

LABORATORY SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

JUNE 2026



LABORATORY SERVICES

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25.1 Enrollment

To enroll in the CSHCN Services Program, laboratories must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, be certified according to the Clinical Laboratory Improvement Amendments (CLIA) of 1988, and comply with all applicable state laws and requirements. Out-of-state laboratory providers must meet all of these conditions and be located in the United States within 50 miles of the Texas state border.

The following laboratories are eligible for enrollment in the CSHCN Services Program:

- A physician's office
 - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
 - Medicare-certified and enrolled as a Medicaid provider
 - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS

Note: *If a physician performs more than 100 laboratory tests per year for other providers in their laboratory, the laboratory must be certified by Medicare, and the provider must enroll as an independent laboratory with TMHP.*

- A hospital laboratory for inpatient, outpatient, and nonpatient client claims (a hospital nonpatient is one who is not registered as an inpatient or an outpatient but whose laboratory services are performed by the hospital laboratory)
 - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
 - Medicare-certified and enrolled as a Medicaid provider
 - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS
- An independent (freestanding) laboratory
 - An independent (freestanding) laboratory enrolled in the CSHCN Services Program is defined as a facility that meets all of the following criteria:
 - Facility independent from a physician's office, ASC, or hospital
 - Meets staff, equipment, and testing capability standards for certification by the Department of State Health Services (DSHS)
 - Medicare-certified and enrolled as a Medicaid provider
 - Providers must also submit a current copy of their permit or license and a copy of the approval letter from DSHS

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Referto: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures.

25.1.1 Clinical Laboratory Improvement Amendments (CLIA) of 1988

To be eligible for reimbursement by the CSHCN Services Program, all providers performing laboratory tests must:

- Pay the applicable fee to Centers for Medicare & Medicaid Services (CMS).
- Contact HHSC at 1-512-834-6650 to receive a CLIA registration or certification number.

Submit CLIA applications to the following address:

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

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

CMS implemented CLIA. The CLIA regulations were published in the February 28, 1992, *Federal Register* and have been amended several times since.

Copies of the CLIA rules and regulations are located at the CMS website at www.cms.hhs.gov. These regulations concern all laboratory testing used for the assessment of human health or the diagnosis, prevention, or treatment of disease. CLIA regulations set standards designed to improve quality in all laboratory testing and include specifications for quality control (QC), quality assurance (QA), patient test management, personnel, and proficiency testing. Under CLIA 88, all clinical laboratories (including those located in physician’s offices), regardless of location, size, or type of laboratory must meet standards based on the complexity of the test(s) they perform.

Important: *The CSHCN Services Program monitors claims submitted by clinical laboratories for CLIA numbers. Claims submitted for laboratory services are denied if there is not a CLIA number on file with the CSHCN Services Program.*

Referto: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

25.1.1.1 Waiver and Physician-Performed Microscopy Procedure (PPMP) Certificates

Providers are responsible for practicing within the limits of their certificates and maintaining awareness of the most current information regarding enforcement of CLIA provisions.

Note: Providers may refer to the CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for a list of waived test and provider-performed microscopy procedures (PPMP) procedure codes.

CSHCN Services Program bills must accurately reflect only those services authorized by CLIA regulations.

25.2 Benefits, Limitations, and Authorization Requirements

Authorization is not required for laboratory services.

The CSHCN Services Program may reimburse the following laboratories for services when the laboratory is certified according to the CLIA regulations and enrolled in the CSHCN Services Program:

- A hospital laboratory for outpatient and nonpatient client claims
- A physician's office
- An independent laboratory

Providers must bill the most specific diagnosis and procedure codes that describes the services provided.

Laboratory tests generally performed as a panel and performed on the same day by the same provider, must be billed as a panel, regardless of the method used to perform the tests (automated or manual).

The CSHCN Services Program pays only the amount allowed for the total component for the same procedure, same client, same date of service, and any provider.

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

Claims filed in excess of the amount allowed for the total component for the same procedure, same dates of service, same client, any provider, are denied.

Claims are paid based on the order in which they are received. For example, if a claim is received for the total component, and if payment has been made for the technical and interpretation component for the same procedure, same dates of service, same client, from any provider, the claim for the total component is denied as previously paid to another provider. The same is true if a total component is paid and subsequent claims are received for the individual components.

25.2.1 Hospital Laboratory Services

Hospital laboratory services are a benefit for inpatient, outpatient, and nonpatient clients. A hospital nonpatient is one who is not registered as an inpatient or an outpatient but whose laboratory services are performed by the hospital laboratory.

Outpatient and nonpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory. However, hospital laboratories may bill for all of the tests performed on a specimen even if a portion of the tests are done by another laboratory on referral from the hospital submitting the claim. If the specimen is collected by venipuncture or catheterization, hospitals may bill procedure code 99001 for collecting and forwarding a specimen to a receiving laboratory. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more laboratories.

In order to bill a handling fee, the receiving laboratory's name and address and unique NPI number must be included on the claim in Blocks 17 and 17B.

In order to bill nonpatient claims for laboratory services, the complete name and address and unique NPI of the attending, ordering, designated, or performing (freestanding ASCs only) provider must be included on the claim in Blocks 17 and 17B.

25.2.2 Independent Laboratory Services

Independent laboratories that provide laboratory tests to clients registered as hospital inpatients or hospital outpatients are not directly reimbursed. Reimbursement must be obtained from the hospital.

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for laboratory tests. An independent laboratory may bill the CSHCN Services Program for tests referred to another laboratory (independent or hospital) only if the independent laboratory performs at least one test and forwards a portion of the same specimen to another laboratory to have one or more tests performed. In this instance, the referring laboratory may bill for tests it performs and all tests the receiving laboratory performs on the specimen. In both instances, an independent laboratory that forwards a specimen to another laboratory may bill a handling fee (procedure code 99001) for collection and forwarding the specimen if the specimen is collected by venipuncture or catheterization.

In order to bill a handling fee, the receiving laboratory's name and address and unique NPI number must be included on the claim in Blocks 17 and 17B.

The CSHCN Services Program covers professional and technical services that an independent laboratory is certified by Medicare to perform.

25.2.3 Physician-Owned Laboratory Services

The CSHCN Services Program reimburses laboratory services ordered by a physician and provided under the provider's personal supervision in a setting other than an inpatient or outpatient hospital.

25.2.3.1 Other Physician Laboratory-Related Services

Physicians may only bill for those laboratory tests that are actually performed in their offices. Clinical laboratory services performed in a physician's office may be reimbursed at 60 percent of the prevailing charge levels. A laboratory handling fee (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside laboratory. Only one lab handling fee per day, per client, may be billed, unless multiple specimens are obtained and sent to different laboratories.

In order to bill a handling fee, the receiving laboratory's name and address and unique NPI must be included on the claim in Blocks 17 and 17B.

Laboratory services must be documented in clients' medical records as medically necessary and reference an appropriate diagnosis.

