



Texas Medicaid Provider Procedures Manual

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2

Provider Handbooks

Radiology and Laboratory Services Handbook

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

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1 General Information

This information is intended for Texas Medicaid independent (freestanding) laboratories, radiological laboratories, and physiological laboratories. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Referto: “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

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

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Referto: Subsection 3.7.4.14, “Payment Window Reimbursement Guidelines” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for additional information about the payment window reimbursement guidelines.

2 Independent Laboratory

The requirements in this section apply to all providers who bill laboratory services.

2.1 Enrollment

Providers must meet the following requirements and submit a complete application in order to enroll as independent (freestanding) laboratory providers:

- The provider must be actively enrolled in Medicare as an independent laboratory.
- The independent laboratory must be independent from a physician's office or hospital.
- The independent laboratory must meet staff, equipment, and testing capability standards for certification by the Health and Human Services Commission (HHSC).

2.1.1 Clinical Laboratory Improvement Amendments (CLIA)

CLIA regulations set standards that are 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.

The regulations concern all laboratory testing that is used for the assessment of human health or the diagnosis, prevention, or treatment of disease. Under CLIA 88, all clinical laboratory providers (including those located in physicians' offices), regardless of location, size, or type of laboratory, must meet certain standards based on the complexity of the tests they perform.

Providers must hold the appropriate CLIA certificates to perform certain tests as indicated in this handbook. Providers that are certified only to perform waived tests must use modifier QW as indicated on the CMS website.

Referto: The [CLIA Regulations and Federal Register Documents](#) page of the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov for the CLIA rules and regulations. The regulations are found at Title 42 Code of Federal Regulations, Part 493.

2.1.2 CLIA Requirements

To be eligible for reimbursement by Medicare and Medicaid, all providers that perform laboratory tests must do the following:

- Pay the applicable fee to 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 Licensing and Certification Division
HHSC
1100 West 49th Street
Austin, TX 78756

- Notify the Texas Medicaid & Healthcare Partnership (TMHP) of the assigned CLIA number at the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

TMHP monitors claims that are submitted by clinical laboratory providers to verify that the clinical laboratory has a CLIA number on file. If the provider does not have a CLIA number on file with TMHP, the laboratory services claims may be denied.

2.2 Services, Benefits, Limitations, and Prior Authorization

Texas Medicaid only covers professional and technical services that an independent laboratory is certified by CLIA to perform.

Provider documentation must be maintained in the client's medical record and must delineate the medical need for administering the laboratory test.

The physician is responsible for providing to the performing laboratory the clinical diagnosis code that is associated with the individual test so that the performing laboratory may bill Texas Medicaid directly for the analysis of the specimen.

Referto: The Current Procedural Terminology (CPT) manual for information regarding examples of laboratory codes. Correct use of CPT coding requires using the most specific laboratory code that matches the services provided, based on the code's description.

2.2.1 CLIA Certificates

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Referto: The [Categorization of Tests](#) page of the CMS website at www.cms.gov for additional information.

Providers that are certified only to perform waived tests must use modifier QW as indicated on the CMS website.

2.2.2 Laboratory Handling Fees and Reference Laboratories

2.2.2.1 Independent Laboratory Providers

An independent laboratory provider may be reimbursed for tests performed in the laboratory and for laboratory handling fees for tests that are forwarded to another laboratory (i.e., reference laboratory).

An independent laboratory that forwards a specimen to another laboratory without performing any tests on that specimen may not bill for any laboratory tests.

An independent laboratory may only bill Texas Medicaid for tests referred to another independent or hospital laboratory if it performs at least one test that it is certified by CLIA to perform, and forwards a portion of the same specimen to the other laboratory to have one or more tests performed. The referring laboratory may then bill for tests it has performed on the specimen. When billing, the following information must be on the claim:

- Block 20: “Yes” box must be checked.
- Block 32: The name, address, and ZIP Code of the reference laboratory (i.e., the laboratory to which the specimen was referred).
- Block 24-J: The provider number of the reference laboratory must be included next to each procedure to be performed by the reference laboratory.

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 if the specimen is collected by routine venipuncture or catheterization.

2.2.2.2 Physician Providers

A physician may bill only one laboratory handling charge (procedure code 99000) per client visit when the specimen is collected by drawing a blood sample through venipuncture or collecting a urine specimen by catheterization, unless the specimen is divided and sent to different laboratories or there are different specimens collected and sent to different laboratories.

The claim must indicate the name and address of each laboratory where a specimen is sent for more than one laboratory handling charge to be paid.

Referto: Subsection 9.2.39, “Laboratory Services” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information about laboratory services reimbursed to physician providers.

2.2.2.3 Outpatient Hospital Providers

An outpatient hospital may be reimbursed for a laboratory handling charge (procedure code 99001) for each independent laboratory to where it sends specimens when the laboratory handling charge is not being billed through other methods.

2.2.2.4 Family Planning Laboratory Tests

Family planning agencies must use procedure code 99000 with a family planning diagnosis code to bill their laboratory handling charges for laboratory specimens sent out; modifier FP must be omitted. Providers may refer to the appropriate section in the provider manual for instructions for billing family planning services. As with procedure code 99000, only one handling fee may be charged for each laboratory to where the agency sends specimens, regardless of the number of specimens taken.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service.

Referto: Subsection 6.1, “Services, Benefits, Limitations, and Prior Authorization” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for the complete list of family planning diagnosis codes.

2.2.3 Nonclinical Laboratory Procedures

The reimbursement for nonclinical laboratory procedure codes can be found on the appropriate Texas Medicaid fee schedules on the TMHP website at www.tmhp.com.

2.2.4 Clinical Laboratory Procedures

The reimbursement for clinical laboratory procedures can be found on the appropriate [Texas Medicaid fee schedule](#). Fee schedules are available on the TMHP website at www.tmhp.com.

2.2.4.1 Repeat Procedures

Modifier 91 should be used for repeat clinical diagnostic tests 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 and services must be documented on appeal.

Providers may appeal claims that have been denied for documentation of time. Most procedure codes that initially required modifier 91 will 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.

2.2.5 Automated Laboratory Tests and Laboratory Paneling

The 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. The Texas Medicaid allowable fee 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.

2.2.5.1 Fee Calculations for Automated Tests and Laboratory Panels

Automated test and laboratory panel procedure codes may be reimbursed according to the appropriate ATP level payment based on the total number of automated tests that are performed on the same day for the same client.

Referto: The “Clinical Laboratory, Automated Test Panels - Insert” [Texas Medicaid fee schedule](#) on the TMHP website at www.tmhp.com for the ATP level payment for automated test and lab panel procedure codes.

