Laboratory Services

CSHCN Services Program Provider Manual

November 2026

TEXAS
Health and Human
Services

LABORATORY SERVICES

Table of Contents

25.1 Enrollment 3
25.1.1 Clinical Laboratory Improvement Amendments (CLIA) of 1988 4
25.1.1.1 Waiver and Physician-Performed Microscopy Procedure (PPMP) Certificates 5
25.2 Benefits, Limitations, and Authorization Requirements 5
25.2.1 Hospital Laboratory Services 5
25.2.2 Independent Laboratory Services 6
25.2.3 Physician-Owned Laboratory Services 6
25.2.3.1 Other Physician Laboratory-Related Services 6
25.2.4 Clinical Pathology Services 6
25.2.5 Other Laboratory Procedures 7
25.2.5.1 Drug Testing and Therapeutic Drug Assays 7
25.2.5.2 *Cytogenetics Testing 8
25.2.5.3 Genetic Testing for Colorectal Cancer 12
25.2.5.3.1 Authorization Requirements 13
25.2.5.3.2 Familial Adenomatous Polyposis (FAP) 13
25.2.5.3.3 Hereditary Nonpolyposis Colorectal Cancer (HNPCC) 14
25.2.5.4 Genetic Testing for Hereditary Breast and Ovarian Cancers 14
25.2.5.4.1 Authorization Requirements 15
25.2.6 Cytopathology of Vaginal, Cervical, and Uterine Sites 16
25.2.7 Cytopathology Studies Other Than Vaginal, Cervical, or Uterine 16
25.2.8 Evocative and Suppression Testing 17
25.2.9 Helicobacter pylori (H. pylori) 17
25.2.10 Hematology and Coagulation 18
25.2.11 Microbiology 19
25.2.11.1 Zika Virus Testing 20
25.2.12 Human Immunodeficiency Virus (HIV) Drug Resistance Testing 20
25.2.13 Organ or Disease-Oriented Panels 20
25.2.14 Urinalysis and Chemistry 21
25.2.15 Other Laboratory Services 22
25.2.16 Repeated Procedures 23
25.2.16.1 Modifier 91 23
25.2.17 Receiving Labs and Lab Handling Fees 23
25.3 Claims Information 24
25.3.1 Modifiers To Use When Billing Laboratory Procedures 24
25.4 Reimbursement 24
25.4.1 Clinical Laboratory Fee Schedule 25
25.4.2 One-day Payment Window Reimbursement Guidelines 25
25.5 TMHP-CSHCN Services Program Contact Center 25

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

Refer to: The TMHP website Required CLIA Lab Certifications web page at www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code.

Refer to: 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.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.*

Refer to: The TMHP website Required CLIA Lab Certifications web page at www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications for required laboratory certifications for each HCPCS procedure code. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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 TMHP website Required CLIA Lab Certifications web page at* www.tmhp.com/resources/rate-and-code-updates/required-clia-lab-certifications *for required laboratory certifications for each HCPCS procedure code.*

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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:

[Revised] 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

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

[Revised] 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

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

[Revised] 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

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

[Revised] 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	Q87A	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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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						

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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	

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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**									

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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									
Opthalmology 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.

Refer to: 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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

Refer to: 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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

Refer to: 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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

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.

Refer to: 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.

CPT ONLY - COPYRIGHT 2025 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.