Laboratory tests generally performed as a panel (chemistries, complete blood counts [CBCs], or urinalyses [UAs]) and performed on the same day by the same provider must be billed as a panel regardless of the method used to perform the test.

Interpretation of laboratory tests for the physician's patients in the hospital, office, or emergency rooms are considered part of the physician's professional services and should not be billed separately.

25.2.4 Clinical Pathology Services

Clinical pathology consultations are a benefit when performed by a clinical pathologist or geneticist. A geneticist may submit claims for procedure codes 80503, 80504, 80505, and 80506 using their National Provider Identifier (NPI).

Independent laboratories may submit claims for procedure codes 80503, 80504, 80505, and 80506 when services are performed in the independent laboratory setting.

Routine conversations between a consultant and an attending physician about test orders or results are not considered consultations.

The service does not qualify as a consultation if the information could ordinarily be furnished by a non-physician laboratory specialist.

Claims for clinical pathology consultations must be submitted with the following documentation:

- The name and address of the physician requesting the consultation, must be included on the claim. The NPI of the physician requesting the consultation should also be included.
- A copy of the written narrative report describing the consultation findings.
- Documented interaction that clearly outlines that the consultant interpreted the test results and made specific recommendations to the ordering physician.

Important: *If the claim does not include all of this information, the clinical pathology consultation will be denied.*

25.2.5 Other Laboratory Procedures

| Procedure Codes | | | |
|-----------------|-------|-------|-------|
| 1 per lifetime | | | |
| S3840 | S3841 | S3842 | S3846 |

25.2.5.1 Drug Testing and Therapeutic Drug Assays

The following procedure codes for drug testing and therapeutic drug assays are benefits of the CSHCN Services Program:

| Procedure Codes | | | | | | | | | |
|-------------------------|-------|--------|-------|-------|-------|-------|-------|-------|-------|
| Drug Testing | | | | | | | | | |
| 80305^ | 80306 | 80307 | 80320 | 80321 | 80322 | 80323 | 80324 | 80325 | 80326 |
| 80327 | 80328 | 80329 | 80330 | 80331 | 80332 | 80333 | 80334 | 80335 | 80336 |
| 80337 | 80338 | 80339 | 80340 | 80341 | 80342 | 80343 | 80344 | 80345 | 80346 |
| 80347 | 80348 | 80349 | 80350 | 80351 | 80352 | 80353 | 80354 | 80355 | 80356 |
| 80357 | 80358 | 80359 | 80360 | 80361 | 80362 | 80363 | 80364 | 80365 | 80366 |
| 80367 | 80368 | 80369 | 80370 | 80371 | 80372 | 80373 | 80374 | 80375 | 80376 |
| 80377 | G0480 | G0481 | G0482 | G0483 | G0659 | | | | |
| Therapeutic Drug Assays | | | | | | | | | |
| 80143 | 80150 | 80151 | 80155 | 80156 | 80157 | 80158 | 80159 | 80161 | 80162 |
| 80163 | 80164 | 80165 | 80167 | 80168 | 80169 | 80170 | 80171 | 80173 | 80175 |
| 80176 | 80177 | 80178^ | 80179 | 80180 | 80181 | 80183 | 80184 | 80185 | 80186 |
| 80188 | 80189 | 80190 | 80192 | 80193 | 80194 | 80195 | 80197 | 80198 | 80199 |
| 80200 | 80201 | 80202 | 80203 | 80204 | 80210 | 80299 | | | |
| ^ QW Modifier | | | | | | | | | |

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

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

Procedure codes 82540, 82550, 82552, 82553, 82554, 83986, and 84311 used for specimen validity testing will be denied when billed on the same date of service, by the same provide, as procedure codes G0480, G0481, G0482, G0483 and G0659.

The following CPT drug assay procedure codes will deny when billed on the same date of service, by the same provider with the corresponding HCPCS drug assay procedure codes identified by an “X” in the following table:

| CPT Drug Assay Procedure Codes to HCPCS Procedure Codes limitations | | | | | |
|--|-------|-------|-------|-------|-------|
| | G0480 | G0481 | G0482 | G0483 | G0659 |
| 80320 | X | | X | X | X |
| 80321 | X | X | X | X | |
| 80323 | X | X | X | X | X |
| 80324 | X | X | X | X | |
| 80325 | X | | | | |
| 80326 | X | X | X | X | X |
| 80327 | X | | | | |
| 80328 | X | | | | |
| 80329 | X | | X | X | X |
| 80330 | X | | | X | |
| 80332 | X | | X | X | X |
| 80333 | X | | | X | |
| 80335 | X | | | | |
| 80336 | X | | | | |
| 80337 | X | | X | X | X |
| 80338 | X | | | | X |
| 80339 | X | | | | X |
| 80342 | X | | | | X |
| 80345 | X | | | | X |
| 80358 | X | | | | X |
| 80363 | X | | | | X |
| 80365 | X | | | | X |
| 80368 | X | | | | X |
| 80369 | X | | | | X |
| 80370 | X | | | | X |
| 80375 | X | | | | X |
| 80377 | X | | | | X |
| X - The “8000” CPT procedure code will be denied if billed with the HCPCS “G” procedure code indicated with an “X”. | | | | | |
| ^QW Modifier | | | | | |

25.2.5.2 Cytogenetics Testing

When billed with an appropriate diagnosis code, cytogenetics testing procedure codes have the following limitations:

| Procedure Code | Quantity Allowed |
|-----------------------|-------------------------|
| Tissue Culture | |
| 88230 | 1 per day, any provider |

| Procedure Code | Quantity Allowed |
|------------------------|--------------------------|
| 88233 | 1 per day, any provider |
| 88237 | 1 per day, any provider |
| 88239 | 1 per day, any provider |
| Chromosome Analysis | |
| 88245 | 1 per day, any provider |
| 88248 | 1 per day, any provider |
| 88249 | 1 per day, any provider |
| 88261 | 1 per day, any provider |
| 88262 | 1 per day, any provider |
| 88263 | 1 per day, any provider |
| 88264 | 1 per day, any provider |
| 88280 | 1 per day, any provider |
| 88283 | 1 per day, any provider |
| 88285 | 1 per day, any provider |
| 88289 | 1 per day, any provider |
| Molecular Cytogenetics | |
| 88271 | 16 per provider, per day |
| 88272 | 10 per provider, per day |
| 88273 | 3 per provider, per day |
| 88274 | 5 per provider, per day |
| 88275 | 10 per provider, per day |

Providers must bill procedure code 88291 for the interpretation and report of cytogenetics testing.