ATP Level Pricing

The amount that is allowed for each automated test and lab panel procedure code that is billed with the same date of service for the same client will be a percentage of the total ATP level payment. To calculate the automated test pricing, the following information is necessary:

- The number of automated tests that are billed for the client for the same date of service (including individual automated tests and all automated tests that are represented by the laboratory panels.) Procedure codes that are duplicated between panels are not counted more than once.
- The ATP pricing fee that corresponds to the number of automated tests that are billed for the client for the same date of service.
- The total billed amount for all automated test and laboratory panel procedure codes that are billed for the client for the same date of service.

The automated test pricing may be calculated as follows:

Step 1

A percentage for each automated test or lab panel detail is derived from dividing the billed amount (B/A) for each procedure by the total billed amount (TB/A) for all automated test and laboratory panel procedure codes with the same date of service for the same client.

Example:

Automated Test	B/A	Percentage
Detail 1 Automated Test	= \$50.00	= 29%
Detail 2 Automated Test	= \$25.00	= 14%
Detail 3 Lab Panel	= \$100.00	= 57%
Detail 4 Clinical Lab Test	= \$20.00	= 0%
	TB/A = \$175.00	

Note: The TB/A is for automated test and laboratory panel procedure codes (details 1, 2, and 3 only). Detail 4 is not included in the calculations for the automated tests because it is a clinical lab procedure code and may be reimbursed as indicated on the fee schedule.

Calculations:

Detail 1	= 50.00 / 175.00	= .285714285714...	= 29%
Detail 2	= 25.00 / 175.00	= .142857142857...	= 14%
Detail 3	= 100.00 / 175.00	= .571428571428...	= 57%

Step 2

The detail allowed amount for each automated test (AT) procedure code will be the calculated percentage of the ATP level payment.

Example:

Automated Test	Number of Automated Tests	Allowed Amount
Detail 1 Automated Test	= 1	= \$3.10
Detail 2 Automated Test	= 1	= \$1.55
Detail 3 Lab Panel	= 4	= \$6.19
Detail 4 Clinical Lab Test	= 0	= Fee Schedule
ATP = 6 = \$10.84		

Note: The total number of automated tests includes the individual automated test procedure codes and the number of automated tests that are represented by each panel procedure code that is billed. Automated tests that are duplicated between panels are not counted more than once.

Calculations:

Detail 1	= 29% of 10.84	= (.285714285714...)X(10.84)	= \$3.10
Detail 2	= 14% of 10.84	= (.142857142857...)X(10.84)	= \$1.55
Detail 3	= 57% of 10.84	= (.571428571428...)X(10.84)	= \$6.19
			\$10.84

Note: If a clinical laboratory procedure code is included in a panel, the fee schedule rate for the clinical laboratory procedure is added to the ATP rate, and the resulting sum is divided among the automated test and laboratory panel procedure codes that are billed for the date of service.

The total allowed amount for all laboratory services that are billed for the client for the same date of service will represent the ATP level pricing combined with any clinical laboratory test fee schedule pricing.

2.2.6 Breast Cancer Gene 1 and 2 (BRCA) Testing

Breast Cancer Gene 1 and 2 (BRCA) testing services are benefits of Texas Medicaid when billed with the following procedure codes:

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

Breast cancer gene 1, early onset (BRCA1) and breast cancer gene 2, susceptibility protein (BRCA2) are tumor repressor genes responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast and ovarian cancer, have been linked to other types of cancer such as pancreatic and prostate, and can be inherited from a person’s mother or father.

Note: Coverage of BRCA mutation analysis testing, including large rearrangement gene mutation analysis testing, are based on the National Comprehensive Cancer Network (NCCN) guidelines.

Interpretation of gene mutation analysis results is not separately reimbursable. Interpretation is part of the physician E/M service.

BRCA gene mutation analysis testing must be ordered based on familial medical history and the availability of previous familial gene mutation analysis testing results and only if the test results will affect treatment decisions or provide prognostic information.

Unaffected male or females with a family history of breast cancer, including diagnosis of ductal carcinoma in situ (DCIS), should only be considered for testing when the appropriate affected family member is unavailable. Clinical judgment should be used to determine if the client has a reasonable likelihood of a mutation, considering the client's current age and the age of the unaffected female relatives who link the client with the affected relatives.

It is mandatory that a client who is at risk for BRCA1, BRCA2, or BRCA large rearrangement genetic mutation receive genetic counseling before and after BRCA gene mutation testing.

BRCA gene mutation analysis testing (procedure codes 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217) is limited to once per lifetime.

The prescribing provider is responsible for ordering the appropriate BRCA test (e.g., BRCA1 versus BRCA2) based on medical necessity of the testing criteria and genetic counseling results. If a client's BRCA test has a positive result, any further BRCA testing services requested with documentation of medical necessity will be considered on a case-by-case basis by Medical Director review for prior authorization.

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

2.2.6.1 Genetic Counseling

Genetic counseling must be provided by a trained genetic counselor, nurse specialist in genetics, or other medical provider possessing expertise in genetic counseling that is not affiliated with the genetic testing laboratory for clients before and after BRCA gene mutation testing.

Both pre- and post-test counseling must provide the depth of content and time for the client to make an informed testing decision. The genetic counseling must be nondirective, and information about the purpose and nature of the tests must be provided to the client.

Pre-test genetic counseling must include:

- The risks and benefits of the specific genetic testing.
- The limitations of the specific genetic testing to be performed and the limitations of interpreting test results for an unaffected individual.

2.2.6.2 Documentation

Providers must maintain the following gene mutation analysis testing documentation in the client's medical record:

- The appropriateness of the genetic testing
- The client's specific high-risk criteria
- The benefit of the specific genetic testing to be performed
- Pre-testing genetic counseling, including all of the following:
 - Pre-test counseling date with the name and qualifications of the counseling professional
 - The risks, benefits, and limitations discussed with the client
 - The client's ability to understand the risks, benefits, and limitations and the client's informed choice to proceed with the specific gene mutation analysis testing as evidenced by the client's signature on a consent form specific to the genetic mutation testing to be performed.
- The client's previous BRCA comprehensive gene mutation analysis testing results to support medical necessity for ordering BRCA gene mutation analysis testing
- Post-testing genetic counseling, including all the following:

- Post-test counseling date with the name and qualifications of the counseling professional
- The client's ability to understand the results of the gene mutation analysis testing and the appropriate medical treatment resulting from the test results.
- The client's treatment plan and any treatment plan changes based on interpretation of the test results

The medical record is subject to retrospective review.

2.2.6.3 Prior Authorization for BRCA Testing

Prior authorization is required for initial BRCA testing (procedure codes 81162, 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217).

