



Texas Medicaid Provider Procedures Manual

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Provider Handbooks

Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook

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

MEDICAL AND NURSING SPECIALISTS, PHYSICIANS, AND PHYSICIAN ASSISTANTS

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1 General Information

The information in this handbook is intended for Texas chiropractors, nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), podiatrists, geneticists, maternity service clinics, physicians, and physician assistants. The handbook provides information about Texas Medicaid's benefits, policies, and procedures.

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 healthcare 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 may also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare 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).

Subsection 2.2, “Provider Enrollment and Responsibilities” in the *Medicaid Managed Care Handbook* (Vol. 2, Provider Handbooks).

Section 4, “THSteps Medical” in the *Children’s Services Handbook* (Vol. 2, Provider Handbooks).

For information on Advanced Practice Registered Nurses (APRNs), refer to:

Section 3, “Certified Nurse Midwife (CNM)” in this handbook.

Subsection 4.1, “Enrollment” in this handbook for information about CRNAs.

Subsection 5.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for information about geneticists.

Subsection 8.1, “Enrollment” in this handbook for information about NPs and CNSs

Section 9, “Physician” in this handbook.

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the 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 3.7.4.19, “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 Chiropractic Manipulative Treatment (CMT)

2.1 Enrollment

To enroll in Texas Medicaid, a doctor of chiropractic medicine (DC) must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

2.2 Services, Benefits, Limitations, and Prior Authorization

CMT performed by a chiropractor licensed by the Texas State Board of Chiropractic Examiners is a benefit of Texas Medicaid.

CMT is limited to an acute condition or an acute exacerbation of a chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day. The 12-month period consists of 12 consecutive months, beginning with the date the client receives the first treatment.

If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute.

CMT is not a benefit of Texas Medicaid for maintenance therapy when:

- Further clinical improvement cannot reasonably be expected from continuous ongoing care.
- The chiropractic treatment becomes supportive rather than corrective in nature.

CMT may be reimbursed when billed using procedure codes 98940, 98941, or 98942.

Procedure codes 98940, 98941, and 98942 must be submitted with the AT modifier. The AT modifier is used to identify treatment provided for an acute condition or an exacerbation of a chronic condition that persists for 180 days or less from the start date of treatment. Providers may file an appeal for a claim denied beyond the 180 days of treatment with documentation supporting that further clinical improvement can be reasonably expected, maximal improvement has not been reached, and further improvement has not ceased.

Procedure code 98940 will be denied as part of another service when billed for the same date of service as 98941 or 98942 by any provider.

Procedure code 98941 will be denied as part of another service when billed for the same date of service as 98942 by any provider.

Texas Medicaid does not reimburse chiropractors for X-ray services, office visits, injections, supplies, appliances, spinalator treatments, laboratory services, physical therapy, or other adjunctive services furnished by themselves or by others under their orders or directions. Additionally, braces or supports, even though ordered by a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) and supplied by a chiropractor are not reimbursable items.

CMT is reimbursed only for a diagnosis of subluxation of the spine. The level of subluxation must be indicated by the appropriate diagnosis codes listed below:

| Diagnosis Codes | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|
| M9900 | M9901 | M9902 | M9903 | M9904 | M9905 | M9908 |

2.2.1 Prior Authorization

Prior authorization is not required for CMT services.

2.3 Documentation Requirements

Manipulations must be provided in accordance with an ongoing, written treatment plan that supports medical necessity of an acute condition or an acute exacerbation of a chronic condition.

Documentation that supports medical necessity for the treatment plan includes all of the following:

- Diagnosis
- Region(s) treated
- Degree of severity
- Impairment characteristics
- Physical examination findings, X-ray, or other pertinent findings
- Specific statements of short- and long-term goals
- A reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and/or the techniques utilized

The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Chiropractic services must be submitted to TMHP in an approved electronic claims 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 them.

When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim 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.

Subsection , “Section 6: Claims Filing” in “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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.2 Reimbursement

The Medicaid rates for chiropractic manipulative treatment (CMT) are reimbursed in accordance with 1 TAC §355.8085. See the [online fee lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

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/resources/rate-and-code-updates.

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.*

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.

3 Certified Nurse Midwife (CNM)

3.1 Provider Enrollment

To enroll in Texas Medicaid, a CNM must be licensed as a registered nurse and as an advanced practice registered nurse (APRN) by the Texas Board of Nursing (BON), and be authorized to practice as a nurse-midwife. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

The American Midwifery Certification Board (AMCB) is responsible for the certification requirements of CNMs.

Referto: The HHSC website at www.healthytexaswomen.org for information about family planning and the locations of family planning clinics that receive funding from the HHSC Family Planning Program.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. Upon initial enrollment and upon re-enrollment, the CNM must complete and submit to TMHP, along with the Texas Medicaid Provider Enrollment Application, the Physician’s Letter of Agreement form that affirms the CNM’s referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the CNM and the physician. The collaborating physician does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1252 (3), if the collaborating physician or group is not a participating provider in Texas Medicaid, the CNM must inform clients of their potential financial responsibility. If the arrangement is changed or canceled, the CNM must notify TMHP Provider Enrollment in writing and a new letter of agreement must be completed and submitted to TMHP within 10 business days of the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies.

Referto: “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, *General Information*) for more information about enrollment in Texas Medicaid.

Subsection 4.2, “Enrollment” in the *Children’s Services Handbook* (Vol. 2, *Provider Handbooks*) for more information about enrollment in the THSteps Program.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the *Radiology and Laboratory Services Handbook* (Vol. 2, *Provider Handbooks*).

3.1.1 Enrollment in Texas Health Steps (THSteps)

CNMs may enroll as providers of THSteps medical checkups for newborns and adolescent females.

3.2 Services, Benefits, Limitations, and Prior Authorization

CNM providers may be reimbursed for family planning, obstetrical, neonatal, and primary care services.

3.2.1 Deliveries

CNM providers may be reimbursed for procedure code 59409, 59410, 59612, or 59614 for delivery services.

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

3.2.2 Newborn Services

Routine newborn care may be reimbursed to CNM providers.

Referto: Subsection 4.3.9, “Newborn Examination” in the *Children’s Services Handbook* (Vol. 2, *Provider Handbooks*).

Subsection 9.2.44, “Newborn Services” in this handbook for additional guidelines and limitations.

3.2.3 Prenatal and Postpartum Services

CNM and physician providers are limited to a combined total of 20 outpatient prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation should reflect the need for increased visits and is subject to retrospective review.

When billing for prenatal services, use modifier TH with the appropriate evaluation and management procedure code to the highest level of specificity.

Postpartum care provided after discharge must be billed using procedure code 59430. Only one postpartum visit is allowed per pregnancy.

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

3.2.4 Laboratory and Radiology Services

Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.

3.2.5 Prior Authorization

Prior authorization is not required for any of these services except delivery in the home. For prior authorization of a home delivery and the related supplies (procedure code S8415), the CNM must submit a written request for prior authorization during the client’s third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third

trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Documentation must also include a plan for access to emergency transport for mother and neonate, if needed. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization will be denied.

3.2.6 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including CNM services.

CNM services are subject to retrospective review and recoupment if documentation does not support the service billed.

3.2.7 Claims Filing and Reimbursement

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

CNM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 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 TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

According to 1 TAC §355.8161(a), the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Note: *CNM providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.*

Physicians who submit a claim using the physician's own provider identifier for services provided by a CNM must submit modifier SB on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a CNM if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by a CNM.

Providers can refer to the [Online Fee Lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

Referto: Subsection 4.1, “General Medicaid Eligibility” in “Section 4: Client Eligibility” (*Vol. 1, General Information*) for information about crossover payments.

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

Subsection 6.1, “Claims Information” in “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*).

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.

4 Certified Registered Nurse Anesthetist (CRNA)

4.1 Enrollment

To enroll in Texas Medicaid, a CRNA must be licensed as a registered nurse (RN) and as an APRN by the Texas BON and must be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An RN under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as acceptable documentation of appropriate licensure and certification for enrollment.

Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. A current copy of the provider’s Council on Certification of Nurse Anesthetists or Recertification of Nurse Anesthetists Certificate must be submitted with the Medicaid provider enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

4.2 Services, Benefits, Limitations, and Prior Authorization

Medically necessary services that are performed by a CRNA are benefits if the services are within the scope of the CRNA’s practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice and to the extent allowed by state law; and are provided under one of the following conditions:

- There is no physician anesthesiologist on the medical staff of the facility where the services are provided (e.g., rural settings).
- There is no physician anesthesiologist available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician, dentist, or podiatrist who performs the procedure that requires the services specifically requests the services of a CRNA.
- The eligible client who requires the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to the policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

Texas Medicaid does not reimburse the CRNA for equipment, drugs, or supplies.

Referto: Subsection 4.2, “Services, Benefits, Limitations, and Prior Authorization” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for information about drugs, equipment and supplies.

4.2.1 Prior Authorization

Services performed by a CRNA are subject to the same prior authorization guidelines as services performed by other provider types.

4.3 Documentation Requirements

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

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

All CRNA services must be billed with a CRNA individual provider identifier or a CRNA group provider identifier. No payment for CRNA services will be made under a hospital or physician provider identifier.

CRNA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 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 TMHP does not key any information from claim 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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

Subsection 9.2.7.9.3, “CRNA, AA, and Other Qualified Professional Services” in this handbook for more information on billing for CRNA services.

4.4.1.1 Interpreting the R&S Report

The Billed Qty field on the Remittance and Status (R&S) Report reflects only the number of time units TMHP processes. The Relative Value Units (RVUs) assigned for the procedure code are not shown in the Billed Qty field.

4.4.2 Reimbursement

A CRNA is reimbursed the lesser of either the CRNA’s billed charges or 92 percent of the reimbursement for the same service paid to a physician (M.D. or D.O.) other than an anesthesiologist in accordance with 1 TAC §355.8221. A CRNA under the supervision of an anesthesiologist is reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

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.*

Referto: Subsection 9.2.7.8, “Reimbursement Methodology” in this handbook for more information about flat fees and time based fees.

5 Geneticists

5.1 Enrollment

5.1.1 Geneticists

Geneticists may enroll in Texas Medicaid as both a physician or physician group and as a geneticist. Enrollment as a geneticist allows enhanced reimbursement for specific procedure codes when a claim is submitted using the geneticist provider identifier.

A provider of genetic services that wishes to enroll in Texas Medicaid as a geneticist must complete the required Medicaid provider enrollment application forms and enter into a written agreement with HHSC. Texas Medicaid provider enrollment forms are available from TMHP, and may be downloaded on the TMHP website at www.tmhp.com. Completed applications are submitted to:

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

Prior to enrollment, applicant qualifications for the provision of genetic services are verified and approved by DSHS. Verification and approval are administered through the Newborn Screening Unit. Basic contract requirements are as follows:

- The provider must be a clinical geneticist (MD or DO) who is board eligible or board certified by the American Board of Medical Geneticists (ABMG).

Note: *Board eligible providers are required to provide documentation reflecting completion of education requirements in a residency program in genetics.*

- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including the clinical geneticist and at least one of the following: nurse, social worker, medical geneticist, or genetic counselor.
- Upon DSHS approval, TMHP issues a provider identifier and a performing provider identifier for the provision of genetic services.
- Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

5.2 Services, Benefits, Limitations, and Prior Authorization

Genetic services may be used to diagnose a condition, optimize disease treatment, predict future disease risk, and prevent adverse drug response. Genetic services may be provided by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and typically include one or more of the following:

- Comprehensive physical exams
- Diagnosis, management, and treatment for clients with genetically-related health problems
- Evaluation of family histories for the client and the client's family members
- Genetic risk assessment
- Genetic laboratory tests
- Interpretation and evaluation of laboratory test results
- Education and counseling of clients, their families, and other medical professionals on the causes of genetic disorders
- Consultation with other medical professionals to provide treatment

Pharmacogenetics encompasses the use of information encoded in DNA to help predict responses to medicines and thereby enhance the effectiveness and safety of medicines for individual clients.

Referto: Subsection 9.2.40, "Pharmacogenetics" in this handbook for additional information about pharmacogenetics services.

5.2.1 Family History

It is important for primary care providers to recognize potential genetic risk factors in a client so that they can make appropriate referrals to a genetic specialist.