Reimbursement for cytogenetics testing is limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|--------|
| C810A | C811A | C812A | C813A | C814A | C817A | C819A | C820A |
| C821A | C822A | C823A | C824A | C825A | C826A | C8280 | C8281 |
| C8282 | C8283 | C8284 | C8285 | C8286 | C8287 | C8288 | C8289 |
| C828A | C8291 | C8292 | C8293 | C8294 | C8295 | C8296 | C8297 |
| C8298 | C8299 | C829A | C830A | C8310 | C8311 | C8312 | C8313 |
| C8314 | C8315 | C8316 | C8317 | C8318 | C8319 | C831A | C83390 |
| C83398 | C833A | C835A | C837A | C8380 | C8381 | C8382 | C8383 |
| C8384 | C8385 | C8386 | C8387 | C8388 | C8389 | C838A | C839A |
| C840A | C841A | C8440 | C8441 | C8442 | C8443 | C8444 | C8445 |
| C8446 | C8447 | C8448 | C8449 | C844A | C8461 | C8462 | C8463 |
| C8464 | C8465 | C8466 | C8467 | C8468 | C8469 | C846A | C8471 |
| C8472 | C8473 | C8474 | C8475 | C8476 | C8477 | C8478 | C8479 |
| C847A | C847B | C849A | C84AA | C84ZA | C851A | C852A | C8581 |
| C8582 | C8584 | C8585 | C8586 | C8587 | C8588 | C8589 | C858A |
| C859A | C8600 | C8601 | C8610 | C8611 | C8620 | C8621 | C8630 |

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C8631 | C8640 | C8641 | C8650 | C8651 | C8660 | C8661 | C8830 |
| C8831 | C8840 | C8841 | C8880 | C8881 | C8890 | C8891 | C9012 |
| C9100 | C9101 | C9102 | C9110 | C9111 | C9112 | C9190 | C9191 |
| C9192 | C91Z0 | C91Z1 | C91Z2 | C9200 | C9201 | C9202 | C9210 |
| C9211 | C9212 | C9220 | C9221 | C9222 | C9230 | C9231 | C9232 |
| C9240 | C9241 | C9242 | C9250 | C9251 | C9252 | C9260 | C9261 |
| C9262 | C9290 | C9291 | C9292 | C92A0 | C92A1 | C92A2 | C92Z0 |
| C92Z1 | C92Z2 | C9300 | C9301 | C9302 | C9310 | C9311 | C9312 |
| C9330 | C9331 | C9390 | C9391 | C9392 | C93Z0 | C93Z1 | C93Z2 |
| C9400 | C9401 | C9402 | C9420 | C9421 | C9422 | C9430 | C9431 |
| C9432 | C9480 | C9481 | C9482 | C9500 | C9501 | C9502 | C9510 |
| C9511 | C9512 | C9590 | C9591 | C9592 | D45 | D821 | E230 |
| E291 | E300 | E3430 | E3431 | E34328 | E34329 | E3439 | E83110 |
| E8359 | F50814 | F5083 | F70 | F71 | F72 | F73 | F78A1 |
| F78A9 | F800 | F801 | F802 | F804 | F8089 | F810 | F812 |
| F8181 | F8189 | F819 | F82 | F840 | F88 | F900 | F901 |
| F902 | F908 | H0589 | H9325 | I77810 | I77811 | I77812 | I77819 |
| L6610 | M2600 | M2601 | M2602 | M2603 | M2604 | M2605 | M2606 |
| M2607 | M2609 | M6590 | M65919 | M65921 | M65922 | M65929 | M65939 |
| M65949 | M65959 | M65969 | M65979 | M6598 | M6599 | N6482 | P2930 |
| P2938 | Q000 | Q001 | Q002 | Q010 | Q011 | Q012 | Q018 |
| Q02 | Q030 | Q031 | Q038 | Q040 | Q041 | Q042 | Q045 |
| Q046 | Q048 | Q050 | Q051 | Q052 | Q054 | Q055 | Q056 |
| Q057 | Q058 | Q062 | Q064 | Q068 | Q0701 | Q0702 | Q0703 |
| Q078 | Q079 | Q100 | Q101 | Q102 | Q103 | Q104 | Q106 |
| Q107 | Q110 | Q111 | Q112 | Q113 | Q120 | Q121 | Q123 |
| Q124 | Q128 | Q129 | Q130 | Q131 | Q132 | Q133 | Q134 |
| Q135 | Q1381 | Q1389 | Q140 | Q141 | Q142 | Q143 | Q148 |
| Q150 | Q158 | Q159 | Q160 | Q161 | Q162 | Q163 | Q164 |
| Q165 | Q169 | Q170 | Q171 | Q172 | Q173 | Q174 | Q175 |
| Q178 | Q179 | Q180 | Q181 | Q182 | Q183 | Q184 | Q185 |
| Q186 | Q187 | Q188 | Q189 | Q200 | Q201 | Q202 | Q203 |
| Q204 | Q205 | Q206 | Q208 | Q209 | Q210 | Q2110 | Q2111 |
| Q2112 | Q2113 | Q2114 | Q2115 | Q2116 | Q2119 | Q2120 | Q2121 |
| Q2122 | Q2123 | Q213 | Q214 | Q218 | Q219 | Q220 | Q221 |
| Q222 | Q223 | Q224 | Q225 | Q228 | Q230 | Q231 | Q232 |
| Q233 | Q234 | Q2381 | Q2382 | Q2388 | Q240 | Q241 | Q242 |
| Q243 | Q244 | Q245 | Q246 | Q248 | Q249 | Q250 | Q251 |
| Q2521 | Q2529 | Q253 | Q2540 | Q2541 | Q2542 | Q2543 | Q2544 |
| Q2545 | Q2546 | Q2547 | Q2548 | Q2549 | Q2572 | Q259 | Q260 |