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

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

The prior authorization request must include documentation that indicates that the client meets one or more of the criteria below:

- An individual (male or female) from a family with a known deleterious BRCA1/BRCA2 mutation
- A female with a personal history of breast cancer, including invasive or ductal carcinoma in situ (DCIS), diagnosed at age 45 years or younger
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age and of an ethnicity associated with higher mutation frequency, such as: Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent
- A female with a personal history of epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers, diagnosed at any age
- A male with a personal history of breast cancer, including DCIS, diagnosed at any age
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 50 years or younger, and has one of the following:
 - An additional primary (2 primary sites, including bilateral or clearly separate ipsilateral) tumors occurring either synchronously or asynchronously
 - At least one close blood relative with breast cancer at any age
 - An unknown or limited family history
- A female with a personal history of breast cancer, including DCIS, diagnosed at age 60 years or younger with triple negative breast cancer
- A female with a personal history of breast cancer, including DCIS, diagnosed at any age, and has one of the following:
 - At least one close blood relative with breast cancer diagnosed at age 50 years or younger
 - At least two close blood relatives with breast cancer at any age
 - At least one close blood relative with epithelial ovarian cancer, including fallopian tube and primary peritoneal cancers
 - At least two close blood relatives with pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age

- A close male blood relative with breast cancer at any age
- A male or female with a personal history of pancreatic cancer or prostate cancer (Gleason score 7 or greater) at any age regardless of ancestry with at least two close blood relatives with one of the following:
 - Breast cancer
 - Ovarian cancer, including fallopian tube and primary peritoneal cancers
 - Prostate cancer (Gleason score 7 or greater)
 - Pancreatic cancer
- A male or female with a personal history of pancreatic cancer at any age and of an ethnicity associated with higher mutation frequency, such as Ashkenazi Jewish, Icelandic, Swedish, or Hungarian descent and one or more close blood relatives with pancreatic cancer
- A male or female with a family history of breast or ovarian cancer, including DCIS with one of the following:
 - At least one first or second degree blood relative meeting any of the criteria above; or
 - At least one third degree blood relative who has breast cancer, including DCIS, or ovarian cancer, including fallopian tube and primary peritoneal cancers, and at least two close blood relatives with one of the following:
 - Breast cancer, including DCIS, of which at least one with breast cancer was diagnosed at 50 years of age or younger
 - Ovarian cancer, including fallopian tube and primary peritoneal cancers

Note: The term “close blood relative” includes first-degree male or female relatives (e.g., parents, siblings), second-degree relatives (e.g., aunts, uncles, grandparents), and third-degree relatives (e.g., first cousins, great grandparents), from the same side of the family as the client.

Prior authorization for additional BRCA testing may be considered on a case-by-case basis by Medical Director review when testing criteria for these studies are met for clients who:

- Have previously been tested for BRCA sequencing gene mutation analysis testing and received negative results. Documentation of negative results for all previous BRCA1 sequencing gene mutation analysis testing is required.
- Every reasonable effort and documentation of the specific efforts made to obtain the previous BRCA sequencing gene mutation analysis test results from the client's genetic testing physician or the testing laboratory.

A completed Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing Prior Authorization Request Form that has been signed and dated by the referring provider must be submitted.

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

For comprehensive sequencing (procedure codes 81162 or 81163), the physician must indicate one of the following on the prior authorization request form:

- The client's familial genetic history that supports medical necessity for the requested BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing.
- Every reasonable effort was made to obtain the client's familial genetic history and have been unable to obtain BRCA1 and BRCA2 comprehensive sequencing gene mutation analysis testing results for the affected family member(s). Documentation of the specific efforts made to obtain the client's familial genetic history must be submitted with the request.

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

To complete the prior authorization process, the provider must mail or fax the request to the TMHP Special Medical Prior Authorization Unit and include documentation of medical necessity.

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

2.2.7 Complete Blood Count (CBC)

A CBC and its components may be reimbursed by Texas Medicaid without prior authorization. The medical necessity for all laboratory services must be documented in the client's medical record, and the services must be referenced to an appropriate diagnosis code.

Texas Medicaid considers a baseline CBC appropriate for the evaluation and management of existing and suspected disease processes. CBC tests should be individualized and based on client history, clinical indications, or proposed therapy, and will not be reimbursed for screening purposes.

When related CBC procedure codes are billed for the same date of service by the same provider, the first procedure code will be reimbursed and all other procedure codes will be denied.

Reticulocyte procedure codes may be reimbursed in addition to the CBC, hemogram, differential analysis, and platelet procedure codes indicated above.

Referto: The appropriate [Texas Medicaid fee schedule](#) on the TMHP website at www.tmhp.com for CBC procedure codes that may be reimbursed.

2.2.8 Drug Testing and Therapeutic Drug Assays

The following procedure codes for drug testing and therapeutic drug assays may be reimbursed by Texas Medicaid:

Procedure Codes											
80150	80155	80156	80157	80158	80159	80162	80163	80164	80165		
80168	80169	80170	80171	80173	80175	80176	80177	80178^	80180		
80183	80184	80185	80186	80188	80190	80192	80194	80195	80197		
80198	80199	80200	80201	80202	80203	80299	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									
^ QW Modifier											

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

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

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

Chemistry procedure codes used for specimen validity testing (procedure codes 82540, 82550, 82552, 82553, 82554, 83986, and 84311) will be denied when submitted on the same date of service by the same provider, as procedure code G0480, G0481, G0482, G0483, or G0659.

The following CPT Drug Assay procedure codes will be denied when billed on the same date of service, by the same provider with the corresponding HCPCS Drug Assay procedure codes identified with an "X":

CPT Drug Assay Procedure Codes					
	G0480	G0481	G0482	G0483	G0659
80305^					X
80306					X
80307					X
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	
80333	X			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 "80000" CPT procedure code will be denied if billed with the HCPCS "G" procedure code indicated with an "X."
 (Blank) There is no relationship between the "80000" CPT procedure code and the HCPCS "G" procedure code. Both procedure codes may be reimbursed if billed with the same date of service.
 ^QW Modifier

2.2.8.1 Documentation Requirements

All services outlined in this section are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided.

2.2.9 Evocative and Suppression Testing

The following procedure codes for evocative and suppression testing may be reimbursed by Texas Medicaid:

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							

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

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.10 Genetic Testing for Colorectal Cancer

Genetic testing is provided to clients who have a first- or second-degree relative who has or has had colorectal cancer in order to determine if the client may have increased risk for developing colorectal cancer.

Note: 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.

Interpretation of gene mutation analysis results are part of the evaluation and management service and will not be reimbursed separately.

Genetic test results, when informative, may influence clinical management decisions. The documentation that is maintained in the client's medical record must reflect that the client 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. The testing must be medically necessary and supported by documentation with a clear rationale for testing, which must be retained in the client's medical record and made available upon request.

2.2.10.1 Documentation Requirements

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

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

The provider must order the test based on the familial medical history and the availability of previous family testing results. The medical record is subject to retrospective review.

Referto: The appropriate [Texas Medicaid fee schedule](#) on the TMHP website at www.tmhp.com for genetic testing procedure codes that may be reimbursed.

2.2.10.2 * Authorization Requirements

[Revised] Prior authorization is required for gene mutation analysis. A completed Special Medical Authorization (SMPA) Request Form, signed and dated by the provider rendering direct care, must be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prior authorized services may be reimbursed once per lifetime when billed by any provider. Additional services will not be prior authorized.