Obtaining an accurate family history is an important part of clinical evaluations, even when genetic abnormalities are not suspected. Knowing the family history may help health-care providers identify single-gene disorders or chromosomal abnormalities that occur in multiple family members or through multiple generations. Some genetic disorders that can be traced through an accurate family history include diabetes, hypertension, certain forms of cancer, and cystic fibrosis. Early identification of the client's risk for one of these diseases can lead to early intervention and preventive measures that can delay onset or improve health conditions.

Using a genetics-specific questionnaire helps to obtain the information needed to identify possible genetic patterns or disorders. The most commonly used questionnaires are provided by the American Medical Association and include the Prenatal Screening Questionnaire, the Pediatric Clinical Genetics Questionnaire, and the Adult History Form.

5.2.2 Genetic Tests

Diagnostic tests to check for genetic abnormalities must be performed only if the test results will affect treatment decisions or provide prognostic information. Tests for conditions that are treated symptomatically are not appropriate since the treatment would not change. Providers who are uncertain whether a test is appropriate are encouraged to contact a geneticist or other specialist to discuss the client's needs.

Any genetic testing and screening procedure must be accompanied by appropriate non-directive counseling, both before and after the procedure. Information must be provided to the client and family (if appropriate) about the possible risks and purpose and nature of the tests being performed.

The interpretation of certain tests, such as nuchal translucency, requires additional education and experience. Texas Medicaid supports national certification standards when available.

5.2.3 Laboratory Practices

For many heritable diseases and conditions, test performance and interpretation of test results require information about client race/ethnicity, family history, and other pertinent clinical and laboratory information. To facilitate test requests and ensure prompt initiation of appropriate testing procedures and accurate interpretation of test results, the requesting provider must be aware of the specific client information needed by the laboratory before tests are ordered.

To help providers make appropriate test selections and requests, handle and submit specimens, and provide clinical care, laboratories that perform molecular genetic testing for heritable diseases and conditions must educate providers that request services about the molecular genetic tests the laboratory performs. For each molecular genetic test, the laboratory must provide the following information:

- Indications for testing
- Relevant clinical and laboratory information
- Client race and ethnicity
- Family history
- Pedigree

Testing performed on a client to provide genetic information for a family member, and testing performed on a non-Medicaid client to provide genetic information for a Medicaid client are not benefits of Texas Medicaid.

5.2.4 Genetic Counselors

Genetic counselor services may be billed by a physician when the genetic counselor is under physician supervision and is an employee of the physician. Services provided by independent genetic counselors are not a benefit of Texas Medicaid.

5.2.5 Genetic Evaluation and Counseling by a Geneticist

A provider enrolled in Texas Medicaid as a geneticist may bill the following evaluation and management codes and receive an enhanced reimbursement. All other procedure codes must be billed under the geneticist's individual, group, or laboratory provider identifier.

| Procedure Code | Limitations |
|---|-------------------------------------|
| 96040 | None |
| 99213 | None |
| 99214 | None |
| 99215 | One per year, any provider |
| 99244 | One every three years, per provider |
| 99245 | One every three years, per provider |
| 99254 | One every three years, per provider |
| 99255 | One every three years, per provider |
| 99402 | One per pregnancy, per provider* |
| 99404 | One every three years, per provider |
| * Exception: Additional services are allowed when documentation of medical necessity to repeat a procedure accompanies a claim. | |

One office consultation, performed by a geneticist, (procedure code 99244 or 99245) may be considered for reimbursement if procedure code 99244, 99245, 99254, or 99255 has not been submitted by and reimbursed to that geneticist in the previous three years.

Inpatient consultations, performed by a geneticist, (procedure code 99254 or 99255) may be reimbursed once every three years regardless of whether an office consultation has been reimbursed in the previous three years.

5.2.6 Prior Authorization

Prior authorization is not required for services billed by a geneticist.

5.3 Documentation Requirements

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

5.4 Claims Filing and Reimbursement

5.4.1 Claims Information

Genetic services must be submitted to TMHP in an approved electronic format or on a CMS-1500 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.

TMHP representatives are available for provider questions about genetic services, such as reimbursement rates and procedures. For more information, call the TMHP Contact Center at 1-800-925-9126.

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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

5.4.2 Reimbursement

Genetic services providers are reimbursed according to the established allowable maximum fee schedule. Providers can refer to the [OFL](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

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.

6 Licensed Midwife (LM)

6.1 Provider Enrollment

To enroll in Texas Medicaid, an LM must be licensed as a midwife by the Texas Department of Licensing and Regulation (TDLR).

Providers cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

An LM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. Upon initial enrollment and upon re-enrollment, the LM must complete and submit to TMHP, along with the Texas Medicaid Provider Enrollment Application, the Physician's Letter of Agreement form that affirms the LM's referring or consulting physician arrangement. A separate letter of agreement must be submitted for each physician or group of physicians with whom an arrangement is made. This agreement must be signed by the LM and the physician.

If the arrangement is changed or canceled, the LM must notify TMHP Provider Enrollment in writing and a new letter of agreement must be completed and submitted to TMHP within 10 business days after the change or cancellation.

The referral physician or group does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1253(c), if the referral physician or group is not a participating provider in Texas Medicaid, the LM must inform clients of their potential financial responsibility.

Referto: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment in Texas Medicaid.

6.2 Services, Benefits, Limitations, and Prior Authorization

LM providers may be reimbursed for obstetrical and newborn care services provided in a freestanding birthing center that is also enrolled as a Texas Medicaid provider.

6.2.1 Deliveries

LM providers may be reimbursed for procedure code 59409 for delivery services.

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

6.2.2 Newborn Services

Newborn care procedure codes 99460 and 99463 may be reimbursed to LM providers.

Referto: Subsection 9.2.44, "Newborn Services" in this handbook for additional guidelines and limitations.

6.2.3 Prenatal Services

LM providers must include modifier TH with the appropriate evaluation and management procedure code (99202, 99211, or 99212) for prenatal services.

LM providers are limited to a total of 20 outpatient prenatal care visits, performed in a birthing center, per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.

If a client is discharged before delivery, LM providers may submit procedure code 99218, 99219, or 99220 for labor services only. Clinical documentation that clearly demonstrates the level of medical decision-making (i.e., moderate or complex) must be included in the client's medical record. All medical documentation is subject to retrospective review. Services that are not supported by the medical documentation are subject to recoupment.

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

6.2.4 Prior Authorization

Prior authorization is not required for services billed by an LM.

6.2.5 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including LM services.

LM services are subject to retrospective review and recoupment if documentation does not support the service billed.

6.2.6 Claims Filing and Reimbursement

LM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 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 TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

According to 1 TAC §355.8161 (b), the Medicaid rate for LMs is 70 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service.

Providers can refer to the [Online Fee Lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

7 Maternity Service Clinics (MSC)

7.1 Provider Enrollment

To enroll in Texas Medicaid, MSCs must submit a complete application and meet the following requirements:

- Must be a facility that is not an administrative, organizational, or financial part of a hospital.
- Must be organized and operated to provide maternity clinic services to outpatients.
- Must comply with all applicable federal, state, and local laws and regulations.
- Must employ or have a contractual agreement or formal arrangement with a licensed MD or DO who assumes professional responsibility for the services provided to the clinic's patients.
- Must adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of State Health Services, unless otherwise specified by the department or its designee.

- Must ensure that services provided to each patient are commensurate with the patient's risk assessment and are documented in the patient's medical record.

The supervising physician's license information must be provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days.

Medicare certification is not a prerequisite for MSC enrollment.

7.1.1 Physician Responsibility

To meet the requirement to assume professional responsibility for the services provided to the clinic's clients, the supervising physician must do the following:

- See the client at least once
- Prescribe the type of care to be provided or approve the client's plan of care (POC)
- Periodically review the need for continued care (if the services are not limited by the prescription)

The physician must base the POC on a risk assessment completed by the physician or by licensed, professional clinic staff. The assessment must be based on findings obtained through a health history, laboratory or screening services, and a physical examination.

7.1.2 Case Management Services to High-Risk Individuals

An MSC that wants to bill and receive reimbursement for case management services to high-risk individuals including infants, pregnant adolescents, and women must meet the eligibility criteria for case management services. To be considered for reimbursement for case management for these clients, the MSC must enroll as a group in Case Management for Children and Pregnant Women, and each eligible case manager must enroll as a performing provider.

Referto: Section 3, "Case Management for Children and Pregnant Women" in the *Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks)* for case management services provider eligibility criteria.

7.2 Services, Benefits, Limitations, and Prior Authorization

Services billed by an MSC are those provided by a physician or by licensed, professional clinic staff and are determined to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do not include deliveries.

MSCs are limited to 20 prenatal care visits and 1 postpartum care visit per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation must reflect the need for increased visits and is subject to retrospective review.

Procedure codes in the following table are for prenatal and postpartum care visits:

| Procedure Codes | | | | | | |
|---|----------|----------|----------|----------|----------|----------|
| 59430* | 99202-TH | 99203-TH | 99204-TH | 99205-TH | 99211-TH | 99212-TH |
| 99213-TH | 99214-TH | 99215-TH | | | | |
| * Procedure code 59430 is not submitted with modifier TH Note: The prenatal visits must be billed with modifier TH | | | | | | |

Providers must bill the most appropriate new or established prenatal visit code or postpartum visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

An MSC may be reimbursed for prenatal and postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for prenatal care and not separately reimbursed. Services other than prenatal and postpartum care visits will be denied. MSCs that are enrolled in Case Management for Children and Pregnant Women as a group may be reimbursed for these services under the group provider identifier assigned to their facility.

Medical services must be furnished on an outpatient basis by the physician or by licensed, professional clinic staff under the direction of the physician and must be within the staff's scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic and ensure through approval of the POC that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

Providers submitting charges for high-risk prenatal care must document the high-risk diagnosis on the claim form and document the condition in the client's medical record.

7.2.1 Initial Prenatal Care Visit Components

The following initial prenatal care visit components should be completed as early as possible in the client's pregnancy.

7.2.1.1 History

History includes OB-GYN, present pregnancy, medical and surgical, substance use, environmental, nutritional, psychosocial (including violence), and family support system.

7.2.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

7.2.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC provider identifier. These services may be ordered by MSC personnel and provided by a reference laboratory.

MSCs must supply the client's Medicaid number and the MSC provider identifier to the reference laboratory when laboratory services are requested.

The laboratory services requested by an MSC may include, but are not limited to, the following:

- Hemoglobin, hematocrit, or complete blood count (CBC)
- Urinalysis
- Blood type and Rh
- Antibody screen
- Rubella antibody titer

- Serology for syphilis
- Hepatitis B surface antigen
- Cervical cytology
- Other laboratory tests

The following tests may be performed at the initial prenatal care visit, as indicated:

- Pregnancy test
- Gonorrhea test
- Urine culture
- Sickle cell test
- Tuberculosis (TB) test
- Chlamydia test

As stated in the Health and Safety Code §81.090, screening for Hepatitis B virus infection, HIV, and Syphilis must be performed at the initial prenatal care visit. In addition, HIV testing must be performed in the third trimester. HBV and Syphilis must be performed at labor and delivery.

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

7.2.1.4 Assessment

Assessment includes pregnancy, general health, medical, and psychosocial.

7.2.1.5 Plan

Plan includes pregnancy, preventive health, medical, and referral as indicated.

7.2.1.6 Education and Counseling

Education and counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health. The education and counseling should also include the need for a medical home and information about THSteps medical and dental checkups for the client.

The complete physical examination may be completed at the second visit if the MSC's routine involves a two-stage initial evaluation.

7.2.2 Subsequent Prenatal Care Visits

The following is a recommended guide for the frequency of subsequent prenatal visits for a regular pregnancy:

- One visit every 4 weeks for the first 28 weeks of pregnancy.
- One visit every 2 to 3 weeks from 28 to 36 weeks of pregnancy.
- One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, CNMs, and MSCs are limited to 20 prenatal care visits per pregnancy and 1 postpartum care visit per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:

- Interim History
- Problems
- Maternal status

- Fetal status

7.2.2.1 Physical Examination

The physical examination must include the following:

- Weight and blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

7.2.2.2 Laboratory Tests

Required laboratory tests include the following:

- Urinalysis for protein and glucose every visit

***Note:** The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.*
- Hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy
- Repeated antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)
- Gestational diabetes screen at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load
- Blood sample for HBsAg screening at the first examination and visit followed by a second blood sample for HBsAg screening on admission for delivery
- Other laboratory tests as indicated by the medical condition of the client

7.2.3 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 59430. A maximum of 1 postpartum visit is allowed per pregnancy.