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|-------|-------|--------|
| Q261 | Q262 | Q263 | Q265 | Q266 | Q268 | Q269 | Q270 |
| Q271 | Q272 | Q2730 | Q2731 | Q2732 | Q2733 | Q2734 | Q274 |
| Q278 | Q279 | Q280 | Q281 | Q282 | Q283 | Q288 | Q289 |
| Q300 | Q301 | Q302 | Q303 | Q308 | Q309 | Q310 | Q311 |
| Q312 | Q313 | Q315 | Q318 | Q320 | Q321 | Q322 | Q323 |
| Q324 | Q330 | Q331 | Q332 | Q333 | Q334 | Q335 | Q336 |
| Q338 | Q339 | Q348 | Q349 | Q351 | Q353 | Q359 | Q360 |
| Q369 | Q370 | Q371 | Q372 | Q373 | Q374 | Q375 | Q380 |
| Q381 | Q382 | Q383 | Q384 | Q385 | Q386 | Q387 | Q388 |
| Q391 | Q392 | Q393 | Q394 | Q395 | Q396 | Q398 | Q400 |
| Q401 | Q402 | Q408 | Q409 | Q410 | Q411 | Q412 | Q419 |
| Q420 | Q421 | Q422 | Q423 | Q428 | Q430 | Q431 | Q432 |
| Q433 | Q434 | Q435 | Q437 | Q438 | Q440 | Q441 | Q442 |
| Q443 | Q444 | Q445 | Q446 | Q4470 | Q4471 | Q4479 | Q450 |
| Q451 | Q452 | Q453 | Q458 | Q459 | Q5001 | Q5002 | Q501 |
| Q502 | Q5031 | Q5032 | Q5039 | Q504 | Q505 | Q506 | Q510 |
| Q5110 | Q5111 | Q5121 | Q5122 | Q5128 | Q515 | Q516 | Q517 |
| Q51811 | Q51821 | Q51828 | Q520 | Q5210 | Q522 | Q523 | Q524 |
| Q525 | Q526 | Q5270 | Q5271 | Q5279 | Q528 | Q529 | Q5300 |
| Q5301 | Q5302 | Q5310 | Q53111 | Q53112 | Q5312 | Q5313 | Q5320 |
| Q53211 | Q53212 | Q5322 | Q5323 | Q539 | Q540 | Q541 | Q542 |
| Q543 | Q544 | Q548 | Q550 | Q551 | Q5521 | Q5522 | Q5523 |
| Q5529 | Q553 | Q554 | Q555 | Q5561 | Q5562 | Q5563 | Q5564 |
| Q5569 | Q558 | Q559 | Q560 | Q561 | Q562 | Q563 | Q564 |
| Q600 | Q601 | Q603 | Q604 | Q606 | Q6101 | Q6119 | Q612 |
| Q613 | Q614 | Q615 | Q618 | Q619 | Q6211 | Q6212 | Q622 |
| Q6231 | Q6239 | Q624 | Q625 | Q6261 | Q6262 | Q6263 | Q628 |
| Q630 | Q631 | Q632 | Q633 | Q638 | Q640 | Q6410 | Q6411 |
| Q6412 | Q6419 | Q642 | Q6431 | Q6432 | Q6433 | Q6439 | Q644 |
| Q645 | Q646 | Q6471 | Q6472 | Q6473 | Q6474 | Q6475 | Q649 |
| Q6501 | Q6502 | Q651 | Q6531 | Q6532 | Q654 | Q6581 | Q6582 |
| Q6589 | Q6600 | Q6601 | Q6602 | Q6610 | Q6611 | Q6612 | Q66211 |
| Q66212 | Q66219 | Q66221 | Q66222 | Q66229 | Q6630 | Q6631 | Q6632 |
| Q6640 | Q6641 | Q6642 | Q6651 | Q6652 | Q666 | Q6670 | Q6671 |
| Q6672 | Q6681 | Q6682 | Q6689 | Q6690 | Q6691 | Q6692 | Q670 |
| Q671 | Q672 | Q673 | Q674 | Q675 | Q676 | Q677 | Q678 |
| Q680 | Q681 | Q682 | Q683 | Q684 | Q688 | Q690 | Q691 |
| Q692 | Q699 | Q7001 | Q7002 | Q7003 | Q7011 | Q7012 | Q7013 |
| Q7021 | Q7022 | Q7023 | Q7031 | Q7032 | Q7033 | Q709 | Q7101 |
| Q7102 | Q7103 | Q7111 | Q7112 | Q7113 | Q7131 | Q7132 | Q7133 |

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| Q7141 | Q7142 | Q7143 | Q7151 | Q7152 | Q7153 | Q7161 | Q7162 |
| Q7163 | Q71811 | Q71812 | Q71813 | Q71891 | Q71892 | Q71893 | Q7191 |
| Q7192 | Q7193 | Q7201 | Q7202 | Q7203 | Q7211 | Q7212 | Q7213 |
| Q7231 | Q7232 | Q7233 | Q7241 | Q7242 | Q7243 | Q7251 | Q7252 |
| Q7253 | Q7261 | Q7262 | Q7263 | Q7271 | Q7272 | Q7273 | Q72811 |
| Q72812 | Q72813 | Q72891 | Q72892 | Q72893 | Q7291 | Q7292 | Q7293 |
| Q730 | Q731 | Q738 | Q740 | Q742 | Q743 | Q748 | Q749 |
| Q75001 | Q75002 | Q75009 | Q7501 | Q75021 | Q75022 | Q75029 | Q7503 |
| Q75041 | Q75042 | Q75049 | Q75051 | Q75052 | Q75058 | Q7508 | Q751 |
| Q752 | Q753 | Q754 | Q755 | Q758 | Q759 | Q760 | Q761 |
| Q762 | Q763 | Q76411 | Q76412 | Q76413 | Q76414 | Q76415 | Q76425 |
| Q76426 | Q76427 | Q76428 | Q7649 | Q765 | Q766 | Q767 | Q768 |
| Q770 | Q771 | Q772 | Q774 | Q775 | Q776 | Q777 | Q780 |
| Q781 | Q782 | Q783 | Q784 | Q788 | Q789 | Q790 | Q791 |
| Q792 | Q793 | Q794 | Q7959 | Q7960 | Q7961 | Q7962 | Q7963 |
| Q7969 | Q798 | Q799 | Q800 | Q801 | Q802 | Q803 | Q804 |
| Q808 | Q820 | Q821 | Q822 | Q823 | Q824 | Q825 | Q826 |
| Q828 | Q830 | Q831 | Q832 | Q833 | Q838 | Q840 | Q841 |
| Q842 | Q843 | Q844 | Q845 | Q846 | Q848 | Q849 | Q8503 |
| Q851 | Q8581 | Q8582 | Q8583 | Q8589 | Q859 | Q870 | Q8711 |
| Q8719 | Q87410 | Q87418 | Q8742 | Q8743 | Q8782 | Q8783 | Q8784 |
| Q8785 | Q8786 | Q8787 | Q8788 | Q8901 | Q8909 | Q891 | Q892 |
| Q893 | Q894 | Q897 | Q8981 | Q8989 | Q899 | Q900 | Q901 |
| Q902 | Q914 | Q915 | Q916 | Q917 | Q920 | Q921 | Q922 |
| Q925 | Q9261 | Q9262 | Q927 | Q928 | Q930 | Q931 | Q932 |
| Q933 | Q934 | Q9351 | Q9352 | Q9359 | Q937 | Q9381 | Q9382 |
| Q9388 | Q9389 | Q950 | Q952 | Q958 | Q960 | Q961 | Q962 |
| Q963 | Q964 | Q968 | Q969 | Q970 | Q971 | Q972 | Q973 |
| Q978 | Q980 | Q981 | Q984 | Q985 | Q986 | Q987 | Q988 |
| Q990 | Q991 | Q992 | Q99811 | Q99812 | Q99813 | Q99818 | Q99819 |
| Q9989 | Q999 | Z31430 | Z31438 | Z315 | Z810 | Z8279 | Z8482 |
| Z8489 | | | | | | | |

25.2.5.3 Genetic Testing for Colorectal Cancer

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

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

Providers must bill the following procedure codes for genetic testing for colorectal cancer:

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

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results. Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the Physical Evaluation and Management (E/M service).