Prior authorization requests may be considered for Familial Adenomatous Polyposis (FAP) testing for clients of any age with well defined hereditary cancer syndromes and for which either a positive or negative result will change medical care. The client for whom the request is made must have more than 20 polyps or a first-degree relative with FAP and a documented mutation.

Note: *Clients who are seven years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

Prior authorization requests may be considered for Hereditary Nonpolyposis Colorectal Cancer (HNPCC) testing for clients of any age. Testing for HNPCC is used to determine whether an individual has an increased risk for colorectal cancer or other HNPCC-associated cancers. Results of the test may influence clinical management decisions. The request must include one or more of the following criteria for testing:

- The client has three or more family members (at least one must be a first-degree relative) who have colorectal cancer, and FAP has been ruled out. Two successive generations were affected, and one or more of the relatives was diagnosed with colorectal cancer at 50 years of age or younger.
- The client has had two HNPCC cancers.
- The client has colorectal cancer and a first-degree relative who also has colorectal cancer or HNPCC extracolonic cancer at 50 years of age or younger or colorectal adenoma at 40 years of age or younger.
- The client has had colorectal cancer or endometrial cancer at 50 years of age or younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern on histology at 50 years of age or younger.
- The client has had signet-cell type colorectal cancer at 50 years of age or younger.
- The client has had colorectal adenoma at 40 years of age or younger.
- The client is an asymptomatic individual with a first- or second-degree relative with a documented HNPCC mutation.

Note: *Clients who are 20 years of age or younger must have clear rationale for testing and documentation of medical necessity from the client's medical record must be submitted with the prior authorization request.*

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

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

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. Medical documentation that is submitted by the physician must verify the client's diagnosis or family history.

Guidelines for MLH1 and MLH2 mutation testing are based on guidelines established by the American College of Medical Genetics and the American Gastroenterological Association.

A request for retroactive authorization must be submitted no later than seven calendar days beginning the day after the lab draw is performed.

2.2.11 Hematology and Coagulation

The following hematology and coagulation procedure codes may be reimbursed by Texas Medicaid:

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
85460	85461	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									

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

The following procedure codes are limited to one per day by the same provider:

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

Procedure codes 85460 and 85461 may be reimbursed for female clients who are 10 through 55 years of age.

Procedure code 85004 will deny if billed on the same day by the same provider as procedure code 85007.

Procedure code 85660 is limited to once per lifetime, 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 client's medical records.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.

2.2.12 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 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.
- Individuals who have virological failure during antiretroviral therapy, laboratory results showing HIV RNA levels greater than 500 and less than 1,000 copies/ml.
- HIV-infected pregnant women before initiation of therapy.
- HIV-infected pregnant women entering pregnancy with HIV RNA levels at or below 400 copies/ml while the women are on therapy.

Documentation must be maintained in the client's medical record to support medical necessity for the HIV drug-resistance testing. Specific documentation requirements are dependent on the rationale for the testing. 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 that support all of the following:

- Acute HIV infection, with identification of the specific viral strain
- Virological failure during antiretroviral therapy with HIV RNA levels greater than 500 and less than 1,000 copies/ml
- Positive pregnancy results in an HIV positive female client
- HIV RNA levels of 400 copies/ml or less during pregnancy

HIV drug-resistance testing is not recommended when one of the following criteria is met:

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

Referto: Subsection B.1.1, "Routine HIV Testing Procedure Codes" in "Appendix B: HIV/AIDS" (*Vol. 1, General Information*) for additional information about HIV testing laboratory procedures.

2.2.13 Microbiology

The following procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
Microbiology									
86703	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	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^	87340	87341	87350	87380	87385	87389^
87390	87391	87400	87420	87425	87427	87430	87449^	87450	87451
87471	87472	87475	87476	87480	87481	87482	87485	87486	87487
87490	87491	87492	87493	87495	87496	87497	87498	87500	87501
87502^	87503+	87510	87511	87512	87516	87517	87520	87521	87522
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	87580	87581
87582	87590	87591	87592	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
87850	87880^	87899^	87900	87901	87902	87903	87904	87905^	87906
87910	87912	87999	G0433^	G0499					
Molecular Testing									
87505	87506	87507	87623	87624	87625				
+Add-on code									
^QW Modifier									

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

The following procedure codes are limited to one 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
87181	87184	87185	87186	87188	87190	87206	87209	87210^	87252
87254	87300	87634^	87801	87809^	87899^	87904			
^ QW Modifier									

Procedure code G0433 will be denied if billed on the same day by the same provider as procedure code 86703.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation’s “Choosing Wisely” lists to determine appropriateness of laboratory tests.

2.2.13.1 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.

2.2.14 Organ or Disease-Oriented Panels

The following organ or disease-oriented panel procedure codes may be reimbursed by Texas Medicaid:

Procedure Codes									
80047^	80048^	80050	80051^	80053^	80055	80061^	80069^	80074	80076
80081									
^ QW Modifier									

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

Procedure codes 80055 and 80081 are limited to female clients who are 10 through 55 years of age. Only one service for procedure code 80055 or one service for procedure code 80081 will be reimbursed per pregnancy to the same provider.

Procedure code 80061 is limited to once per rolling year, by any provider, when performed as part of a preventative care medical checkup.

The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined; including any other automated tests billed for the client for the same date of service (DOS). The Texas Medicaid allowable fee 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 DOS.

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 may be billed.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation’s “Choosing Wisely” lists to determine appropriateness of laboratory tests.

2.2.15 Pharmacogenetics

Referto: Subsection 9.2.40, “Pharmacogenetics” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

2.2.16 Urinalysis and Chemistry

The following urinalysis and chemistry procedure codes may be reimbursed by Texas Medicaid for once per day:

Procedure Codes									
Urinalysis									
81000	81001	81002*	81003^	81005	81007^	81015	81020	81025*	81050
81099									
Chemistry									
*CLIA Waived test									
+Add-on code									
^ QW Modifier									

Procedure Codes									
82009	82010^	82013	82016	82017	82024	82030	82040^	82042	82043^
82044^	82045	82075	82085	82088	82103	82104	82105	82106	82107
82108	82120^	82127	82128	82131	82135	82136	82139	82140	82143
82150^	82154	82157	82160	82163	82164	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	82656	82657	82658	82664	82668
82670	82671	82672	82677	82679^	82693	82696	82705	82710	82715
82725	82726	82728	82731	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	83634	83655^	83661	83662	83663	83664	83670
83690	83695	83698	83700	83701	83704	83718^	83719	83721^	83722
83727	83735	83775	83785	83789	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
84030	84035	84060	84066	84075^	84078	84080	84081	84085	84087
84100	84105	84106	84110	84112	84119	84120	84126	84132^	84133
84134	84135	84138	84140	84143	84144	84145	84146	84150	84152
84153	84154	84155^	84156	84157	84160	84163	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
*CLIA Waived test +Add-on code ^ QW Modifier									

Procedure Codes									
84585	84586	84588	84590	84591	84597	84600	84620	84630	84681
84702	84703^	84704	84999						
Molecular Testing									
83006									
Ophthalmology and Optometry									
83861^									
*CLIA Waived test +Add-on code ^ QW Modifier									

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Referto: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

For waived tests, providers must use modifier QW as indicated on the CMS website.

