the above table are pending a rate hearing and approval of expenditures. Providers will be notified in a future article 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 Code									
0608T									

Surgical Procedure Codes									
0620T	0621T	0622T	0627T	0628T	0629T	0630T	0631T		

Radiological Procedure Codes									
0623T	0624T	0625T	0626T	0632T	0633T	0634T	0635T	0636T	0637T
0638T	0639T								

Laboratory Procedure Codes									
0227U	0228U	0229U	0230U	0231U	0232U	0233U	0234U	0235U	0236U
0237U	0238U	0239U	0240U	0241U					

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

Discontinued Procedure Codes

The 2021 HCPCS discontinued procedure codes are no longer reimbursed after December 31, 2020. The following is a list of procedure codes that have been discontinued:

Procedure Codes									
19324	19366	32405	49220	57112	58293	61870	62163	63180	63182
69605	76970	78135	81545	87450	92585	92586	92992	92993	94250
94400	94750	94770	95071	99201	C9060	C9062	C9064	C9066	C9745
C9747	C9749	D3427	D5994	D6052	D7960	G0297	G1005	G1006	G2058
G2089	G2102	G2103	G2104	G2114	G2117	G2119	G2120	G2123	G2124
G2130	G2131	G2132	G2133	G2134	G2135	G2153	G2154	G2155	G2156
G2157	G2158	G2159	G2160	G2161	G2162	G2163	G2164	G2165	G2166
G8398	G8442	G8509	G8571	G8572	G8573	G8574	G8627	G8628	G8671

Procedure Codes									
G8672	G8674	G8730	G8731	G8732	G8809	G8810	G8811	G8872	G8873
G8874	G8939	G8959	G8960	G8973	G8974	G8975	G8976	G9232	G9239
G9240	G9241	G9256	G9257	G9258	G9259	G9260	G9261	G9262	G9263
G9264	G9265	G9266	G9300	G9301	G9302	G9303	G9304	G9326	G9327
G9329	G9340	G9365	G9366	G9389	G9390	G9469	G9503	G9523	G9524
G9525	G9526	G9532	G9558	G9559	G9560	G9573	G9574	G9600	G9601
G9602	G9615	G9616	G9617	G9701	G9738	G9739	G9747	G9748	G9749
G9750	G9759	G9798	G9799	G9800	G9801	G9802	G9803	G9804	G9814
G9815	G9816	G9817	G9825	G9826	G9827	G9828	G9829	G9833	G9834
G9835	G9836	G9837	G9849	G9850	G9851	G9855	G9856	G9857	G9924
G9933	G9934	G9935	G9936	G9937	G9966	G9967	M1015	M1023	M1024
M1033	M1061	M1062	M1063	M1064	M1065	M1066	M1136	M1137	M1138
M1139	M1140	M1144							

The following informational reporting procedure codes have been discontinued:

Procedure Codes									
0058T	0085T	0111T	0126T	0228T	0229T	0230T	0231T	0295T	0296T
0297T	0298T	0381T	0382T	0383T	0384T	0385T	0386T	0396T	0400T
0401T	0405T								

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

Replacement Procedure Codes

Effective for dates of service on or after January 1, 2021, the following discontinued procedure codes will be replaced by the corresponding replacement procedure codes:

Type of Service	Replacement Codes	Discontinued Codes	Medicaid Rate	CSHCN Rate
2	30468	C9749	0-20 yrs: $394.77 21-999 yrs: $375.97	0-20 yrs: $394.77 21-999 yrs: $375.97
2	55880	C9747	Not a benefit	Not a benefit
2	69705	C9745	Requires rate hearing	Requires rate review
2	69706	C9745	Requires rate hearing	Requires rate review
9	A9591	C9060	Not a benefit	Not a benefit
1	J9144	C9062	$45.19	Requires rate review
1	J9281	C9064	$320.64	Requires rate review
1	J9317	C9066	$30.02	Requires rate review

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, 2021:

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 **800-925-9126** or the TMHP-CSHCN Services Program Contact Center at **800-568-2413**.

Modifiers

The following table lists the revised modifier:

Revised Modifier									
57									

Providers may contact the appropriate copyright holder to obtain the modifier description. ■