Genetic testing for colorectal cancer is limited to once per lifetime. Additional tests will not be authorized.

25.2.5.3.1 Authorization Requirements

Prior authorization is required for genetic testing for colorectal cancer.

A completed CSHCN Services Program Authorization and Prior Authorization Request form, signed and dated by the referring providers, must be submitted:

- Any provider's signature, including the prescribing provider's, on a submitted document indicates the provider certifies, to the best of the provider's knowledge, the information in the document is true, accurate and complete.
- All documentation submitted with a provider's signature must have a date next to the signature and must be kept in the client's medical record.
- Stamped signatures will not be accepted.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the services requested. The client's medical record must include documentation of formal pre-test counseling, including assessment of the client's ability to understand the risks and limitations of the test, and the client's informed choice to proceed with the genetic testing for colorectal cancer. The medical record is subject to retrospective review.

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

25.2.5.3.2 Familial Adenomatous Polyposis (FAP)

Prior authorization for testing Familial Adenomatous Polyposis (FAP) (procedure codes 81201, 81202, and 81203) may be offered to individuals who have well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care.

Documentation must include one of the following:

- Client with greater than 20 polyps.
- Client with a first-degree relative with FAP and a documented mutation.
- Clients who are seven years of age or younger must have rationale for testing and documentation of medical necessity included in the client's medical record and submitted with the prior authorization request.

25.2.5.3.3 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

The following procedure codes require prior authorization for testing Hereditary Nonpolyposis Colorectal Cancer (HNPCC) to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 81292 | 81293 | 81294 | 81295 | 81296 | 81297 | 81298 | 81299 | 81300 | 81301 |
| 81317 | 81318 | 81319 | | | | | | | |

Results of the test may influence clinical management decisions.

Documentation of medical necessity must include one of the following:

- Client has three or more family members (one of whom is a first-degree relative) with colorectal cancer and two successive generations are affected and one or more of the colorectal cancers were diagnosed at 50 years of age or younger and FAP has been ruled out.
- A client has had two HNPCC cancers.
- A client has colorectal cancer and a first-degree relative with either colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger.
- A client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- A client has had right-sided colorectal cancer with an undifferentiated pattern or histology at 50 years of age or younger.
- A client has had signet-cell type colorectal cancer at 50 years of age or younger.
- A client has had colorectal adenoma at 40 years of age or younger.
- A client is an asymptomatic individual with a first or second-degree relative with a documented HNPCC mutation.
- A client has a family history of malignant neoplasm in the gastrointestinal tract.

Clients who are twenty years of age or younger must have a clear rationale for testing and documentation of medical necessity from the client’s record must be submitted with the prior authorization request.

25.2.5.4 Genetic Testing for Hereditary Breast and Ovarian Cancers

Genetic testing for hereditary breast and ovarian cancers is provided to clients who are at least 18 years of age with an inherited increased risk (having a first-, second- or third-degree relative) for developing breast and certain other cancers.

Genetic testing of mutations in BRCA1 and BRCA2, the genes associated with hereditary breast and ovarian cancer, is based on the National Comprehensive Cancer Network (NCCN) guidelines. These guidelines highly recommend genetic counseling to clients when genetic testing is offered and after test results are disclosed.

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

Providers must bill the following procedure codes genetic testing for hereditary breast and ovarian cancers:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 81162 | 81163 | 81164 | 81165 | 81166 | 81167 | 81212 | 81215 | 81216 | 81217 |

The provider must order the most appropriate test based on familial medical history and the availability of previous family testing results only if the test results will affect treatment decisions or provide prognostic information. Interpretation of genetic testing results is not separately reimbursable. Interpretation is part of the physician evaluation and management (E/M) service.

Genetic testing for hereditary breast and ovarian cancers is limited to once per lifetime. Additional tests will not be authorized.

Genetic testing for hereditary breast and ovarian cancer predisposition is not covered as a screening test in the general population.

25.2.5.4.1 Authorization Requirements

Prior authorization is required for all BRCA1/BRCA2 genetic testing for susceptibility to breast and ovarian cancer.

A completed CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization Form, signed and dated by the ordering practitioner, must be submitted and approved prior to the date of service. The form must include:

- The physician's signature on a submitted document that indicates that the physician certifies, to the best of the physician's knowledge, the information in the document is true, accurate, and complete.
- All documentation must be submitted with a physician's signature with a date next to the signature and must be kept in the client's medical record.
- No stamped signatures will be accepted.

To facilitate a determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including accurate medical necessity of the service(s) requested. Documentation supporting the medical need for genetic testing of hereditary breast and ovarian cancers must include:

- The client's diagnosis and prognosis, including the age of onset and the specific location of cancer
- The client's family history, if applicable, including the specifics about the relationship to the client, cancer site, and the age of cancer diagnosis
- The NCCN criterion met supporting the need for the specific test requested
- Documentation of how the result of the test will directly impact the plan of treatment delivered to the client.

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

To complete the prior authorization process, the provider must complete and submit the prior authorization request and required documentation to the TMHP CSHCN Services Program Authorization Department.

If the service is medically necessary and is provided after hours or on a recognized holiday or weekend, the service may be authorized when the request is submitted on the next business day. A completed CSHCN Services Program Genetic Testing for Hereditary Breast and/or Ovarian Cancer Prior Authorization form and supporting documentation must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines are not given by the CSHCN Services Program for providers to correct incomplete PA requests.

The client's medical record must include a copy of the prior authorization request, all submitted documentation, and an assessment of the client's ability to understand the risks and limitations of the test as well as the client's informed choice to proceed with the genetic testing. The medical record is subject to retrospective review.

25.2.6 Cytopathology of Vaginal, Cervical, and Uterine Sites

Because of the technical nature of processing and interpreting a Pap smear or specimen for cytopathology, pathologists are the only physician specialty reimbursed with the following exception:

Exception: *Other physician specialties equipped to perform Pap smears in their offices must have modifier SU on the claim form.*

Procurement and handling of the Pap smear or specimen for cytopathology is considered part of the evaluation and management of the client and is not reimbursed separately.

A pathologist must report the place of service (POS) according to where the Pap smear is interpreted: office (POS 1), inpatient (POS 3), outpatient (POS 5), or independent laboratory (POS 6).