Texas Medicaid limits reimbursement for the procedure codes listed in the table above to one per day without a modifier and one per day with a modifier when billed by the same provider.

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

Procedure codes 82013, 82105, 82106, 82677, 83080, 84163, and 84704 are limited to one per 210 days when billed by any provider.

Procedure code 83698 is limited to the following diagnosis codes:

Diagnosis Codes							
E1165	E119	E139	E7800	E7801	E781	E782	E783
E7841	E7849	E785	I2584				

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.

Procedure codes 82757, 84066, 84152, and 84154 are limited to male clients.

Procedure codes 82120, 84135, and 84138 are limited to female clients.

The following procedure codes are restricted to females who are 10 through 55 years of age:

Procedure Codes									
81025*	82106	82143	82731	83632	83661	83662	83663	83664	84112
84163									
*CLIA waived tests									

Referto: Subsection 9.2.25.8, “*Helicobacter Pylori (H. pylori)*” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for information about limitations on procedure codes 83009, 83013, and 83014.

2.2.17 Additional Laboratory Services

2.2.17.1 Colorectal Cancer Screening

Referto: Subsection 4.2.8, “*Colorectal Cancer Screening*” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)*.

Subsection 9.2.15.2, “*Colorectal Cancer Screening*” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.2 Cytopathology Studies

Referto: Subsection 9.2.25.4, “*Cytopathology Studies—Other Than Gynecological*” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

Subsection 6.14, “*Pap Smear (Cytopathology Studies)*” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.3 Helicobacter pylori Testing

Referto: Subsection 9.2.25.8, “*Helicobacter Pylori (H. pylori)*” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.4 Laboratory Services for Clients on Dialysis

Referto: Subsection 6.2.9, “*Laboratory and Radiology Services*” in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.5 Prognostic Breast and Gynecological Cancer Studies

Referto: Subsection 6.2.9, “*Laboratory and Radiology Services*” in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.6 THSteps Outpatient Laboratory Services

Referto: Subsection 5.3.11.6, “*Laboratory Test*” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

2.2.17.7 Authorization Requirements

Prior authorization is not required for most laboratory services. Providers may refer to the specific sections for those services that require authorizations.

2.3 Documentation Requirements

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

Independent laboratory documentation must include the physician’s signed and dated order for the laboratory tests. The specific tests ordered by the physician must be listed on the order. The test results must also be included in the documentation.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service using a family planning diagnosis code.

Referto: Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for information about Medicaid Title XIX Family Planning Services.

Subsection 6.1, “Services, Benefits, Limitations, and Prior Authorization” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for information about the Texas Women’s Health Program.

A National Provider Identifier (NPI) is required for all claims. In addition, for paper claims, the Texas Provider Identifier (TPI) is required for the billing and performing provider only. NPI-only is required for all other fields.

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

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

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

“Section 6: Claims Filing” (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.1.1 Electronic Filing for Laboratory Providers

Referring provider information is always required on laboratory claims. Failure to submit this data will result in a claim rejection on the TMHP Electronic Data Interchange (EDI).

When the place of service is 6, and the billing provider identifier belongs to a laboratory, there is no need to submit the same provider identifier in the facility ID field. This notation causes the claim to suspend processing unnecessarily, and may cause a delay in the disposition of the claim. For questions about the electronic fields, contact the commercial software vendor or the TMHP EDI Help Desk at 1-888-863-3638.

2.4.2 Reimbursement

The Medicaid rates for independent laboratories are calculated in accordance with 1 TAC §355.8085 and §355.8610, and the Deficit Reduction Act (DEFRA) of 1984. By federal law, Medicaid payments for clinical laboratory services cannot exceed the Medicare payment for that service.

As the result of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, independent laboratories are not directly reimbursed by Texas Medicaid when providing tests to clients who are registered as hospital inpatients. Hospital reimbursements (i.e., inpatient DRG reimbursement) include payment for all pathology and laboratory services, including those sent to referral laboratories. Hospital-based and

referral laboratory providers must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. These services are not billable to Medicaid-covered clients.

Referto: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*).

Texas Medicaid pays up to the amount allowed for the total component for the same procedure, same client, same date of service, any provider.

- Providers who perform 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 TMHP has already made payment for the technical or interpretation component for the same procedure, same dates of service, same client, any provider, the claim for the total component will be denied as previously paid to another provider. The same is true if a total component has already been paid and claims are received for the individual components. Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations.

3 Radiological and physiological laboratory services

3.1 Enrollment

To enroll in Texas Medicaid, physiological laboratory, portable X-ray supplier, independent diagnostic testing facility (IDTF), and radiological laboratory providers must be actively enrolled in Medicare.

3.1.1 Enrollment Criteria for Mammography Providers

All mammography providers, including those providing stereotactic biopsies, must be certified by the Bureau of Radiation Control (BRC).

Additionally, the Department of State Health Services (DSHS) issues mammography certification to providers who render mammography services. Providers can submit this certification to the TMHP Provider Enrollment Department in lieu of certification issued by the Food and Drug Administration (FDA), because a mammography certification issued by DSHS is recognized by the FDA. TMHP will also accept mammography certification issued by the FDA. The certificate will contain the BRC certification number, dates of issue and expiration, type of service, and Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program provider identifiers.

Providers must check the expiration date of their mammography certification and submit an updated mammography certification prior to the expiration date. The certifications can be uploaded to PIMS, faxed to 1-512-514-4214, or mailed to:

Texas Medicaid & Healthcare Partnership
 Provider Enrollment
 PO Box 200795
 Austin, TX 78720-0795

3.2 Services, Benefits, Limitations, and Prior Authorization

The following high-technology radiology services may be reimbursed by Texas Medicaid with prior authorization:

- Cardiac nuclear imaging
- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Functional MRI (fMRI)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET) scan imaging

Note: Providers and facilities are required to use the lowest possible radiation dose that is consistent with acceptable image quality for cardiac nuclear imaging, CT, and PET examinations of all clients. It is recommended that providers and facilities use national standards such as those established by the American College of Radiology in their ACR Practice Guidelines and Technical Standards manual.

Radiology interpretations in any place of service will be denied if they are billed by the attending physician. Services that are billed by the attending physician are included in the facility fee and are not reimbursed separately.

Note: The 3-dimensional (3-D) obstetric ultrasound is not a benefit of Texas Medicaid.

Referto: PA section for exceptions to prior authorization.