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

7.2.4 Prior Authorization

Prior authorization is not required for services rendered in MSCs.

7.3 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client’s 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

7.4 Claims Filing and Reimbursement

MSC services must be submitted to TMHP in an approved electronic format or on the CMS-1500 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 TMHP does not key any information from claim 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.

MSCs are reimbursed in accordance with 1 TAC §355.8085. Providers can refer to the [OFL](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

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.*

8 Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS)

For other APRNs, see Section 4, “Certified Registered Nurse Anesthetist (CRNA)” in this handbook for information regarding CRNAs, and Section 3, “Certified Nurse Midwife (CNM)” in this handbook for information about certified nurse midwives (CNMs).

8.1 Enrollment

To enroll in Texas Medicaid, an NP or CNS must be licensed as a registered nurse and as an APRN by the Texas BON. A registered nurse under the multistate licensure compact may be licensed in another state but certified as an APRN for the state of Texas by the Texas BON. Texas Medicaid accepts a signed letter of certification from the Texas BON as documentation of appropriate licensure and certification for enrollment.

Providers cannot be enrolled if their license is due to expire within 30 days.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services.

All APRNs (including CNMs, CRNAs, CNSs, and NPs) are enrolled within the categories of practice as determined by the Texas BON. CNSs and NPs must enroll as an APRN; CNMs and CRNAs may enroll using their specific titles.

Referto: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Section 3, “Certified Nurse Midwife (CNM)” in this handbook for more information on CNM enrollment.

Section 4, “Certified Registered Nurse Anesthetist (CRNA)” in this handbook for more information on CRNA enrollment.

APRNs may be included as primary care providers in the provider network for Medicaid and CHIP programs (both fee-for-service and managed care), regardless of whether the physician supervising the APRN is enrolled in Medicaid or in the provider network.

8.1.1 Enrollment in Texas Health Steps (THSteps)

APRNs, including NPs, and CNSs, who are recognized by the Texas BON can enroll as THSteps providers and provide checkup services within their scope of practice. Specific information is found in the Children's Services Handbook.

Referto: subsection 5.2, "Enrollment" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information on enrollment procedures.

8.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for NPs and CNSs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

NPs and CNSs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own provider identifier for services provided by an NP or CNS must submit modifier SA on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Benefit limitation information for services can be found in Section 9, "Physician" in this handbook, the *Children's Services Handbook (Vol. 2, Provider Handbooks)*, and the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

Payment for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.

Referto: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

Section 9, "Physician" in this handbook.

Section 4, "THSteps Medical" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for more information on THSteps services.

8.2.1 Prior Authorization

Services performed by an NP or CNS are subject to the same prior authorization guidelines as services performed by other provider types.

8.3 Documentation Requirements

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

8.4 Claims Filing and Reimbursement

8.4.1 Claims Information

APRN services must be submitted to TMHP in an approved electronic format or on the CMS-1500 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 TMHP does not key any information from claim 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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

8.4.2 Reimbursement

According to 1 TAC §355.8281, the Medicaid rate for NPs and CNSs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. When NPs or CNSs bill Medicaid directly for services they performed, they must use their individual provider identifier. If the services are performed by the NP or CNS but billed by a physician or physician group, the billing provider is the physician or physician group. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an NP or CNS if the physician does not make a decision regarding the client’s care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, and injections provided by an NP or CNS.

Note: *NP and CNS providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.*

Providers can refer to the [OFL](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

Referto: Subsection 1.1, “Provider Enrollment” in “Section 1: Provider Enrollment and Responsibilities” (*Vol. 1, General Information*).

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.

9 Physician

9.1 Enrollment

9.1.1 Physicians and Doctors

To enroll in Texas Medicaid to provide medical services, physicians (MD or DO), doctors of dental surgery [DDS], and doctors of podiatric medicine (DPM) must be authorized by the licensing authority of their profession to practice in the state where the services are performed at the time they are provided.

Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days. A current Texas license must be submitted.

Important: *The Centers for Medicare & Medicaid Services (CMS) guidelines mandate that physicians who provide durable medical equipment (DME) products such as spacers or nebulizers are required to enroll as Texas Medicaid DME providers.*

All physicians except gynecologists, pediatricians, pediatric subspecialists, pediatric psychiatrists, and providers performing only Texas Health Steps (THSteps) medical or dental checkups must be enrolled in Medicare before enrolling in Medicaid. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

9.2 Services, Benefits, Limitations, and Prior Authorization

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific code that matches the services provided, based on the code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management (E/M) services. The medical record must document the specific elements necessary to satisfy the criteria for the level of services as described in CPT. Reimbursement may be recouped when the medical record documents a different level of service from what is submitted on the claim. The level of service provided and documented must be medically necessary, based on the clinical situation and needs of the client.

To receive reimbursement, providers must document the following information in the client's medical record:

- The service
- The date rendered
- Pertinent information about the client's condition supporting the need for the service
- The care given

Physician services include those reasonable and medically necessary services ordered and performed by physicians or under physician supervision that are within the scope of practice of their profession as defined by state law.

9.2.1 Electronic Signatures in Prior Authorizations

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Referto: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

9.2.2 Teaching Physician and Resident Physician

The roles of the teaching physician and resident physician occur in the context of an accredited graduate medical education (GME) training program.

The teaching physician is the Medicaid-enrolled physician who is professionally responsible for the particular services that were provided and are being submitted for reimbursement; the physician must be affiliated and in good standing with an accredited GME program and must possess all appropriate licensure.

Physician services must be performed personally by the teaching physician or by the person to whom the physician has delegated the responsibility. The level of supervision required may be direct or personal.

In all cases, the client's medical record must clearly document that the teaching physician provided identifiable supervision of the resident. As defined below, the supervision must be direct or personal depending on the setting and the clinical circumstances:

- Direct supervision means that the teaching physician must be in the same office, building, or facility when and where the service is provided and must be immediately available to furnish assistance and direction.
- *Personal supervision* means that the teaching physician must be physically present in the room when and where the service is being provided.

Personal supervision by the teaching physician is required during the key portions of all major surgeries and the key portions of all other physician services billed to Texas Medicaid if the immediate supervision, participation, or intervention of the supervising physician is medically prudent in order to assure the health and safety of the client. Physician services that require personal supervision may include invasive procedures and evaluation and management services that require complex medical decision making. Situations that require personal supervision include those in which:

- The clinical condition of the client is unstable or will likely become unstable during, or as a result of, the planned medical intervention.
- The planned medical intervention, even under optimal conditions will result in a medically reasonable risk for significant morbidity or death following the procedure.
- Deviation from the expected technique at the time the procedure or service is performed presents a medically reasonable, causally-related, foreseeable risk to the patient's life or health.

This criterion applies regardless of the place of service.

The teaching physician must provide medically appropriate, identifiable direct supervision for all other services that do not require personal supervision.

The following prerequisites apply when the teaching physician submits claims for services performed, in whole or in part, by the resident physician in the inpatient hospital setting, the outpatient hospital setting, and surgical services and procedures.

Note: *When requesting services for prior authorization at patient discharge, the signature of the resident on the actual prescription is permitted as long as the Medicaid enrolled attending/supervising physician's signature appears on the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form and on any letters or documentation provided to support medical necessity. The resident's order and the Title XIX Form signed by the attending/supervising physician must be for the same service.*

9.2.2.1 Teaching Physician Prerequisites

Services provided in an outpatient setting.

All requirements for personal or direct supervision in the outpatient setting must be met for the services to qualify for reimbursement. The following tasks must be performed by the teaching physician and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement:

- Review the patient's history and physical examination.
- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Assure that any necessary supervision of interns or residents was provided.
- Confirm that documentation in the medical record supports the level of service provided.

Exception: *Exception for E/M services furnished in certain primary care centers. Teaching physicians that meet the primary care exception under Medicare are allowed to bill for low-level and mid-level E/M services furnished by residents in the absence of a teaching physician. Facilities that meet the primary care exception under Medicare may bill Texas Medicaid, Family Planning, or the Children with Special Health Care Needs (CSHCN) Services Program for new patient services (procedure codes 99202 and 99203) and established patient services (procedure codes 99211, 99212, and 99213).*

Note: *All services provided in an outpatient setting that do not qualify for the exception above require that the teaching physician examine the patient.*

Services provided in an inpatient setting.

For services provided in an inpatient setting, the teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient no later than 36 hours after the patient's admission and before the patient's discharge.
- Confirm or revise the patient's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.
- Confirm that documentation in the medical record supports the level of service provided.
- A face-to-face encounter with the client on the same day as any services provided by the resident physician.

Surgical services and procedures.

The teaching surgeon is responsible for the patient's preoperative, operative, and postoperative care. The teaching physician must demonstrate that medically appropriate supervision was provided. The following tasks must be performed and their completion must be documented in the patient's medical record before the claims are submitted for consideration of reimbursement. The documentation must be made in the same manner as required by federal regulations under Medicare:

- Review the patient's history, review the resident's physical examination, and examine the patient within a reasonable period of time after the patient's admission and before the patient's discharge.

- Confirm or revise the client's diagnosis.
- Determine the course of treatment to be followed.
- Document the teaching physician's presence and participation in the major surgical or other complex and dangerous procedure or situation.

Important: *Reimbursement may be reduced, denied, or recouped if the prerequisites are not documented in the medical record. The documentation must be made in the same manner as required by federal regulations under Medicare.*

9.2.3 Substitute Physician

Physicians may bill for the service of a substitute physician who sees clients in the billing physician's practice under either a reciprocal or locum tenens arrangement.

A reciprocal arrangement is one in which a substitute physician covers for the billing physician on an occasional basis when the billing physician is unavailable to provide services. Reciprocal arrangements are limited to a continuous period no longer than 14 days and do not have to be in writing.

A locum tenens arrangement is one in which a substitute physician assumes the practice of a billing physician for a temporary period no longer than 90 days when the billing physician is absent for reasons such as illness, pregnancy, vacation, continuing medical education, or active duty in the armed forces. The locum tenens arrangement may be extended for a continuous period of longer than 90 days if the billing physician's absence is due to being called or ordered to active duty as a member of a reserve component of the armed forces. Locum tenens arrangements must be in writing.

The substitute physician must be enrolled in Texas Medicaid and must not be on the Texas Medicaid or HHSC Family Planning Program provider exclusion list. The billing provider's name, address, and national provider identifier must appear in Block 33 of the claim form. The name and office or mailing address of the substitute physician must be documented on the claim in Block 19, *not* Block 33.

When a physician bills for a substitute physician, modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the substitute physician. The Q5 modifier is used to indicate a reciprocal arrangement and the Q6 modifier is used to indicate a locum tenens arrangement.

When physicians in a group practice bill substitute physician services, the performing provider identifier of the physician for whom the substitute provided services must be in Block 24J.

Physicians must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation as detailed above will be subject to recoupment.

9.2.4 Aerosol Treatment

Nebulized aerosol treatments (procedure codes 94640, 94644, and 94645) with short-acting beta-agonists are a benefit of Texas Medicaid and considered medically necessary when breathing is compromised by certain acute medical conditions. Documentation to support an aerosol treatment for the worsening of an acute or chronic condition must be maintained in the client's medical record and is subject to retrospective review.

Procedure code 94645 is only a benefit in the outpatient setting, specifically in a hospital emergency department or an urgent care clinic.

Pulse oximetry and evaluation of the client's use of an aerosol generator, nebulizer, or metered-dose inhaler are considered part of an evaluation and management (E/M) visit and will not be reimbursed separately.

Hypertonic saline used in aerosol therapy will be denied if billed separately.

Referto: Subsection 4.2.20.1, "Aerosol Treatment" in the *Inpatient and Outpatient Hospital Services Handbook* (Vol. 2, *Provider Handbooks*).

9.2.4.1 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) is a benefit for Texas Medicaid.

FeNO measurement provided in the physician's office is considered medically necessary as an adjunct to the established clinical and laboratory assessments for diagnosing and assessing asthma, predicting exacerbations, and evaluating the response of a client who has asthma to anti-inflammatory therapy. FeNO measurement may be reimbursed by Texas Medicaid when the test is used as follows:

- To assist in assessing the etiology of respiratory symptoms.
- To help identify the eosinophilic asthma phenotype.
- To assess potential response or failure to respond to anti-inflammatory agents, particularly inhaled corticosteroids (ICS).
- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma.
- To guide changes in dosing of anti-inflammatory medications, i.e., step-down dosing, step-up dosing, or discontinuation of anti-inflammatory medications.
- To assist in the evaluation of adherence to anti-inflammatory medications.
- To assess whether airway inflammation is contributing to respiratory symptoms.