The following procedure codes are payable for gynecological cytopathology services and may be reimbursed only to pathologists and CLIA-certified laboratories whose directors providing technical supervision of cytopathology services are pathologists:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 88142 | 88143 | 88147 | 88148 | 88150 | 88152 | 88153 | 88155 | 88164 | 88165 |
| 88166 | 88167 | 88174 | 88175 | | | | | | |

Procedure codes 88155 is an add-on code to be used in conjunction with the following cytopathology procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 88142 | 88143 | 88147 | 88148 | 88150 | 88152 | 88153 | 88164 | 88165 | 88166 |
| 88167 | 88174 | 88175 | | | | | | | |

The interpretation portion of any gynecological cytopathology test must be reported using only procedure code 88141 and type of service “I.” Reimbursement is restricted to laboratories and pathologists. The interpretation portion may be reimbursed in addition to the following cytopathology procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 88142 | 88143 | 88147 | 88148 | 88150 | 88152 | 88153 | 88164 | 88165 | 88166 |
| 88167 | 88174 | 88175 | | | | | | | |

25.2.7 Cytopathology Studies Other Than Vaginal, Cervical, or Uterine

Procurement and handling of the specimen is not reimbursed separately for cytopathology of sites other than vaginal, cervical, or uterine and is considered part of the evaluation and management of the client. These procedures may be reimbursed according to the POS where the cytopathology smear is interpreted.

Procedure codes 88160, 88161, and 88162 are payable for the total component and technical component in the office (place of service [POS] 1), outpatient setting (POS 5), or independent laboratory (POS 6). Procedure codes 88160, 88161, and 88162 are payable for the interpretation in the inpatient (POS 3) or outpatient (POS 5) settings.

Procedure codes 88160, 88161, and 88162 are payable to a pathologist for the interpretation in the inpatient hospital (POS 3) and outpatient (POS 5) settings.

Procedure codes 88160 or 88161 total components and interpretations are denied as part of the total component and interpretation for procedure code 88162.

Procedure code 88160 total component and interpretation is denied as part of the total component and interpretation for procedure code 88161.

Reimbursement for the total component or interpretation and technical component for procedure codes 88160, 88161, and 88162 is limited to pathologists (doctor of medicine [MD] and doctor of osteopathy [DO]) and laboratories (CLIA-certified to provide pathology services).

25.2.8 Evocative and Suppression Testing

Evocative and suppression testing is a benefit when billed for the total component.

Providers must bill the following procedure codes for evocative suppression testing:

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

25.2.9 Helicobacter pylori (H. pylori)

H. pylori testing is a benefit. Serology testing for H. pylori is a noninvasive diagnostic procedure preferred for initial diagnosis but is not indicated once a diagnosis is made.

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

- New onset uncomplicated dyspepsia
- New onset dyspepsia that is responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAIDs] or use of antisecretory agents) (If conservative treatment does not eliminate the symptoms, further testing may be indicated to determine the presence of H. pylori.)
- Screening for H. pylori in asymptomatic clients
- Dyspeptic clients who require endoscopy and biopsy
- A negative endoscopy in the previous 90 days
- A planned endoscopy
- New onset H. pylori that is still being treated

Serology testing is not indicated or a benefit for monitoring response to therapy.

The following procedure codes may be reimbursed by the CSHCN Services Program:

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

These procedure codes are considered a clinical lab service and must be billed using type of service (TOS) 5. The interpretation/professional component TOS I is not separately reimbursed.

H. pylori testing may be indicated for symptomatic clients with a documented history of chronic or recurrent duodenal ulcers, gastric ulcers, or chronic gastritis. The history should delineate the failed conservative treatment for the condition.

The amplified probe technique (procedure code 87513) is limited to 2 times per 28 days when submitted for the same procedure by any provider.

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

If a follow-up breath or stool test is used to document the eradication of H. pylori, the medical record should contain evidence of one of the following:

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

Providers cannot be reimbursed for testing for the eradication of H. pylori, procedure codes 78267, 78268, 83013, 83014, and 87338 within 35 days of the initial test.

H. pylori testing will be denied if it is performed within 90 days of the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 43200 | 43201 | 43202 | 43216 | 43217 | 43229 | 43231 | 43232 | 43235 | 43236 |
| 43237 | 43238 | 43239 | 43241 | 43242 | 43250 | 43251 | 43259 | 43270 | |

Procedure codes 78267, 78268, 83013, 83014, and 87338 may be reimbursed within 90 days of the procedure codes in the preceding table if the provider submits documentation that indicates the client was tested for eradication after treatment.

25.2.10 Hematology and Coagulation

The following hematology and coagulation procedure codes are benefits of the CSHCN Services Program:

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

The following procedure codes may be reimbursed once per day by the same provider:

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

Procedure code 85027 will deny if billed on the same date of service by the same provider as procedure codes 85007 and 85009.

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

25.2.11 Microbiology

The following microbiology procedure codes are benefits of the CSHCN Services Program:

| Procedure Codes | | | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| 86790 | 86794 | 87003 | 87015 | 87040 | 87045 | 87046 | 87070 | 87071 | 87073 |
| 87075 | 87076 | 87077^ | 87081 | 87084 | 87086 | 87088 | 87101 | 87102 | 87103 |
| 87106 | 87107 | 87109 | 87110 | 87116 | 87118 | 87140 | 87143 | 87147 | 87149 |
| 87150 | 87152 | 87153 | 87158 | 87164 | 87166 | 87168 | 87169 | 87172 | 87176 |
| 87177 | 87181 | 87182 | 87184 | 87185 | 87186 | 87187+ | 87188 | 87190 | 87197 |
| 87205 | 87206 | 87207 | 87209 | 87210^ | 87220 | 87230 | 87250 | 87252 | 87253 |
| 87254 | 87255 | 87260 | 87265 | 87267 | 87269 | 87270 | 87271 | 87272 | 87273 |
| 87274 | 87275 | 87276 | 87278 | 87279 | 87280 | 87281 | 87283 | 87285 | 87290 |
| 87299 | 87300 | 87301 | 87305 | 87320 | 87324 | 87327 | 87328 | 87329 | 87332 |
| 87335 | 87336 | 87337 | 87338^ | 87339 | 87340 | 87341 | 87350 | 87380 | 87385 |
| 87389^ | 87390 | 87391 | 87400^ | 87420^ | 87425 | 87427 | 87430^ | 87449^ | 87451 |
| 87467 | 87468 | 87469 | 87471 | 87472 | 87475 | 87476 | 87478 | 87480 | 87481 |
| 87482 | 87484 | 87485 | 87486 | 87487 | 87490 | 87491^ | 87492 | 87493 | 87494 |
| 87495 | 87496 | 87497 | 87498 | 87500 | 87501 | 87502^ | 87503+ | 87505 | 87506 |
| 87507 | 87510 | 87511 | 87512 | 87513 | 87516 | 87517 | 87520 | 87521^ | 87522 |
| 87523 | 87525 | 87526 | 87527 | 87528 | 87529 | 87530 | 87531 | 87532 | 87533 |
| 87534 | 87535 | 87536 | 87537 | 87538 | 87539 | 87540 | 87541 | 87542 | 87550 |
| 87551 | 87552 | 87555 | 87556 | 87557 | 87560 | 87561 | 87562 | 87563^ | 87564 |
| 87580 | 87581 | 87582 | 87590 | 87591^ | 87592 | 87593 | 87594 | 87623 | 87624 |
| 87625 | 87626 | 87627 | 87631^ | 87632 | 87633^ | 87634^ | 87640 | 87641 | 87650 |
| 87651^ | 87652 | 87653 | 87660 | 87661 | 87662 | 87797 | 87798 | 87799 | 87800 |
| 87801^ | 87802 | 87803 | 87804^ | 87806^ | 87807^ | 87808^ | 87809^ | 87810 | 87812 |
| 87850 | 87880^ | 87899^ | 87900 | 87901 | 87902 | 87903 | 87904+ | 87905* | 87906 |
| 87910 | 87912 | 87999 | G0499 | | | | | | |