3.2.1 Cardiac Nuclear Imaging

Cardiac nuclear imaging is a benefit of Texas Medicaid and may be reimbursed using the following procedure codes:

Procedure Codes									
78414	78428	78451	78452	78453	78454	78466	78468	78472	78473
78481	78483	78494	78496						

The cardiac nuclear imaging study may be reimbursed separately from the diagnostic radiopharmaceutical.

Referto: The [online fee lookup \(OFL\)](#) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.1.1 Authorization Requirements

Authorization is required for cardiac nuclear imaging.

Referto: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in this handbook.

3.2.2 Computed Tomography and Magnetic Resonance Imaging

CT, CTA, MRI, fMRI, and MRA services are benefits of Texas Medicaid.

The following procedure codes may be reimbursed with prior authorization for CT, CTA, MRI, fMRI, and MRA radiology services:

Procedure Codes									
70336	70450	70460	70470	70480	70481	70482	70486	70487	70488
70490	70491	70492	70496	70498	70540	70542	70543	70544	70545
70546	70547	70548	70549	70551	70552	70553	70554	70555	71250
71260	71270	71275	71550	71551	71552	71555	72125	72126	72127
72128	72129	72130	72131	72132	72133	72141	72142	72146	72147
72148	72149	72156	72157	72158	72159	72191	72192	72193	72194
72195	72196	72197	72198	73200	73201	73202	73206	73218	73219
73220	73221	73222	73223	73225	73700	73701	73702	73706	73718
73719	73720	73721	73722	73723	73725	74150	74160	74170	74174
74175	74176	74177	74178	74181	74182	74183	74185	75557	75559
75561	75563	75565	75571	75572	75573	75574	75635	76376	76377
76380	76390	76497	76498	77011	77046	77047	77048	77049	77084

Texas Medicaid may reimburse the total component for procedure codes 76497 and 76498 when the service is rendered in the office and outpatient hospital setting by radiation treatment center providers.

The professional component may be reimbursed when the service is rendered in the office, inpatient hospital, or outpatient hospital setting by physician providers.

The technical component will be a benefit when rendered in the office setting by physician, radiation treatment center, portable X-ray supplier, radiological laboratory, and physiological laboratory providers.

Procedure codes 76497 and 76498 will be a benefit when rendered in the outpatient hospital setting by radiation treatment center providers.

The following revenue codes must be billed with the most appropriate corresponding procedure code for CT, CTA, MRI, fMRI, and MRA radiology services rendered by outpatient hospital providers:

Revenue Codes							
350	351	352	359	610	611	612	619

The addition of post 3-D reconstruction (procedure codes 76376 and 76377) CT, CTA, MRI, and MRA studies must be prior authorized. No additional payment will be made in absence of prior authorization.

3.2.2.1 Functional MRI (fMRI)

Texas Medicaid considers fMRI medically necessary when it is being used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.

Neurofunctional testing procedure code 96020 must be reported in conjunction with brain fMRI procedure code 70555. Procedure code 96020 is informational and will not be reimbursed separately.

3.2.2.2 Intraoperative MRI (iMRI)

Indications for intracranial neurosurgical procedures using intraoperative MRI (iMRI) include, but are not limited to, the following:

- Oncologic neurosurgical procedures
- Epilepsy
- Chiari surgery
- Deep brain stimulators

Only one iMRI procedure code may be billed per operative session. Procedure codes 70557, 70558, and 70559 must not be billed in conjunction with procedure code 61751, 77021, or 77022.

Intraoperative MRI procedure codes 70557, 70558, and 70559 that are billed with modifier 26 may be reimbursed to physician providers for interpretation.

Procedure codes 75559 and 75563 must be billed in conjunction with stress testing procedure codes 93015, 93016, 93017, and 93018.

3.2.2.3 Authorization Requirements and Flexibility

Authorization is required for CT, CTA, MRI, fMRI, and MRA procedures.

Note: *Intraoperative MRI (iMRI) does not require prior authorization.*

Referto: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in this handbook.

If the ordering physician or radiologist determines that a CT, CTA, MRI, fMRI, or MRA procedure that is different from the authorized procedure is required or that additional procedures are required, the following will apply:

- The procedure performed is less complex than the procedure authorized but of the same modality (e.g., an MRI with contrast is prior authorized and the actual procedure performed is an MRI without contrast). Full reimbursement is allowed for the billed procedure.
- The authorized procedure is performed and an additional higher-level procedure of the same modality is deemed medically necessary within the same authorization period. A separate authorization is required. The additional procedure must be prior authorized separately and submitted on a separate claim.
- The procedure billed is more complex than the procedure authorized but of the same modality. No authorization update will result in reimbursement according to the rate of the lesser authorized code. For full reimbursement of the more complex procedure, the authorization requires an update.

The following table includes the recognized relationships for authorization flexibility:

Level 1 (High)	Level 2 (Moderate)	Level 3 (Low)
70470	70460	70450
70482	70481	70480
70488	70487	70486
70492	70491	70490
70543	70542	70540
70546	70545	70544
70549	70548	70547
70553	70552	70551

Level 1 (High)	Level 2 (Moderate)	Level 3 (Low)
71270	71260	71250
71552	71551	71550
72127	72126	72125
72130	72129	72128
72133	72132	72131
72156	72142	72141
72157	72147	72146
72158	72149	72148
72194	72193	72192
72197	72196	72195
73202	73201	73200
73220	73219	73218
73223	73222	73221
73702	73701	73700
73720	73719	73718
73723	73722	73721
74170	74160	74150
74178	74177	74176
74183	74182	74181
75559	75557	
75563	75561	

3.2.3 Positron Emission Tomography (PET) Scan Imaging

PET scan imaging services are benefits of Texas Medicaid and may be reimbursed using the following procedure codes:

Procedure Codes						
78608	78811	78812	78813	78814	78815	78816

Procedure codes 78459, 78491, and 78492 are not reimbursed by Texas Medicaid.

The PET scan procedure may be reimbursed separately from the diagnostic radiopharmaceutical.

Referto: The [online fee lookup \(OFL\)](#) or the applicable fee schedules on the TMHP website at www.tmhp.com to review the diagnostic radiopharmaceuticals that are reimbursed by Texas Medicaid.

3.2.3.1 Authorization Requirements

Prior authorization is required for PET imaging services.

Referto: Subsection 3.2.6, “Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.4 Radiology/Diagnostic Imaging Policy

Radiography and fluoroscopy radiology/diagnostic imaging may be reimbursed by Texas Medicaid using the following procedure codes:

Procedure Codes				
74775	75956	75957	75958	75959

Procedure code 74775 may be reimbursed for services rendered to clients who are 20 years of age and younger.

The procedure code in Column A must be billed with the procedure codes in Column B by the same provider with the same date of service to be reimbursed:

Column A	Column B
75956	33880
75957	33881
75958	33883 or 33884
33884	33883
75959	33886

Texas Medicaid may reimburse the professional interpretation component only when the physician bills procedure codes 75956, 75957, 75958, or 75959. The professional and technical service may be reimbursed to the inpatient hospital through the DRG reimbursement.