The technical and interpretation components of procedure code 95012 will not be reimbursed separately, as the instrument produces an exhaled nitric oxide (NO) measurement that requires little interpretation. Procedure code 95012 will be limited to once per day and must be submitted with procedure code 94010 or 94060.

If FeNO is measured during an office visit where additional E/M components are fulfilled, a separate E/M procedure code may be reimbursed if it is submitted with modifier 25.

9.2.5 Allergy Services

Texas Medicaid uses the following guidelines for reimbursement of allergy services.

9.2.5.1 Allergy Immunotherapy

Allergen immunotherapy consists of the parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage which is maintained as maintenance therapy.

Preparation of the allergy vial or extracts is a benefit of Texas Medicaid when preparations are made in accordance with the American Academy of Allergy, Asthma, and Immunology. Claims for preparations should be submitted using the following procedure codes:

| Procedure Codes for Preparation of Allergy Vial or Extract | | | | | | |
|--|-------|-------|-------|-------|-------|-------|
| 95145 | 95146 | 95147 | 95148 | 95149 | 95165 | 95170 |

Administration of the allergy extract may be reimbursed using procedure codes 95115 and 95117.

Rapid desensitization may be reimbursed using procedure code 95180 when submitted with diagnosis code Z516.

Allergen immunotherapy is a benefit for clients who have allergy conditions when the following criteria are met:

- A diagnosed hypersensitivity to an allergen can be indicated by one of the valid diagnosis codes listed below.

- Hypersensitivity cannot be managed by avoidance or pharmacologic therapy to control allergic symptoms, or the client has unacceptable side effects with pharmacologic therapy.
- The pharmacologic treatment is refused by the client or leads to significant side effects.
- The allergen content is based on appropriate skin testing, and the allergens are prepared for the client individually.

The preparation of the allergy vial or extract and the administration of an injection may be reimbursed for the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| H1045 | H6501 | H6502 | H6503 | H6504 | H6505 | H6506 | H65111 |
| H65112 | H65113 | H65114 | H65115 | H65116 | H65191 | H65192 | H65193 |
| H65194 | H65195 | H65196 | H6521 | H6522 | H6523 | H65491 | H65492 |
| H65493 | J301 | J302 | J305 | J3081 | J3089 | J309 | J441 |
| J449 | J4520 | J4521 | J4522 | J4530 | J4531 | J4532 | J4540 |
| J4541 | J4542 | J4550 | J4551 | J4552 | J45901 | J45902 | J45909 |
| J45998 | L500 | M041 | M042 | M048 | M049 | T531X4A | T531X4D |
| T531X4S | T532X4A | T532X4D | T532X4S | T533X4A | T533X4D | T533X4S | T534X4A |
| T534X4D | T534X4S | T536X4A | T536X4D | T536X4S | T59812A | T59812D | T59812S |
| T63001A | T63001D | T63001S | T63002A | T63002D | T63002S | T63003A | T63003D |
| T63003S | T63004A | T63004D | T63004S | T63011A | T63011D | T63011S | T63012A |
| T63012D | T63012S | T63013A | T63013D | T63013S | T63014A | T63014D | T63014S |
| T63021A | T63021D | T63021S | T63022A | T63022D | T63022S | T63023A | T63023D |
| T63023S | T63024A | T63024D | T63024S | T63031A | T63031D | T63031S | T63032A |
| T63032D | T63032S | T63033A | T63033D | T63033S | T63034A | T63034D | T63034S |
| T63041A | T63041D | T63041S | T63042A | T63042D | T63042S | T63043A | T63043D |
| T63043S | T63044A | T63044D | T63044S | T63061A | T63061D | T63061S | T63062A |
| T63062D | T63062S | T63063A | T63063D | T63063S | T63064A | T63064D | T63064S |
| T63071A | T63071D | T63072A | T63073A | T63073D | T63073S | T63074A | T63074D |
| T63074S | T63081A | T63081D | T63081S | T63082A | T63082D | T63082S | T63083A |
| T63083D | T63083S | T63084A | T63084D | T63084S | T63091A | T63091D | T63091S |
| T63092A | T63092D | T63092S | T63093A | T63093D | T63093S | T63094A | T63094D |
| T63094S | T63111A | T63111D | T63111S | T63112A | T63112D | T63112S | T63113A |
| T63113D | T63113S | T63114A | T63114D | T63114S | T63121A | T63121D | T63121S |
| T63122A | T63122D | T63122S | T63123A | T63123D | T63123S | T63124A | T63124D |
| T63124S | T63191A | T63191D | T63191S | T63192A | T63192D | T63192S | T63193A |
| T63193D | T63193S | T63194A | T63194D | T63194S | T632X1A | T632X1D | T632X1S |
| T632X2A | T632X2D | T632X2S | T632X3A | T632X3D | T632X3S | T632X4A | T632X4D |
| T632X4S | T63301A | T63301D | T63301S | T63302A | T63302D | T63302S | T63303A |
| T63303D | T63303S | T63304A | T63304D | T63304S | T63311A | T63311D | T63311S |
| T63312A | T63312D | T63312S | T63313A | T63313D | T63313S | T63314A | T63314D |
| T63314S | T63321A | T63321D | T63321S | T63322A | T63322D | T63322S | T63323A |
| T63323D | T63323S | T63324A | T63324D | T63324S | T63331A | T63331D | T63331S |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T63332A | T63332D | T63332S | T63333A | T63333D | T63333S | T63334A | T63334D |
| T63334S | T63391A | T63391D | T63391S | T63392A | T63392D | T63392S | T63393A |
| T63393D | T63393S | T63394A | T63394D | T63394S | T63411A | T63411D | T63411S |
| T63412A | T63412D | T63412S | T63413A | T63413D | T63413S | T63414A | T63414D |
| T63414S | T63421A | T63421D | T63421S | T63422A | T63422D | T63422S | T63423A |
| T63423D | T63423S | T63424A | T63424D | T63424S | T63431A | T63431D | T63431S |
| T63432A | T63432D | T63432S | T63433A | T63433D | T63433S | T63434A | T63434D |
| T63434S | T63441A | T63441D | T63441S | T63442A | T63442D | T63442S | T63443A |
| T63443D | T63443S | T63444A | T63444D | T63444S | T63451A | T63451D | T63451S |
| T63452A | T63452D | T63452S | T63453A | T63453D | T63453S | T63454A | T63454D |
| T63454S | T63461A | T63461D | T63461S | T63462A | T63462D | T63462S | T63463A |
| T63463D | T63463S | T63464A | T63464D | T63464S | T63481A | T63481D | T63481S |
| T63482A | T63482D | T63482S | T63483A | T63483D | T63483S | T63484A | T63484D |
| T63484S | T63511A | T63511D | T63511S | T63512A | T63512D | T63512S | T63513A |
| T63513D | T63513S | T63514A | T63514D | T63514S | T63591A | T63591D | T63591S |
| T63592A | T63592D | T63592S | T63593A | T63593D | T63593S | T63594A | T63594D |
| T63594S | T63611A | T63611D | T63611S | T63612A | T63612D | T63612S | T63613A |
| T63613D | T63613S | T63614A | T63614D | T63614S | T63621A | T63621D | T63621S |
| T63622A | T63622D | T63622S | T63623A | T63623D | T63623S | T63624A | T63624D |
| T63624S | T63631A | T63631D | T63631S | T63632A | T63632D | T63632S | T63633A |
| T63633D | T63633S | T63634A | T63634D | T63634S | T63691A | T63691D | T63691S |
| T63692A | T63692D | T63692S | T63693A | T63693D | T63693S | T63694A | T63694D |
| T63694S | T63711A | T63711D | T63711S | T63712A | T63712D | T63712S | T63713A |
| T63713D | T63713S | T63714A | T63714D | T63714S | T63791A | T63791D | T63791S |
| T63792A | T63792D | T63792S | T63793A | T63793D | T63793S | T63794A | T63794D |
| T63794S | T63811A | T63811D | T63811S | T63812A | T63812D | T63812S | T63813A |
| T63813D | T63813S | T63814A | T63814D | T63814S | T63821A | T63821D | T63821S |
| T63822A | T63822D | T63822S | T63823A | T63823D | T63823S | T63824A | T63824D |
| T63824S | T63831A | T63831D | T63831S | T63832A | T63832D | T63832S | T63833A |
| T63833D | T63833S | T63834A | T63834D | T63834S | T63891A | T63891D | T63891S |
| T63892A | T63892D | T63892S | T63893A | T63893D | T63893S | T63894A | T63894D |
| T63894S | T6391XA | T6391XD | T6391xS | T6392XA | T6392xD | T6392xS | T6393XA |
| T6393xD | T6393xS | T6394XA | T6394xD | T6394xS | T65824A | T65824D | T65824S |

9.2.5.1.1 Prior Authorization for Allergy Immunotherapy

Authorization is not required for immunotherapy services; however, requests for services beyond the established limits of 160 doses per one-year period for procedure code 95165 may be considered for prior authorization with documentation of medical necessity. Documentation must be submitted to the Special Medical Prior Authorization Department and include the following information:

- Copy of the allergen testing results
- Severity and periodicity of symptoms

- Physical limitations created by the symptoms
- Concurrent drug treatment
- Explanation of how efficacy has not been achieved with prior treatment and the objectives of the new anticipated treatment program

9.2.5.1.2 Limitations of Allergy Immunotherapy

The quantity billed for the allergy extract preparation procedure must represent the total number of doses to be administered from the vial. If the number of doses is not stated on the claim, a quantity of one is allowed.

Note: A “dose” is defined as the amount of antigen(s) administered in a single injection from a multidose vial.

Procedure code 95165 is limited to a total of 160 doses per one-year period, which begins the date the immunotherapy is initiated. Additional doses may be considered for reimbursement through prior authorization with documentation of medical necessity. Procedure code 95165 is limited to no more than ten doses per vial.

When an injection is given from a vial, providers should use an administration-only procedure code (95115 or 95117). Reimbursement for the administration is limited to one per day.

An office visit, clinic visit, treatment or observation room visit is not considered for reimbursement in addition to the fee for the preparation or the administration of the allergy vial or extract unless the additional visit results in a non-allergy-related diagnosis or a re-evaluation of the client’s condition. The following E/M procedure codes may be submitted with modifier 25:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 | 99217 |
| 99218 | 99219 | 99220 | | | | | | | |

Allergen immunotherapy that is considered experimental, investigational, or unproven is not a benefit of Texas Medicaid.

Single dose vials (procedure code 95144) are not a benefit of Texas Medicaid.

Referto: Subsection 4.5.5, “Outpatient Hospital Revenue Codes” in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information about outpatient hospital revenue codes for clinic visits, treatment rooms, and observation services.

9.2.5.2 Allergy Testing

Texas Medicaid benefits include allergy testing for clients with clinically significant allergic symptoms. Allergy testing is focused on determining the allergens that cause a particular reaction and the degree of the reaction. Allergy testing also provides justification for recommendations of particular medicines, of immunotherapy, or of specific avoidance measures in the environment.

Evaluation and management E/M services will not be reimbursed on the same date of service as allergy testing. Allergy testing will be paid and the E/M service will be denied as part of another procedure on the same date of service.

The following allergy tests are benefits of Texas Medicaid:

- Percutaneous and intracutaneous skin test. The skin test for IgE-mediated disease with allergenic extracts is used in the assessment of allergy-prone clients. The test involves the introduction of small quantities of test allergens below the epidermis. Procedure codes 95004, 95017, 95018, 95024, 95027, and/or 95028 should be used to submit skin tests for consideration of reimbursement.

- *Patch or application tests.* Patch testing (procedure code 95044) is used for diagnosing contact allergic dermatitis.
- *Photo or photo patch skin test.* Procedure codes 95052 and 95056 may be used for diagnosing contact allergic dermatitis.
- *Ophthalmic mucous membrane or direct nasal mucous membrane tests.* Nasal or ophthalmic mucous membrane tests (procedure codes 95060 and 95065) are used for the diagnosis of either food or inhalant allergies and involve the direct administration of the allergen to the mucosa.
- *Inhalation bronchial challenge testing (not including necessary pulmonary function tests).* Bronchial challenge testing with methacholine, histamine, or allergens (procedure code 95070) is used for defining asthma or airway hyperactivity when skin testing results are not consistent with the client's medical history. Results of these tests are evaluated by objective measures of pulmonary function.