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

The following procedure codes may be reimbursed once per day by the same provider:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|--------|-------|--------|--------|--------|-------|-------|
| 86790 | 86794 | 87015 | 87046 | 87071 | 87075 | 87076 | 87077^ | 87081 | 87088 |
| 87101 | 87102 | 87106 | 87107 | 87140 | 87147 | 87149 | 87150 | 87152 | 87153 |
| 87154 | 87181 | 87182 | 87184 | 87185 | 87186 | 87188 | 87190 | 87206 | 87209 |
| 87210^ | 87252 | 87254 | 87634^ | 87300 | 87801^ | 87809^ | 87899^ | 87904 | |

25.2.11.1 Zika Virus Testing

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

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

25.2.12 Human Immunodeficiency Virus (HIV) Drug Resistance Testing

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

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

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

- Individuals who have an initial (new onset) acute HIV infection, to determine if a drug-resistant viral strain was transmitted, and to plan a drug regimen accordingly; or
- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500, and less than 1000 copies/ml.

Documentation must be maintained in the client’s medical record to support medical necessity for drug-resistance testing. Specific documentation requirements are dependent upon testing rationale.

Documentation must include, but is not limited to, the date the drug regimen was initiated, the dosage and frequency of the prescribed medication, and laboratory tests which support all of the following:

- Acute HIV infection, with identification of the specific viral strain; and
- Virological failure during antiretroviral therapy with HIV RNA levels greater than 500 and less than 1000 copies/ml.

Drug resistance testing is not recommended if one of the following criteria is met:

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

25.2.13 Organ or Disease-Oriented Panels

The following organ or disease-oriented panel procedure codes are benefits of the CSHCN Services Program:

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

For all procedure codes listed in the organ or disease-oriented panels table above, refer to the Current Procedural Terminology (CPT) manual for information regarding laboratory panels and appropriate modifiers.

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

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

25.2.14 Urinalysis and Chemistry

The following urinalysis and chemistry procedure codes are benefits of the CSHCN Services Program:

| Procedure Codes | | | | | | | | | |
|---|-------------|--------|--------|--------|--------|--------|--------|--------|--------|
| Urinalysis | | | | | | | | | |
| 81000 | 81001 | 81002* | 81003^ | 81005 | 81015 | 81020 | 81050 | 81099 | |
| Chemistry | | | | | | | | | |
| 82009 | 82010^ | 82013 | 82016 | 82017 | 82024 | 82030 | 82040^ | 82042* | 82043^ |
| 82044^ | 82045 | 82075 | 82077 | 82085 | 82088 | 82103 | 82104 | 82105 | 82107 |
| 82108 | 82120^ | 82127 | 82128 | 82131 | 82135 | 82136 | 82139 | 82140 | 82150^ |
| 82154 | 82157 | 82160 | 82163 | 82164 | 82166 | 82172 | 82175 | 82180 | 82190 |
| 82232 | 82239 | 82240 | 82247^ | 82248 | 82252 | 82261 | 82270* | 82271^ | 82272* |
| 82274^ | 82286 | 82300 | 82306 | 82308 | 82310^ | 82330^ | 82331 | 82340 | 82355 |
| 82360 | 82365 | 82370 | 82373 | 82374^ | 82375 | 82376 | 82378 | 82379 | 82380 |
| 82382 | 82383 | 82384 | 82387 | 82390 | 82397 | 82415 | 82435^ | 82436 | 82438 |
| 82441 | 82465^ | 82480 | 82482 | 82485 | 82495 | 82507 | 82523^ | 82525 | 82528 |
| 82530 | 82533 | 82540 | 82542 | 82550^ | 82552 | 82553 | 82554 | 82565^ | 82570^ |
| 82575 | 82585 | 82595 | 82600 | 82607 | 82608 | 82610 | 82615 | 82626 | 82627 |
| 82633 | 82634 | 82638 | 82642 | 82652 | 82653 | 82656 | 82657 | 82658 | 82664 |
| 82668 | 82670 | 82671 | 82672 | 82677 | 82679^ | 82681 | 82693 | 82696 | 82705 |
| 82710 | 82715 | 82725 | 82726 | 82728 | 82735 | 82746 | 82747 | 82757 | 82759 |
| 82760 | 82775 | 82776 | 82784 | 82785 | 82787 | 82800 | 82803 | 82805 | 82810 |
| 82820 | 82930 | 82938 | 82941 | 82943 | 82945 | 82946 | 82947^ | 82948 | 82950^ |
| 82951^ | 82952+ ^ | 82955 | 82960 | 82963 | 82965 | 82977^ | 82978 | 82979 | 82985^ |
| 83001^ | 83002^ | 83003 | 83009 | 83010 | 83012 | 83013 | 83014 | 83015 | 83018 |
| 83020 | 83021 | 83026* | 83030 | 83033 | 83036^ | 83037^ | 83045 | 83050 | 83051 |
| 83060 | 83065 | 83068 | 83069 | 83070 | 83080 | 83088 | 83090 | 83150 | 83491 |
| 83497 | 83498 | 83500 | 83505 | 83516^ | 83518 | 83519 | 83520* | 83525 | 83527 |
| 83528 | 83540 | 83550 | 83570 | 83582 | 83586 | 83593 | 83605^ | 83615 | 83625 |
| 83630 | 83631 | 83632 | 83633 | 83655^ | 83670 | 83690 | 83695 | 83698 | 83700 |
| 83701 | 83704 | 83718^ | 83719 | 83721^ | 83722 | 83727 | 83735 | 83775 | 83785 |
| 83825 | 83835 | 83857 | 83864 | 83872 | 83873 | 83874 | 83880^ | 83883 | 83885 |
| 83915 | 83916 | 83918 | 83919 | 83921 | 83930 | 83935 | 83937 | 83945 | 83950 |
| 83951 | 83970 | 83986^ | 83992 | 83993 | 84035 | 84060 | 84066 | 84075^ | 84078 |
| 84080 | 84081 | 84085 | 84087 | 84100 | 84105 | 84106 | 84110 | 84119 | 84120 |
| 84126 | 84132^ | 84133 | 84134 | 84135 | 84138 | 84140 | 84143 | 84144 | 84145 |
| *CLIA Waived test +Add-on code ^QW Modifier | | | | | | | | | |