3.2.4.1 Authorization Requirements

Prior authorization is not required for the radiology/diagnostic imaging procedure codes in this section.

3.2.5 Physician-Performed Radiology Services

Referto: Subsection 9.2.61, “Radiology Services” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.6 Authorization Requirements for CT, CTA, MRI, fMRI, MRA, PET, and Cardiac Nuclear Imaging Services

Prior authorization is not required for emergency department services, outpatient observation services, or inpatient hospital radiology services.

Prior authorization is required for outpatient nonemergent services (i.e., those that are planned or scheduled). Prior authorization must be obtained before the service is rendered.

The following table summarizes the authorization requirements for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging services:

Condition	Authorization Requirements
Emergency department visit	<p>Authorization is not required for emergency department radiology services that are rendered during an emergency department visit.</p> <ul style="list-style-type: none"> For professional claims, the appropriate radiology procedure code must be billed with modifier U6. The facility may be reimbursed using the appropriate, corresponding emergency services revenue code.

Condition	Authorization Requirements
Outpatient observation	<p>Authorization is not required for radiology services rendered during outpatient observation.</p> <ul style="list-style-type: none"> • For professional claims, the appropriate radiology procedure code must be billed with modifier U6. • The facility may be reimbursed using the appropriate, corresponding outpatient observation revenue code.
Nonemergent condition: planned or scheduled radiology service	<p>Texas Medicaid defines a nonemergent condition as a symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical, or diagnostic studies prior to diagnosis and treatment.</p> <p>Prior authorization is required for outpatient nonemergent (i.e., those studies that are planned or scheduled) CT, CTA, MRI, fMRI, MRA, PET scan, and cardiac nuclear imaging services.</p> <p>Important: <i>The authorization number must be on the claim when it is submitted to TMHP for reimbursement. Only one authorization is allowed per claim. For the most accurate and efficient claims processing, TMHP recommends that the procedure code that is submitted on the claim match the procedure code that is authorized. Providers are encouraged to contact TMHP and update the prior authorization if the ordering physician or radiologist changes the actual procedure that is performed. Providers have 14 calendar days after the day on which the study was completed to update the prior authorization.</i></p> <p>Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization.</p> <p>Referto: Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.</p>
Outpatient urgent condition	<p>Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures.</p> <p>Texas Medicaid defines an urgent condition as a symptom or condition that is not an emergency, but requires further diagnostic work-up or treatment within 24 hours to avoid a subsequent emergent situation.</p> <p>Referto: Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.</p> <p>Note: <i>Additional or alternate studies identified and ordered by the radiologist at the time of a prior-authorized study meet the definition of urgent condition and require retroactive authorization.</i></p>

Condition	Authorization Requirements
Outpatient emergent condition	<p>Retroactive authorization is required for unplanned radiology procedures performed during other planned or scheduled outpatient visits or procedures.</p> <p>Texas Medicaid defines an emergent condition as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance use) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in at least one of the following:</p> <ul style="list-style-type: none"> • Placing the recipient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction to any bodily organ or part <p>The physician must determine that a medical emergency, which imminently threatens life or limb exists and that the medical emergency requires advanced diagnostic imaging.</p> <p>Referto: Subsection 3.2.6.1, “Retroactive Authorization” in this handbook.</p>
Inpatient hospital	Authorization is not required for inpatient hospital radiology services.

Prior authorization of nonemergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the service and must be maintained in the client’s medical record, both by the ordering physician (i.e., the physician who orders the study) and the performing facility.

Nationally-accepted guidelines and radiology protocols based on medical literature are used in the authorization processes for urgent, emergent, and nonemergent services. These include, but are not limited to:

- American College of Radiology (specifically, their Appropriateness Criteria)
- American Academy of Neurology
- American Academy of Orthopedic Surgeons
- American College of Cardiology
- American Heart Association
- National Comprehensive Cancer Care Network

Referto: Subsection 3.2.2.3, “Authorization Requirements and Flexibility” in this handbook for information about authorization flexibility for CT, CTA, MRI, fMRI, and MRA procedures.

3.2.6.1 Retroactive Authorization

A request for retroactive authorization for an emergent or urgent CT, MR, PET, or cardiac nuclear imaging service must be submitted no later than 14 calendar days after the day on which the study was completed.

Retroactive authorization of urgent or emergent services is considered on an individual basis, adhering to standard clinical evidence-based guidelines. Documentation must support medical necessity for the study and must be maintained in the client’s medical record, both by the ordering physician (i.e., the physician ordering the study) and the performing facility.

Retroactive authorization for outpatient urgent services is considered when all of the following criteria are met:

- The physician who renders the imaging service determines, during the provision of prior-authorized services, that additional or alternate procedures are medically indicated.
- The urgent condition requires additional or alternate advanced diagnostic imaging.

Retroactive authorization for outpatient emergent services is considered when all of the following criteria are met:

- The physician determines that a medical emergency that imminently threatens life or limb exists.
- The medical emergency requires advanced diagnostic imaging.

Retroactive authorization is not required when a prior-authorized CT or MR procedure is changed by the ordering physician or radiologist to a lesser procedure of the same modality (e.g., MRI with contrast is authorized and the actual procedure performed is MRI without contrast).

3.2.6.2 Request Form and Documentation

Regardless of method of submission, the ordering physician must complete and retain the Radiology Prior Authorization Request Form with an original signature in the client's medical record.

Providers must submit the form with the request information related to the medical necessity for the service, including all of the following:

- Diagnosis
- Treatment history
- Treatment plan
- Medications that the client is currently taking
- Previous imaging results

Providers may also be asked to provide additional documentation as necessary during the authorization process.

Section 1 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the ordering physician before requesting prior authorization, regardless of the method of request for authorization.

Section 2 of the Radiology Prior Authorization Request Form must be completed, signed, and dated by the physician who performs the service prior to requesting retroactive authorization for urgent or emergent studies.

Residents, physician assistants (PAs), and nurse practitioners (NPs) may order radiological procedures; however, the ordering or referring clinician must sign the authorization form and provide the group or supervising provider's provider identifier.

The Radiology Decision Support Tool is provided by eviCore as a resource for providers. eviCore uses the evidence-based guidelines to authorize advanced imaging services for TMHP, and these guidelines help providers determine the most appropriate treatment option for the client related to advanced imaging services. The documents include the recognized clinical guidelines for CT, CTA, MR, MRA, PET, and cardiac nuclear imaging studies.

Referto: Section 3, “Inpatient Hospital (Medical/Surgical Acute Care Inpatient Facility)” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)*.

Section 9, “Physician” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information on MRI and contrast material.

The [Radiology Prior Auth Services](#) page of the TMHP website at www.tmhp.com for the Radiology Decision Support Tool.