Procedure code 95199 may be used for an unlisted allergy or clinical immunologic service or procedure if there is not a specific procedure code that describes the service performed. Prior authorization is required for unlisted procedure codes. Every effort must be used to bill with the appropriate CPT code that describes the procedure being performed. If a code does not exist to describe the service performed, prior authorization may be requested using unlisted procedure code 95199 and must be submitted with documentation to assist in determining coverage. The documentation submitted must include all of the following:

- The client's diagnosis
- Medical records indicating prior treatment for this diagnosis and the medical necessity of the requested procedure
- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A CPT or HCPCS procedure code that is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service (POS) the procedure is to be performed
- The physician's intended fee for this procedure

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

The number of allergy tests performed must be indicated on the claim. When the number of tests is not specified, a quantity of one is allowed.

9.2.5.2.1 Allergy Blood Tests

Allergy blood testing procedure codes 86001, 86003, 86005, and 86008 are a benefit when the test is performed for a reason that includes, but is not limited to, the following:

- The client is unable to discontinue medications
- An allergy skin test is inappropriate for the client for the following reasons:
 - The client is pediatric
 - The client is disabled
 - The client suffers from a skin condition such as dermatitis

Radioallergosorbent tests (RAST) and multiple antigen simultaneous tests (MAST) are benefits of Texas Medicaid. RAST testing is used to detect specific allergens. RAST testing is usually performed by an independent lab; however, there are physicians who have the capability of performing these tests in their

offices. Physicians who submit RAST/MAST tests performed in the office setting must use modifier SU to be considered for reimbursement. Without the use of the SU modifier, RAST/MAST testing submitted with POS 1 (office) is denied with the message, “Lab performed outside of office must be billed by the performing facility.”

RAST/MAST tests must be submitted using procedure codes 86003, 86005, and 86008.

Procedure code 86001 is limited to 20 allergens per rolling year, any provider.

Procedure code 86003 and 86008 are limited to 30 allergens per rolling year, any provider.

Procedure code 86005 is limited to 4 multiallergen tests per rolling year, same provider.

9.2.5.2.2 Collagen Skin Test

Collagen skin tests are a benefit of Texas Medicaid using procedure code Q3031. Collagen skin tests are administered to detect a hypersensitivity to bovine collagen. This skin test is given four weeks prior to any type of surgical procedure that utilizes collagen.

Collagen injections that are used for cosmetic surgery are not considered medically necessary and are not a benefit of Texas Medicaid.

9.2.5.2.3 Prior Authorization

Prior authorization is required for collagen skin test procedure code Q3031.

Prior authorization requests for Texas Medicaid fee-for-service clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department.

Prior authorization is required for procedure codes 86001, 86003, and 86005 only if the limits are exceeded. The following medical documentation must be submitted to the SMPA Department with the prior authorization request for additional procedures:

- Results of any previous treatment
- Documentation that explains why the client’s treatment could not be completed within the policy limits for the requested procedures
- Client diagnosis and conditions that support the medical necessity for the additional procedures requested
- Client outcomes that the requested procedures will achieve

9.2.5.2.4 Ingestion Challenge Test

Ingestion challenge tests are a benefit of Texas Medicaid using procedure codes 95076 and 95079.

Procedure code 95076 is limited to one service per day, any provider.

Procedure code 95079 is limited to twice per day, any provider.

Add-on procedure code 95079 must be billed with primary procedure code 95076.

9.2.6 Ambulance Transport Services - Nonemergency

Nonemergency ambulance services require prior authorization in circumstances not involving an emergency. Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services.

Referto: [Non-emergency Ambulance Prior Authorization Request](https://www.tmhp.com) on the TMHP website at www.tmhp.com.

Subsection 2.2.2, “Nonemergency Ambulance Transport Services” in the *Ambulance Services Handbook* (Vol. 2, *Provider Handbooks*) for more information about ambulance services.

Subsection 5.1.8, “Prior Authorization for Nonemergency Ambulance Transport” in “Section 5: Fee-for-Service Prior Authorizations” (Vol. 1, *General Information*) for more information about nonemergency ambulance transport prior authorization.

9.2.7 Anesthesia

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement.

Medicaid may reimburse anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) for administering anesthesia as defined within their individual scope of practice.

9.2.7.1 Medical Direction by an Anesthesiologist

Medical direction by an anesthesiologist of an anesthesia practitioner (CRNA, AA, or other qualified professional) is a benefit of Texas Medicaid if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.
- The anesthesiologist is physically present in the operating suite.

Exception: *Anesthesiologists may be considered for reimbursement when they medically direct more than four anesthesia services or simultaneously supervise a combination of more than four CRNAs, AAs, or other qualified professionals under emergency circumstances only.*

Medical direction provided by an anesthesiologist is a benefit of Texas Medicaid if the following criteria are met:

- The anesthesiologist performs a preanesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical portions of the anesthesia plan, including induction and emergence.
- The anesthesiologist ensures that a qualified professional can perform the procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at intervals.
- The anesthesiologist provides direct supervision when medically directing an anesthesia procedure. Direct supervision means the anesthesiologist must be immediately available to furnish assistance and direction.
- The anesthesiologist provides postanesthesia care.

The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist who directs the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:

- Address an emergency of short duration in the immediate area
- Administer an epidural or caudal anesthetic to ease labor pain
- Provide periodic, rather than continuous, monitoring of an obstetrical patient
- Receive clients entering the operating suite for the next surgery

- Check or discharge clients in the recovery room
- Handle scheduling matters

As noted above, an anesthesiologist may concurrently medically direct up to four anesthesia procedures. Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicaid client. For example, if three procedures are medically directed but only two involve Medicaid clients, the Medicaid claims must be billed as concurrent medical direction of three procedures.

For medical direction, the anesthesiologist must document in the client's medical record that he or she did the following:

- Performed the pre-anesthetic exam and evaluation.
- Provided indicated post-anesthesia care.
- Was present during the critical and key portions of the anesthesia procedure, including, if applicable, induction and emergence.
- Was present during the anesthesia procedure to monitor the client's status.

The following information must be available to state agencies upon request and is subject to retrospective review:

- The name of each CRNA, AA, or other qualified professional that was concurrently medically directed or supervised and a description of the procedure that was performed must be documented and maintained.
- Signatures of the anesthesiologist, CRNA, AA, or other qualified professional involved in administering anesthesia services must be documented in the client's medical record.

9.2.7.2 Anesthesia for Sterilization

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 the complete list of family planning diagnosis codes.

Subsection 2.2.8, "Sterilization and Sterilization-Related Procedures" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

Section 4, "Federally Qualified Health Center (FQHC)" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for more information about FQHCs and billing the annual family planning examination for Title XIX clients.

9.2.7.3 Anesthesia for Labor and Delivery

Providers must bill the most appropriate procedure code for the service provided. Other time-based procedure codes cannot be submitted if either 01960 or 01967 is the most appropriate procedure code.

The following procedure codes must be used for obstetrical anesthesia:

| Procedure Codes | | | | | |
|-----------------|-------|-------|-------|-------|-------|
| 01960 | 01961 | 01963 | 01967 | 01968 | 01969 |

Procedure codes 01960 and 01967 are limited to once every 210 days when billed by any provider and are reimbursed a flat fee. The time reported must be in minutes. Providers should refer to the definition of time in the CPT manual in the "Anesthesia Guidelines—Time Reporting" section.

Procedure code 01968 or 01969 may be considered for reimbursement when submitted with procedure code 01967. For a Cesarean delivery following a planned vaginal delivery, the anesthesia administered during labor must be billed with procedure code 01967 and must indicate the time in minutes that represents the time between the start and stop times for the procedure. The additional anesthesia services administered during the operative session for a Cesarean delivery must be submitted using procedure code 01968 or 01969 and must indicate the time spent administering the epidural and the actual face-to-face time spent with the client. The insertion and injection of the epidural are not considered separately for reimbursement.

All time must be documented in block 24D of the claim form or the appropriate field of the chosen electronic format.

For continuous epidural analgesia procedure codes, Texas Medicaid reimburses providers for the time when the physician is physically present and monitors the continuous epidural. Reimbursable time refers to the period between the catheter insertion and when the delivery commences.

9.2.7.4 Anesthesia Provided by the Surgeon (Other Than Labor and Delivery)

Local, regional, or general anesthesia provided by the operating surgeon is not reimbursed separately from the surgery. A surgeon billing for a surgery will not be reimbursed for the anesthesia when billing for the surgery, even when using the CPT modifier 47. The anesthesia service is included in the global surgical fee.

9.2.7.5 Complicated Anesthesia

The following procedure codes may be reimbursed in addition to an anesthesia procedure or service: 99100, 99116, 99135, and 99140. Documentation supporting the medical necessity for use of the procedure codes may be subject to retrospective review.

Procedure code 99140 is not reimbursed for diagnosis code O80 or O82 when one of these diagnoses is documented as the referenced diagnosis on the claim. The referenced diagnosis must indicate the complicating condition. An emergency is defined as existing when delay in treatment of the client would lead to a significant increase in the threat to life or body part.

9.2.7.6 Multiple Procedures

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items.

When billing for multiple anesthesia services performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.

9.2.7.7 Monitored Anesthesia Care

Monitored anesthesia care may include any of the following:

- Intraoperative monitoring by an anesthesiologist or qualified professional under the medical direction of an anesthesiologist
- Monitoring of the client's vital physiological signs in anticipation of the need for general anesthesia
- Monitoring of the client's development of an adverse physiological reaction to a surgical procedure

Anesthesiologists, CRNAs, AAs, or other qualified professionals may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier.

9.2.7.8 Reimbursement Methodology

There are two types of reimbursement for anesthesia procedure codes.

- Flat fee
- Time-based fees, which require documentation of the exact amount of face-to-face time with the client

Anesthesiologists directing one or multiple CRNAs and/or AAs during medical procedures will be reimbursed at 50 percent of the established reimbursement rate.

An AA under the supervision of an anesthesiologist is reimbursed the lesser of the billed charges or 50 percent of the calculated payment for a supervised anesthesia service.

If multiple CRNAs, anesthesiologists, or anesthesiologist assistants under anesthesiologist supervision are providing anesthesia services for a client, only one CRNA or AA and one anesthesiologist may be reimbursed.

Both the flat-fee and time-based-fee procedure codes must be submitted with modifiers and are subject to medical direction/supervision reimbursement adjustments.

Flat Fees

Both OB related anesthesia procedure codes 01960 and 01967 are considered for reimbursement with a flat-fee rate.

- Flat fees are subject to medically-directed modifier combination adjustments based on the modifier submitted with the anesthesia procedure code.
- The time-based add-on procedure code 01968 must be billed in addition to the flat fee when anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia has occurred.

For flat-fee anesthesiology codes, anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance, that is, when the client may be safely placed under postoperative supervision.

Time-Based Fees

For time-based anesthesiology procedure codes, anesthesia time is the time during which an anesthesia practitioner is present with the client. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

For time-based anesthesiology codes, anesthesia practitioners must document interruptions in anesthesia time in the client's medical record.

The documented time must be the same in the records or claims of the anesthesiologist and other anesthesia practitioners who were medically directed by the anesthesiologist.

One time unit is equal to 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

Reimbursement of time-based anesthesia services is derived by adding the RVUs (e.g., base units) for the procedures performed (when multiple procedures are performed use the procedure with the highest RVUs) to the total face-to-face anesthesia time in minutes divided by 15 minutes, multiplied by the appropriate conversion factor:

$$[\text{RVUs} + (\text{Minutes} / 15)] \times \text{Conversion Factor} = \text{Anesthesia Reimbursement}$$

| Provider Type Description - Physician Pricing Example | | | | |
|---|---|-------------------|---|------------------------------------|
| Time: 120 minutes | = | 120/15 | = | 8 (quantity billed) |
| Procedure code: 00851 | = | (6 RVUs) 6.00 + 8 | = | 14.00 |
| Conversion factor: \$19.58 | = | 14.00 x 19.58 | = | \$274.12 (physician reimbursement) |

Conversion Factor

A conversion factor is the multiplier that transforms relative values into payment amounts. There is a standard conversion factor for anesthesia services.