| Procedure Codes | | | | | | | | | |
|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| 84146 | 84150 | 84152 | 84153 | 84154 | 84155^ | 84156 | 84157* | 84160 | 84165 |
| 84166 | 84181 | 84182 | 84202 | 84203 | 84206 | 84207 | 84210 | 84220 | 84228 |
| 84233 | 84234 | 84235 | 84238 | 84244 | 84252 | 84255 | 84260 | 84270 | 84275 |
| 84285 | 84295^ | 84300 | 84302 | 84305 | 84307 | 84311 | 84315 | 84375 | 84376 |
| 84377 | 84378 | 84379 | 84392 | 84402 | 84403 | 84425 | 84430 | 84431 | 84432 |
| 84436 | 84437 | 84439 | 84442 | 84443^ | 84445 | 84446 | 84449 | 84450^ | 84460^ |
| 84466 | 84478^ | 84479 | 84480 | 84481 | 84482 | 84484 | 84485 | 84488 | 84490 |
| 84510 | 84512 | 84520^ | 84525 | 84540 | 84545 | 84550^ | 84560 | 84577 | 84578 |
| 84580 | 84583 | 84585 | 84586 | 84588 | 84590 | 84591 | 84597 | 84600 | 84620 |
| 84630 | 84681 | 84702 | 84703^ | 84999 | | | | | |
| Molecular Testing | | | | | | | | | |
| 83006 | | | | | | | | | |
| Ophthalmology and Optometry | | | | | | | | | |
| 83861^ | | | | | | | | | |
| *CLIA Waived test +Add-on code ^QW Modifier | | | | | | | | | |

Procedure codes 81099, 82105, 82107, 82803, 82805, 82948, 84703, and 84999 are limited to one per day when billed by any provider.

Procedure code 84583 will be denied if billed on the same day by the same provider as procedure codes 81000, 81001, 81002, 81003, 81005, or 81020.

Procedure code 82270 is limited to one per rolling year when billed by any provider.

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

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

Referto: Section 25.2.9, “*Helicobacter pylori* (*H. pylori*)” in this chapter for information about limitations on procedure codes 83009, 83013, and 83014.

25.2.15 Other Laboratory Services

The following procedure codes are denied for pathologists as noncovered for specialty type

| Procedure Codes | | | |
|-----------------|-------|-------|-------|
| Surgery | | | |
| 36430 | 36440 | 36455 | |
| Consultation | | | |
| 99252 | 99253 | 99254 | 99255 |

Payment may be considered on appeal if the pathologist can document the medical necessity of performing the procedures.

25.2.16 Repeated Procedures

25.2.16.1 Modifier 91

Modifier 91 must be used for clinical diagnostic laboratory tests performed more than one time per day as follows:

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

Certain procedure codes have been removed from modifier 91 auditing. These are procedure codes that have been identified as routinely being performed at the same time, more than twice per day for each analyte. Documentation of time is required. If no time documentation is received, the claim will be denied. Providers may appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 91 continue to be audited for modifier 91.

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

Referto: Chapter 7, “Appeals and Administrative Review.”

25.2.17 Receiving Labs and Lab Handling Fees

An independent laboratory may not bill for laboratory tests when the specimen is forwarded to another laboratory without performing any tests on that specimen. An independent laboratory may bill the CSHCN Services Program for tests referred to another laboratory (independent or hospital) only if the independent laboratory performs at least one test and forwards a portion of the same specimen to another laboratory (receiving laboratory) to have one or more tests performed. In this instance, the receiving laboratory may bill for tests it performs and all tests the receiving laboratory performs on the specimen. When billing, the *YES* box in Block 20 of the CMS-1500 paper claim form must be marked, the complete name, NPI, address, and ZIP code of the outside receiving laboratory where the specimen was forwarded must be entered in Block 32, and the taxonomy code of the receiving laboratory must be indicated in Block 24j next to each procedure to be performed by the receiving laboratory. Enter the taxonomy code in the shaded area of the field. Enter the NPI in the unshaded area of the field.

Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories.

In order to bill a handling fee, the receiving laboratory’s name and address and unique NPI number must be included on the claim in Blocks 17 and 17B.

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

When billing for laboratory services, providers should use the date the specimen is collected as the date of service. If the specimen is sent to a receiving laboratory and the client is an inpatient, the hospital is responsible for payment of these services to the receiving laboratory.

25.3 Claims Information

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

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

Laboratory services providers must indicate the specific laboratory procedure codes that are being submitted for claims filing.

The Healthcare Common Procedure Coding System (HCPCS)/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Referto: Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information about electronic claims submissions.

Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing.

Section 5.7.2.4, “CMS-1500 Paper Claim Form Instructions” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

25.3.1 Modifiers To Use When Billing Laboratory Procedures

Providers may use an appropriate modifier to bill for laboratory procedures as needed.

Providers may refer to the CMS website at www.cms.gov for guidelines on which modifier to use when submitting claims for laboratory services.

25.4 Reimbursement

In compliance with state and federal law, the CSHCN Services Program reimburses laboratories for most services according to maximum fees established by federal law, Medicare, or HHSC. Clinical laboratory services may be reimbursed the lower of the national fee schedule amount, the billed amount, or the amount allowed by Texas Medicaid. Some services (e.g., anatomical pathology) may be reimbursed according to the Texas Medicaid Reimbursement Methodology (TMRM). For automated lab tests, the fees that are paid are calculated by compiling the number of automated tests on the date of service and assigning an automated test panel payment code.

Physicians may be reimbursed for laboratory services the lower of the billed amount or the amount allowed by Texas Medicaid. Outpatient hospitals may be reimbursed for laboratory services at 72 percent of the rate equivalent to the hospital’s Medicaid interim rate.

As the result of the *Tax Equity and Fiscal Responsibility Act* (TEFRA) of 1982, independent laboratories are not directly reimbursed by the CSHCN Services Program when providing tests to clients registered as hospital inpatients or hospital outpatients. Reimbursement must be obtained from the hospital. These services cannot be billed to the client.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

25.4.1 Clinical Laboratory Fee Schedule

The *Deficit Reduction Act* (DEFRA) of 1984 requires clinical diagnostic laboratory tests that are performed in a physician’s office by an independent laboratory or a hospital laboratory for its outpatients be reimbursed on the basis of maximum fee schedules. The Texas Medicare carrier publishes the fee schedules on an annual basis. By federal law, the CSHCN Services Program payment *cannot* exceed that allowed by Medicare.

25.4.2 One-day Payment Window Reimbursement Guidelines

According to the one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within 1 day of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

The one-day payment window reimbursement guidelines do not apply for professional services that are rendered in the inpatient hospital setting.

Referto: Section 24.3.7, “Payment Window Reimbursement Guidelines” in Chapter 24, “Hospital” for additional information about the one-day payment window reimbursement guidelines.

25.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.