3.2.6.3 * Methods of Submission

Authorization requests for CT, CTA, MRI, fMRI, MRA, PET, and cardiac nuclear imaging studies for Texas Medicaid clients must be submitted to eviCore. eviCore is the TMHP subcontractor for high-tech radiology services. Providers can submit authorizations to eviCore:

- [Revised] On the eviCore website at www.evicore.com/provider
- By telephone to 1-800-572-2116
- By fax to 1-800-572-2119
- By mail to:

[Revised] Texas Medicaid & Healthcare Partnership
400 Buckwalter Place Blvd
Bluffton, SC 29910

All prior authorization requests for outpatient urgent or emergent radiology services should be made by telephone in order to ensure a timely response. Requests for retroactive authorization may be submitted online using the eviCore prior authorization portal, or by telephone, fax, or mail.

3.2.7 Additional Radiology and Physiological Laboratory Services

3.2.7.1 Ambulatory Electroencephalogram

Referto: Subsection 9.2.25.2, “Ambulatory Electroencephalogram (Ambulatory EEG)” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.2 Brachytherapy

Referto: Subsection 9.2.60.1, “Brachytherapy” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.3 Diagnostic Doppler Sonography

Referto: Subsection 9.2.26, “Diagnostic Doppler Sonography” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.4 Electrocardiograms

Referto: Subsection 9.2.25.6, “Electrocardiogram (ECG)” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.5 Electromyography (EMG) and Nerve Conduction Studies (NCS)

Referto: Subsection 9.2.25.7, “Esophageal pH Probe Monitoring” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information.

Subsection 4.2.10, “Electrodiagnostic (EDX) Testing” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.6 Esophageal pH Probe Monitoring

Referto: Subsection 9.2.25.7, “Esophageal pH Probe Monitoring” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.7 Mammography Services

The following procedure codes will be denied if the provider does not have a BRC mammography certification on file:

Procedure Codes		
77032	77053	77054

Referto: Subsection 9.2.15.5, “Prognostic Breast and Gynecological Cancer Studies” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information about mammography services.

3.2.7.8 Nonsurgical Vision Services

Referto: Subsection 4.3.5.4, “Ophthalmic Ultrasound” in the *Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.9 Obstetric Services

Referto: Section 4, “Obstetric Services” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.10 Radiation Therapy Services

Referto: Subsection 9.2.60, “Radiation Therapy” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for information about radiation therapy, including brachytherapy and stereotactic radiosurgery.

3.2.7.11 Screening and Diagnostic Studies of the Breast

Referto: Subsection 9.2.15.4, “Mammography (Screening and Diagnostic Studies of the Breast)” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.2.7.12 Sleep Studies

Referto: Subsection 9.2.67, “Sleep Studies” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)*.

3.3 Documentation Requirements

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

3.4 Claims Filing and Reimbursement**3.4.1 Claims Information**

Claims for radiological and physiological laboratory services and portable X-ray supplier services must include the referring or ordering provider. Radiological and physiological laboratory services and portable X-ray supplier services must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

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

“Section 6: Claims Filing” (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

3.4.1.1 Diagnosis Requirements

A diagnosis is not required with a provider’s request for payment except when providing the following services:

- Ambulatory Electroencephalogram (A/EEG)
- Arteriogram
- Cardiac nuclear imaging
- Chest X-ray
- Computed tomography imaging (CT)
- Echography
- Electrocardiogram (ECG)
- Functional MRI (fMRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance imaging (MRI)
- Mammographies, noninvasive diagnostic studies
- Positron emission tomography (PET) scan
- Polysomnographies
- Venographies

Claims for all services provided to clients who are eligible for “Emergency Care Only” must have a diagnosis to be considered for reimbursement. As with all procedures billed to Texas Medicaid, most baseline screening or comparison studies are not a benefit.

Referto: Section 9, “Physician” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)* for more information on these services.

3.4.1.2 Modifier Requirements for Type of Service Assignment

For the radiology, physiological lab, and X-ray procedures in this chapter, providers must bill modifier 26 for the interpretation component or modifier TC for the technical component. No modifier is necessary for the total component.

Referto: Subsection 6.2.5, “Modifier Requirements for TOS Assignment” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

Subsection 6.3.2, “Type of Service (TOS)” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

3.4.2 Reimbursement

Radiological and physiological laboratory and portable X-ray supplier providers are reimbursed in accordance with 1 TAC §355.8085. Providers can refer to the [Online Fee Lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Referto: Subsection 2.2, “Fee-for-Service Reimbursement Methodology” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*) for more information about reimbursement.

Texas Medicaid pays only up to the amount allowed for the total component for the same procedure submitted for reimbursement by the same provider for the same client with the same date of service. Providers who perform the technical service and the interpretation must bill the total component. Providers who perform only the technical service must bill the technical component, and those who perform only the interpretation must bill the interpretation component. The total component and the technical or interpretation component for the same procedure are not reimbursed separately when billed by any provider with the same date of service; the first claim may be reimbursed and the additional claim(s) will be denied. Claims are considered for reimbursement based on the order in which they are received.

For example, if a claim is received for the total component and TMHP has already made payment for the technical or interpretation component for the same procedure with the same date of service for the same client, regardless of provider, the claim for the total component is denied. The same is true if a total component has already been paid and claims are received for the individual components.

Radiology and physiological laboratory and portable X-ray services are not payable when the client is in an inpatient setting. The reimbursement for these services are included in the diagnosis-related group (DRG) payment.

Imaging services submitted by outpatient hospital providers may be reimbursed a flat fee.

Imaging services procedure codes can be found on the TMHP fee schedule website titled, “Hospital Outpatient Imaging Services.”

Texas Medicaid implemented mandated rate reductions for certain services. The Online Fee Lookup (OFL) and static fee schedules include a column titled “Adjusted Fee” to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/pages/topics/rates.aspx.

3.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Bulletin* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the [CMS NCCI web page](#) for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

4 Claims Resources

Resource	Location
Acronym Dictionary	“Appendix C: Acronym Dictionary” (<i>Vol. 1, General Information</i>)

Resource	Location
Automated Inquiry System (AIS)	Subsection A.10, “TMHP Telephone and Fax Communication” in “Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>)
State, federal, and TMHP contact information	“Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>)
TMHP electronic claims submission information	Subsection 6.2, “TMHP Electronic Claims Submission” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>)
TMHP Electronic Data Interchange (EDI) information	“Section 3: TMHP Electronic Data Interchange (EDI)” (<i>Vol. 1, General Information</i>)

5 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

6 * Forms

The following linked forms can also be found on the [Forms](#) page of the Provider section of the TMHP website at www.tmhp.com:

[Revised] Forms
Hereditary Breast and Ovarian Cancer (HBOC) Genetic Testing

7 Claim Form Examples

The following linked claim form examples can also be found on the [Claim Form Examples](#) page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Independent Laboratory
Office Visit with Lab and Radiology
Radiological/Physiological Laboratory and Portable X-Ray Supplier