9.2.7.9 Anesthesia Modifiers

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier combination whether billing as the sole provider or for the medical direction of CRNAs, AAs, or other qualified professionals.

When an anesthesia procedure is billed without the appropriate reimbursement modifiers or is billed with modifier combinations other than those listed below in the Modifier Combinations section, the claim will be denied.

A procedure billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) will be denied if another claim has been paid indicating the service was personally performed by, and reimbursed to, a CRNA (modifier QZ) for the same client, date of service, and procedure code. The opposite is also true—a CRNA-administered procedure will be denied if a previous claim was paid to an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

9.2.7.9.1 State-Defined Modifiers

Modifiers U1 (indicating one Medicaid claim billed by an anesthesia practitioner) and U2 (indicating two Medicaid claims) are state-defined modifiers that must be billed by an anesthesiologist, CRNA, AA, or other qualified professional.

Modifier U1, indicating that only one Medicaid claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two Medicaid claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit modifier U1 or U2 in combination with an appropriate pricing modifier (AA, GC, QY, QK, AD, QZ, QX) when billing for any payable anesthesia procedure codes.

9.2.7.9.2 Modifier Combinations

When a single claim per client is billed by the anesthesiologist for personally performing the anesthesia service, the AA and U1 modifier combination must be billed together.

Anesthesiologists may be reimbursed for medical direction of CRNAs, AAs, or other qualified professional by using one of the following modifier combinations:

| Modifier Combination Submitted by Anesthesiologist | When is it used? | Who will submit claims? |
|---|---|---|
| Anesthesiologist Directing Other Qualified Professionals | | |
| QY and U1 | When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one CRNA, AA, or other qualified professional, the QY + U1 modifier combination must be billed together when the CRNA, AA, or qualified professional are a part of a clinic/group. | Only the anesthesiologist |
| AA, U1, and GC | When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of an anesthesia procedure provided by one resident physician. <i>Note: For procedure code 01967 medical supervision of resident physicians rather than medical direction is required, however, modifiers AA-U1-GC must still be noted on the claim.</i> | Only the anesthesiologist |
| QK and U1 | When a single claim per client is billed by the anesthesiologist for medically directing anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. | Only the anesthesiologist |
| AD and U1 (Emergency circumstances only) | When a single claim per client is billed by the anesthesiologist for medical supervision of anesthesia services for more than four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures. | Only the anesthesiologist |
| Anesthesiologist Directing CRNAs or AAs | | |
| QY and U2 | When two claims per client are billed, one by the medically directing anesthesiologist and one by the CRNA, AA, or other qualified professional. | Both the anesthesiologist and CRNA, AA, or other qualified professional |
| QK and U2 | When two claims per client are billed for medically directed anesthesia services of two, three, or four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. | Both the anesthesiologist and CRNA, AA, or other qualified professional |

| Modifier Combination Submitted by Anesthesiologist | When is it used? | Who will submit claims? |
|--|--|---|
| AD and U2 (Emergency circumstances only) | When two claims per client are billed for the medical supervision of more than four concurrent anesthesia procedures provided by CRNAs, AAs, or other qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures. | Both the anesthesiologist and CRNA, AA, or other qualified professional |

9.2.7.9.3 CRNA, AA, and Other Qualified Professional Services

Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the physician.

Modifiers QX and U2 must be submitted by a CRNA, AA, or other qualified professional who provided services under the medical direction of an anesthesiologist.

9.2.7.10 Prior Authorization for Anesthesia

9.2.7.10.1 Anesthesia for Medical Services

Anesthesia services provided in combination with most medical surgical procedures do not require prior authorization. However, some medical surgical procedures may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon will be denied.

9.2.7.11 Claims Filing

Texas Medicaid reimburses anesthesiologists based on the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 paper claim form).
- Person (physician, CRNA, or AA) administering anesthesia (modifiers must be used to designate this provider type).
- Time in minutes.
- Any other appropriate modifier (refer to subsection 6.3.5, “Modifiers” in “Section 6: Claims Filing” (*Vol. 1, General Information*) for a list of the most common modifiers).

9.2.7.12 Anesthesia (General) for THSteps Dental

Referto: Section 3, “Texas Health Steps (THSteps) Dental” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for additional information.

9.2.8 Bariatric Surgery

Bariatric surgery is considered medically necessary when used as a means to treat covered medical conditions that are caused or significantly worsened by the client’s obesity in cases where those comorbid conditions cannot be adequately treated by standard measures unless significant weight reduction takes place. The pathophysiology of the covered comorbid conditions must be sufficiently severe that the expected benefits of weight loss subsequent to this surgery significantly outweigh the risks associated with bariatric surgery.

The following procedure codes may be reimbursed for medically necessary bariatric surgery services with prior authorization: 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, and 43888.

Bariatric surgery is not a benefit when the primary purpose of the surgery is any of the following:

- For weight loss for its own sake
- For cosmetic purposes
- For reasons of psychological dissatisfaction with personal body image
- For the client's or provider's convenience or preference

9.2.8.1 Prior Authorization for Bariatric Surgery

All clients must meet the criteria outlined below.

The same contraindications exist for bariatric surgery as for any other elective abdominal surgery. Documentation provided for prior authorization must attest that none of the following additional contraindications exist:

- Endocrine cause for obesity, inflammatory bowel disease, chronic pancreatitis, cirrhosis, portal hypertension, or abnormalities of the gastrointestinal tract
- Chronic, long-term steroid treatment
- Pregnant, or plans to become pregnant within 18 months
- Noncompliance with medical treatment
- Significant psychological disorders that would be exacerbated or interfere with the long-term management of the client after the operation
- Active malignancy

All clients must undergo preoperative psychological evaluation by a behavioral health provider and have clearance for surgery if any of the following conditions exist:

- They have a history of psychiatric or psychological disorders.
- They are currently under the care of a psychologist or psychiatrist.
- They are on psychotropic medications.

The client's medical record must include documentation of the evaluation.

Clients without a history of psychiatric or psychological disorder must also undergo a preoperative psychological evaluation by a behavioral health provider and have clearance for surgery. The client's medical record must include documentation that the client is psychologically mature and able to cope with the postsurgical changes of the surgery.

Documentation must be submitted with the prior authorization request that is signed by the surgeon and attests that the services are provided by a facility in Texas that is one of the following:

- Accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
- A children's hospital that has a bariatric surgery program and provides access to an experienced surgeon who employs a team that is capable of long-term follow-up of the metabolic and psychosocial needs of the client and family.

Bariatric surgery for clients who are 20 years of age and younger may be prior authorized when the client meets all of the following criteria:

- The client has reached a Tanner Scale stage IV or V plus 95 percent of adult height based on bone age.
- The client has a body mass index (BMI) of greater than or equal to 40 kg/m².

- The client has one or more comorbid conditions that are exacerbated by or attributable to obesity.
- Female clients must be at least 13 years of age and menstruating.
- Male clients must be at least 15 years of age.

Bariatric surgery for clients who are 21 years of age and older may be prior authorized when the client meets all of the following criteria:

- The client has a BMI of greater than or equal to 35 kg/m².
- The client has one or more of the following comorbid conditions that are exacerbated by or attributable to obesity:
 - Obesity-associated hypoventilation
 - Moderate to severe sleep apnea (defined as apnea/hypoapnea index of 16 or more events per hour)
 - Congestive heart failure
 - Obesity-induced cardiomyopathy
 - Refractory hypertension resistant to pharmacotherapy (defined as blood pressure greater than 140mmHg systolic or greater than 90mmHg diastolic, despite maximally tolerated doses of at least three different classes of antihypertensive medications)
 - Pseudotumor cerebri (documented idiopathic intracerebral hypertension)
 - Adult onset (Type II) diabetes (with or without complications) with Hgb A1c greater than 9 percent, regardless of therapy, or 7 to 9 percent on maximal medical therapy (defined as taking insulin or maximally tolerated doses of at least two different classes of oral hypoglycemic medications)
 - Cardiovascular or peripheral vascular disease
 - Refractory hyperlipidemia (defined as triglycerides greater than 250 mg/dl, cholesterol greater than 220/mg/dl, HDL less than 35 mg/dl, or LDL greater than 200 mg/dl, despite maximally tolerated doses of at least two different classes of lipid-lowering medications)
 - Recurrent or chronic skin ulcerations with infection
 - Pulmonary hypertension
 - Chronic joint disease, deterioration of the joint cartilage, and the formation of new bone (bone spurs) at the margins of the joints, with symptoms that severely affect work or leisure activities, on maximal medical therapy (defined as maximally tolerated dose of a non-steroidal anti-inflammatory drug (NSAID) or COX-II inhibitor or acetaminophen and the completion of at least one physical-therapist-supervised exercise program)
 - Hepatic steatosis without evidence of active inflammation

Documentation must include a summary of the treatment provided for the client's comorbid conditions, including descriptions of how the client's response to standard treatment measures are unsatisfactory and why the bariatric surgery is medically necessary in the context of current treatment and medically-reasonable alternatives that are available.

Referral for bariatric surgery to the bariatric surgeon is required from the practitioner who is treating the comorbid condition(s). The bariatric surgeon will determine the client's eligibility for bariatric surgery. Documentation of the referral must be submitted with the prior authorization request.

The client must have had previous unsuccessful medical treatment for obesity, as documented in the medical record. All of the following minimal requirements must be met:

- The client has made a diligent effort to achieve healthy body weight with such efforts described in the medical record and certified by the operating surgeon.
- The client has failed to maintain a healthy weight despite a minimum of 6 months documented regular participation in a structured dietary program overseen by a physician (M.D. or D.O.) within 12 months of the request date.

Documentation that is submitted for prior authorization must also include all of the following:

- The process by which the client will receive postoperative surgical, nutritional, and psychological services.
- Affirmation that the client and the parent/guardian (if applicable) understand and will support the changes in eating habits that must accompany the surgery and the extensive postoperative follow-up.

Repeat bariatric surgery may be considered medically necessary in either of the following circumstances:

- To correct complications from bariatric surgery such as band malfunction, obstruction, or stricture
- To convert to a Roux-en-Y gastroenterostomy or to correct pouch failure in an otherwise compliant client when the initial bariatric surgery met medical necessity criteria

Note: *Conversion to a Roux-en-Y gastroenterostomy may be considered medically necessary for clients who have not had adequate success (defined as a loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure, and the client has been compliant with a prescribed nutrition and exercise program following the procedure.*

All documentation required for prior authorization is to be maintained in the client's medical record and is subject to retrospective review. This includes medical records from both the practitioner treating the comorbid condition(s) and the bariatric surgeon.

Providers may fax or mail prior authorization requests for bariatric surgery services for clients who are 20 years of age and younger to the TMHP Comprehensive Care Program (CCP) Prior Authorization Department. Prior authorization requests for clients who are 21 years of age and older may be faxed or mailed to the TMHP Special Medical Prior Authorization Department.

Clients may be eligible under Texas Medicaid or CCP for separate reimbursement for nutritional and psychological assessment and counseling associated with bariatric surgery.

Behavioral health services provided as part of the preoperative or postoperative phase of bariatric surgery are subject to behavioral health guidelines, and are not considered part of the bariatric surgery.

Referto: Subsection 7, "Inpatient Psychiatric Services" in the *Behavioral Health and Case Management Services Handbook* (Vol. 2, *Provider Handbooks*) for information about behavioral health services.

9.2.9 **Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer**

Live BCG for intravesical (procedure code 90586) or transvesical (procedure code J9030) are benefits of Texas Medicaid for the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|------|-------|------|------|------|------|------|
| C670 | C671 | C672 | C673 | C674 | C675 | C676 | C677 |
| C678 | C679 | C7911 | D090 | | | | |

Procedure code 90585 is a benefit of Texas Medicaid for diagnosis code Z23. Authorization is not required for the BCG vaccine.

Bladder instillation of anticarcinogenic agent (procedure code 51720) may be reimbursed separately when billed with BCG instillation (procedure code 90586 or J9030).

9.2.10 Behavioral Health Services

Referto: *The Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks).*

9.2.11 Biopsy

A biopsy refers to the surgical excision of tissue for pathological examination.

If a surgeon bills separate charges for a surgical procedure and a biopsy on the same organ or structure on the same day, the charges are reviewed and reimbursed only for the service with the higher of the allowed amounts.

9.2.12 Biofeedback Services

Biofeedback services are a benefit of Texas Medicaid for clients who are 4 years of age and older with the following conditions:

- Urinary incontinence
- Fecal incontinence
- Migraine and tension headache

Biofeedback services may be reimbursed using procedure codes 90901, 90912, and 90913.

Biofeedback services are limited to a maximum of 18 sessions rendered by any provider for the lifetime of each client for each condition.

Biofeedback services that are not a benefit of Texas Medicaid are the following:

- Biofeedback performed in the home setting
- Neurofeedback (such as, but not limited to, electroencephalography [EEG])
- Treatment for muscle tension, except tension headache
- Psychological, psychophysiological, and behavioral health therapy and psychosomatic conditions
- Investigational or experimental biofeedback services and procedures

Procedure codes 90901, 90912, and 90913 are limited to one service per day. The reimbursement for procedure codes 90901, 90912, and 90913 include all modalities of the biofeedback training performed on the same day, regardless of the time increments or the number of modalities performed.

Any device used during a biofeedback session is considered part of the procedure and will not be reimbursed separately.

9.2.12.1 Biofeedback Certification

A staff member who is certified by Biofeedback Certification International Alliance (BCIA) must perform biofeedback services.

The certification types accepted by Texas Medicaid are the following:

- General biofeedback certification (BCB)
- Pelvic muscle dysfunction biofeedback certification (BCB-PMD)

Providers must maintain documentation in the client's medical record to support the medical necessity of the biofeedback service provided. Documentation must include the name of the staff person who provided the biofeedback and the prescribing physician must maintain in the office a record of the current certification of the staff member(s) who perform biofeedback. Documentation is subject to retrospective review.

9.2.12.2 Prior Authorization for Biofeedback Services

Prior authorization is required for biofeedback services.

- Any combination of procedure codes 90901, 90912, and 90913 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older.
- Procedure code 90901 is a benefit for biofeedback sessions for migraine or tension headache conditions.

The initial request may include up to 12 visits and not exceed a total duration of 12 weeks. Documentation of the following must be submitted for consideration of prior authorization:

- Conventional treatments that were given but were not successful, including, but not limited to, pharmacotherapy, exercise, rest, and heating and cooling modalities.
- Statements from the prescribing physician that the client is capable of understanding the requirements and agrees actively to participate in the biofeedback sessions.
- Name and certification information for the person performing the training.

In addition, documentation must be submitted to support the specific type of biofeedback requested.

Urinary and Fecal Incontinence

- Diagnosis of fecal or urinary stress, urge, overflow, or a mix of stress and urge incontinence in a client who is 4 years of age or older.
- Exclusion by the physician of any underlying medical conditions that could be causing the problem.
- Failed pelvic floor muscle exercise (PME) training for clients who are 21 years of age and older.

***Note:** Failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PME exercises.*

Migraine and tension headache

- A diagnosis of migraine, tension headache, or mixed migraine and tension headache.
- Symptoms that occur with a duration of at least 4 hours for at least 15 days a month over at least 3 months.
- Failure of first-line approaches, including avoidance of precipitating stimuli and pharmacological prophylaxis.

Prior authorization requests must be submitted by the physician to the Special Medical Prior Authorization (SMPA) Department. The request must be submitted with documentation that supports medical necessity. Providers may submit prior authorization requests online through the TMHP website at www.tmhp.com, by fax to 1-512-514-4213, or by mail to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727

After the client completes the initial biofeedback treatment course, prior authorization may be considered for a total of six follow-up sessions not to exceed three sessions per week and total duration not to exceed eight weeks. Providers must submit prior authorization documentation for the same condition as the original request, and must include each original symptom and how it has objectively improved. Documentation may include, but is not limited to, the following:

- For treatment of urinary incontinence, improvement in continence scores, vitality, health, a decrease in high-grade stress incontinence, nocturnal enuresis, and urine loss with activity. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For treatment of fecal incontinence, improvement in continence scores, squeeze and anal pressures, squeeze duration, vitality, and health. In clients who are 21 years of age and older, evidence of increased pelvic floor contraction strength and the ability to hold the contractions longer and to perform more repetitions.
- For migraine and tension headaches, diminished intensity, frequency, and duration of the headache activity.

9.2.13 Blepharoplasty Procedures

Procedure codes 15820, 15821, 67911, 67961, 67966, 67971, 67973, 67974, and 67975 are not diagnosis-restricted.

Procedure codes 67901, 67902, 67903, 67904, 67906, 67908, and 67909 may be reimbursed for clients who are 20 years of age and younger without prior authorization when performed for one of the following diagnosis codes:

| Diagnosis Codes | | | |
|-----------------|------|------|------|
| Q100 | Q101 | Q102 | Q103 |

Procedure codes 67901, 67902, 67903, 67904, 67906, and 67908 do not require prior authorization for clients who are 21 years of age and older when billed for the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| H0231 | H0232 | H0234 | H0235 | H02411 | H02412 | H02413 | H02421 |
| H02422 | H02423 | H02431 | H02432 | H02433 | | | |

Blepharoplasty for clients who are 21 years of age and older requires mandatory prior authorization. The following information from the physician is required at the time of the request for blepharoplasty for procedure codes 15820, 15821, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911:

- A brief history and physical evaluation
- Photographs of the eyelid problem
- Visual field measurements
- Diagnosis code

The following blepharoplasty and eyelid repair procedures do not require prior authorization:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 67916 | 67917 | 67923 | 67924 | 67961 | 67966 | 67971 | 67973 | 67974 | 67975 |

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

Retroactive authorization may be granted on an appeal basis when submitted with the appropriate documentation.

9.2.14 Bone Growth Stimulation

Professional services for bone growth stimulation (procedure codes 20974, 20975, and 20979) are a benefit of Texas Medicaid.

Prior authorization is required for a bone growth stimulator device (procedure codes E0747, E0748, E0749, and E0760).

Referto: Subsection 2.2.8, “Bone Growth Stimulators” in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (Vol. 2, *Provider Handbooks*) for prior authorization criteria.

9.2.14.1 Invasive Bone Growth Stimulation

Invasive bone growth stimulation (procedure code 20975) is indicated for the following conditions:

- Nonunion of long bone fractures (i.e., clavicle, humerus, radius, ulna, femur, tibia, fibula, and metacarpal, metatarsal, carpal, and tarsal bones). Nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for three or more months prior to starting treatment with the bone growth stimulator. Serial radiographs must include a minimum of 2 sets of radiographs separated by a minimum of 90 days. Each set of radiographs must include multiple views of the fracture site.
- Failed fusion of a joint other than the spine when a minimum of three months has elapsed since the joint fusion was performed.
- Congenital pseudoarthrosis.
- An adjunct to spinal fusion surgery for patients at high risk for pseudoarthrosis due to previously failed spinal fusion at the same site.
- An adjunct to multiple-level fusion, which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.).

9.2.14.2 Non-invasive Bone Growth Stimulation

Non-invasive bone growth stimulation (procedure code 20974) is indicated for the following conditions:

- Nonunions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three or more months despite appropriate fracture care.
- Delayed unions of fractures of failed arthrodesis at high risk sites (e.g., open or segmental tibial fractures, carpal navicular fractures).

Documentation must also indicate all of the following:

- Serial radiographs have confirmed that no progressive signs of healing have occurred.
- The fractured gap is 1 cm or less.
- The individual can be adequately immobilized and is likely to comply with non-weight-bearing restrictions.

Non-invasive bone growth stimulation for spinal application is indicated for the following conditions:

- One or more failed fusions.
- Grade II or worse spondylolisthesis.
- A multiple-level fusion with extensive bone grafting is required.
- Other risk factors for fusion failure are present, including gross obesity, degenerative osteoarthritis, severe spondylolisthesis, current smoking, previous fusion surgery, previous disc surgery, or gross instability.

9.2.14.3 Ultrasound Bone Growth Stimulation

Ultrasound bone growth stimulation (procedure code 20979) is indicated for nonunion of a fracture, other than the skull or vertebrae, in a skeletally mature person, which is documented by a minimum of two sets of radiographs that were:

- Obtained prior to starting treatment with the osteogenesis stimulator.
- Separated by a minimum of 90 days.
- Taken with multiple views of the fracture site.
- Accompanied by a written interpretation by a physician who states that there has been no clinically significant evidence of fracture healing between the two set of radiographs.

Documentation must also indicate evidence of all of the following:

- The fracture is not tumor-related.
- The fracture is not fresh (less than 7 days), closed or grade I open, tibial diaphyseal fractures, or closed fractures of the distal radius (Colles fracture).

9.2.14.4 Reimbursement

Professional claims that are submitted for bone growth stimulation (procedure codes 20974, 20975, and 20979) may be reimbursed if the claim includes documentation of one of the following:

- Documentation of medical necessity as outlined for each type of bone growth stimulation.
- The corresponding bone growth stimulator device was submitted within 95 days of the date the bone growth stimulation procedure was performed.

The appropriate evaluation and management (E/M) procedure code must be billed for monitoring the effectiveness of bone growth stimulation treatment.

Procedure codes 20974, 20975, and 20979 are limited to one per six months. During the six-month limitation period, a subsequent fracture that meets the criteria for a bone growth stimulator may be reimbursed after the submission of an appeal with documentation of medical necessity that demonstrates the criteria have been met.

9.2.15 Cancer Screening and Testing

9.2.15.1 BRCA Testing

Referto: Subsection 2.2.6, “Breast Cancer Gene 1 and 2 (BRCA) Testing” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

9.2.15.2 Colorectal Cancer Screening

Colorectal cancer screening is a benefit of Texas Medicaid. Fecal occult blood tests, multi-targeted stool DNA (mt-sDNA) tests, screening colonoscopies, and sigmoidoscopies are evidenced based methods of colorectal cancer screening. Screening refers to the testing of asymptomatic persons to assess their risk

for the development of colorectal cancer. Screening has been shown to decrease mortality due to this cancer by detecting cancers at earlier stages and allowing the removal of adenomas, thus preventing the subsequent development of cancer.

The American Cancer Society (ACS) recommends screening people at average risk for colorectal cancer beginning at 45 years of age by any of the following methods:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT) every year, or
- A multi-targeted stool DNA test (mt-sDNA) every three years, or
- Flexible sigmoidoscopy every five years, or
- A Flexible sigmoidoscopy every ten years, in addition to annual FIT screening, or
- Colonoscopy every ten years

Note: For FOBT, the take-home multiple sample method with three samples should be used.

The U.S. Preventative Services Task Force (USPSTF) guidelines indicate that the net benefit of colorectal cancer screening in adults who are 76 years of age and older who have been previously screened is small. The risks should be considered on an individual basis, as screening in this age group is most appropriate for those healthy enough to undergo treatment.

The ACS and USPSTF recommends screening for people at high-risk for colorectal cancer once every two years.

Indications/characteristics of a high-risk individual may include one or more of the following:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- There is a family history of familial adenomatous polyposis.
- There is a family history of hereditary nonpolyposis colorectal cancer.
- There is a personal history of adenomatous polyps.
- There is a personal history of colorectal cancer.
- There is a personal history of colonic polyps.
- There is a personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Note: "Relative" means close blood relatives including first degree male or female relatives (parents, siblings, or children), second-degree relatives (aunts, uncles, grandparents, nieces, nephews), and third-degree relatives (first cousins, great-grandparents) who are on the same side of the family as the clients.

Colorectal screening services are considered for reimbursement when submitted using procedure codes G0328 (with modifier QW), G0104, G0105, and G0121, by associated risk category based on the ACS and USPSTF frequency recommendations. Reimbursement for these procedure codes is considered when medical necessity is documented in the client's record.

Fecal Occult Blood Tests

Procedure code G0328 (with modifier QW) and 82270 may be reimbursed once per rolling year for clients who are 45 years of age and older.

MT-sDNA Test

Procedure code 81528 is considered for reimbursement once every three years for clients who are 45 years of age and older.

Sigmoidoscopies

Procedure code G0104 is considered for reimbursement once every five years for clients who are 45 years of age and older when submitted with diagnosis code Z0000, Z0001, Z1210, Z1211, Z1213, Z859, Z86002, Z86003, Z86004, Z86006, Z86007, or Z86010, as recommended by the ACS and USPSTF. Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

If a lesion or growth is detected that results in a biopsy or removal of the growth during a screening flexible sigmoidoscopy, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal must be reported.

Colonoscopies: Average Risk

Procedure code G0121 is considered for reimbursement once every ten rolling years for clients who are 45 years of age and older when submitted with diagnosis code Z0000, Z0001, Z1210, Z1211, or Z1213. Diagnosis code Z0000 or Z0001 may be used for screening if no other diagnosis is appropriate for the service rendered, but not more frequently than recommended by the USPSTF.

Colonoscopies: High-Risk

Procedure code G0105 is considered for reimbursement once every two years for clients who meet the definition of high-risk. Procedure code G0105 must be submitted with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| K5000 | K50011 | K50012 | K50013 | K50014 | K50018 | K5010 | K50111 |
| K50112 | K50113 | K50114 | K50118 | K5080 | K50811 | K50812 | K50813 |
| K50814 | K50818 | K5090 | K50911 | K50912 | K50913 | K50914 | K50918 |
| K50919 | K5120 | K51211 | K51212 | K51213 | K51214 | K51218 | K5130 |
| K51311 | K51312 | K51313 | K51314 | K51318 | K5180 | K51811 | K51812 |
| K51813 | K51814 | K51818 | K5190 | K51911 | K51912 | K51913 | K51914 |
| K51918 | K51919 | K523 | K5281 | K5282 | K52831 | K52832 | K52838 |
| K52839 | K5289 | K529 | Z800 | Z8371 | Z85038 | Z85048 | Z859 |
| Z86002 | Z86003 | Z86004 | Z86006 | Z86007 | Z86010 | | |

9.2.15.2.1 Prior Authorization for Colorectal Cancer Screening

Prior authorization is not required for colorectal screening.

9.2.15.2.2 9.2.15.2.2 Exclusions

Barium enemas for colorectal cancer screening are not a benefit of Texas Medicaid.

9.2.15.3 Genetic Testing for Colorectal Cancer

Genetic testing for colorectal cancer may be considered for reimbursement to independent laboratories with prior authorization.

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

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

Genetic testing for colorectal cancer may be considered for reimbursement with the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 81201 | 81202 | 81203 | 81210 | 81233 | 81237 | 81275 | 81288 | 81292 | 81293 |
| 81294 | 81295 | 81296 | 81297 | 81298 | 81299 | 81300 | 81301 | 81317 | 81318 |
| 81319 | 81327 | | | | | | | | |

Diagnosis code Z800 is acceptable as a diagnosis for the procedure codes in the table above. Prior authorization is still required and must be obtained for these services. Interpretation of gene mutation analysis results is not reimbursed separately. Interpretation is part of the physician E/M service.

The genetic testing for colorectal testing procedure codes in the table above are limited to once per lifetime for any procedure code by any provider. Testing is limited to once per lifetime for any procedure code by any provider, regardless of whether additional services are authorized.

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 most appropriate test based on familial medical history and the availability of previous family testing results.

The medical record is subject to retrospective review.

9.2.15.3.1 Testing for Familial Adenomatous Polyposis

Testing for familial adenomatous polyposis (procedure codes 81201, 81202, and 81203) may be offered to clients who have well-defined hereditary cancer syndromes and for whom a positive or negative result will change medical care. Testing for familial adenomatous polyposis may be considered for reimbursement with documentation of at least one of the following:

- The client has more than 20 polyps.
- The client has a first-degree relative with familial adenomatous polyposis and a documented mutation.
- For clients who are 7 years of age and younger, 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.

9.2.15.3.2 Hereditary Nonpolyposis Colorectal Cancer (HNPCC)

Testing for HNPCC (procedure codes 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, and 81319) is used to determine whether a client has an increased risk of colorectal cancer or other HNPCC-associated cancers, including Lynch Syndrome. Results of the test may influence clinical management decisions. Testing for HNPCC may be considered for reimbursement with documentation of at least one of the following:

- The client has three or more family members, one of whom is a first-degree relative, with colorectal cancer; two successive generations are affected; one or more of the colorectal cancers was diagnosed before the family member was 50 years of age; and familial adenomatous polyposis has been ruled out for the client.
- The client has had two previous HNPCCs.
- The client has colorectal cancer and a first-degree relative who has one of the following:
 - Colorectal cancer or HNPCC extracolonic cancer at 50 years of age and younger
 - Colorectal adenoma at 40 years of age and younger
- The client has had colorectal cancer or endometrial cancer at 50 years of age and younger.
- The client has had right-sided colorectal cancer with an undifferentiated pattern of histology at 50 years of age and younger.
- The client has had signet-cell type colorectal cancer at 50 years of age and younger.
- The client has had a colorectal adenoma at 40 years of age and younger.
- The client is asymptomatic and has a first- or second-degree relative who has a documented HNPCC mutation.
- The client has a family history of malignant neoplasm in the gastrointestinal tract.
- For clients who are 20 years of age and younger, 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.

9.2.15.3.3 Prior Authorization for Genetic Testing for Colorectal Cancer

Prior authorization is required for genetic testing for colorectal cancer. A completed Special Medical Authorization Request Form must be signed, dated, and submitted by the ordering provider rendering direct care. Requests from laboratories will not be processed. The provider should then share the authorization number with the laboratory submitting the claim.

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.

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 verification of the 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. The form may be faxed to 1-512-514-4213 or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

A request for retroactive authorization must be submitted no later than 7 calendar days after the lab draw is performed. To facilitate a determination of medical necessity and avoid unnecessary denials, the ordering physician rendering care must provide correct and complete information, including the accurate medical necessity of the services requested.

9.2.15.4 Mammography (Screening and Diagnostic Studies of the Breast)

The following breast imaging studies are benefits of Texas Medicaid:

- Screening mammogram
- Diagnostic mammogram
- Diagnostic breast ultrasound

The American Cancer Society recommends that women discuss when to start breast cancer screening mammography with their provider beginning at 40 years of age.

By the age of 45 all women should begin annual breast cancer mammography screening.

By the age of 55 women may transition to screening with mammography every other year, or in some cases may continue annual screenings in consultation with their healthcare provider.

Digital breast tomosynthesis (DBT), also known as three-dimensional (3D) mammography, provides 3D images and is a modification of conventional mammography. Screening DBT is used, along with conventional screening mammography, to detect breast changes in women who have no signs or symptoms of breast cancer.

Diagnostic DBT is used, along with conventional diagnostic mammography, to diagnose breast disease in women or men who have breast symptoms or findings on physical examination or screening mammogram.

A screening mammogram may be billed using procedure code 77067.

Procedure code 77063 must be billed with primary procedure code 77067. Reimbursement may be considered for procedure code 77063 when performed on the same date of service, by any provider, as procedure code 77067.

Procedure codes 77063 and 77067 are limited to one per rolling year, any provider.

A diagnostic mammogram may be billed using procedure code 77065 or 77066.

Procedure code 77065 will be denied if it is submitted for the same date of service as procedure code 77066 by any provider.

Procedure code G0279 must be billed with primary procedure code 77065 or 77066. Reimbursement may be considered for procedure code G0279 when performed on the same date of service, by any provider, as procedure code 77065 or 77066.

Reimbursement may be considered for a screening mammogram (procedure code 77063 or 77067) performed on the same patient on the same date of service as a diagnostic mammogram (procedure code 77065, 77066, or G0279), by submitting the diagnostic mammography with the modifier GG.

A mammogram may be indicated for a male client based on medical necessity due to existing signs and symptoms. In such rare circumstances, procedure codes 77065, 77066, and G0279 may be considered for reimbursement.

Other breast diagnostic radiology procedures may be medically necessary based on existing signs and symptoms. When indicated, such procedures may be considered for reimbursement using procedure code 76098, 77053, or 77054. Procedure code 77053 will be denied if it is submitted for the same date of service as procedure code 77054 by any provider. Procedure code 76098 may be reimbursed for both male and female clients.

Breast ultrasound may be considered for reimbursement using procedure code 76641 or 76642.

Authorization is not required for these services.

The prescribing physician must maintain documentation of medical necessity in the client's medical record.

The radiologist or interpreting physician at the testing facility may determine and document that, because of the abnormal result of the diagnostic test performed, additional studies are medically necessary. The radiologist or interpreting physician ordering the additional studies must provide documentation to the prescribing physician.

9.2.15.5 Prognostic Breast and Gynecological Cancer Studies

Prognostic breast and gynecological cancer studies are benefits of Texas Medicaid when ordered by a physician for the purpose of determining the best course of treatment for a patient with breast/gynecological cancers.

Prognostic breast and gynecological cancer studies are divided into three categories: Receptor assays, Her-2/neu, and gene expression profiling.

- Receptor Assays (procedure codes 84233 and 84234) - The estrogen receptor assay (ERA) and the progesterone receptor assay (PRA) are tests in which a tissue sample is exposed to radioactively tagged estrogen or progesterone. The presence of these receptors can have prognostic significance in breast and endometrial cancer.
- Her-2/neu (procedure codes 83950, 88237, 88239, 88271, 88274, 88291, 88341, 88342, 88344, 88360, 88361, 88364, 88365, 88366, 88367, 88368, 88369, 88373, 88374, and 88377) - Human epidermal growth factor receptor 2 (Her-2/neu) is responsible for the production of a protein that signals cell growth. The overexpression of Her-2/neu in breast cancer is associated with decreased overall survival and response to some therapies. Each procedure used in the analysis should be coded separately.
- Gene expression profiling (procedure code 81519) - Gene expression profiling using the Oncotype DX® Breast Cancer Assay analyzes the expression of a panel of 21 genes to predict the likelihood of breast cancer recurrence in clients with newly diagnosed early stage invasive breast cancer.

Reimbursement for procedure codes 88360 and 88361 is limited to claims with a diagnosis of breast or uterine cancer as listed in the following table:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C50011 | C50012 | C50021 | C50022 | C50111 | C50112 | C50121 | C50122 |
| C50211 | C50212 | C50221 | C50222 | C50311 | C50312 | C50321 | C50322 |
| C50411 | C50412 | C50421 | C50422 | C50511 | C50512 | C50521 | C50522 |
| C50611 | C50612 | C50621 | C50622 | C50811 | C50812 | C50821 | C50822 |
| C50921 | C50922 | C540 | C541 | C542 | C543 | C548 | C792 |
| C7981 | D0501 | D0502 | D0511 | D0512 | D0581 | D0582 | |

Testing for other diagnoses will be denied.

Interpretation of receptor assays, and Her-2/neu results is not considered separately for reimbursement. Interpretation is part of the physician's E/M service.

Gene expression profiling (procedure code 81519) is a benefit when all of the following criteria are met:

- The test is ordered by an oncologist.
- The client has newly diagnosed breast cancer. ("Newly diagnosed" means that not more than six months have elapsed since the initial diagnosis.)

- The clinical stage of the breast cancer is I or II.
- Axillary node biopsy is negative for tumor, and there is no evidence of metastatic breast cancer.
- The primary tumor is estrogen receptor-positive, and Her-2/neu receptor negative, or the primary tumor is Her-2/neu receptor positive and less than 1 cm in diameter.
- The client is a candidate for adjuvant chemotherapy.
- The outcome of the test will guide decision-making regarding adjuvant chemotherapy.
- The client has one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| C50011 | C50012 | C50021 | C50022 | C50111 | C50112 | C50121 | C50122 |
| C50211 | C50212 | C50221 | C50222 | C50311 | C50312 | C50321 | C50322 |
| C50411 | C50412 | C50421 | C50422 | C50511 | C50512 | C50521 | C50522 |
| C50611 | C50612 | C50621 | C50622 | C50811 | C50812 | C50821 | C50822 |
| C50911 | C50912 | C50921 | C50922 | D0501 | D0502 | D0511 | D0512 |
| D0581 | D0582 | Z170 | | | | | |

Gene expression profiling is limited to once per lifetime, but may be considered for reimbursement more than once per lifetime for the same client on appeal. The provider must submit documentation that demonstrates that the client has a new, second, primary breast cancer diagnosis that meets the criteria described above.

The provider must maintain documentation of medical necessity in the client's medical record. Retro-spective review may be performed to ensure that the documentation supports the medical necessity of the service.

Gene expression profiling is not covered for repeat testing or testing of multiple tumor sites in the same client.

Tests for gene expression profiling other than Oncotype DX® are considered experimental and investigational, and are not benefits of Texas Medicaid.

9.2.16 Capsulotomy

A capsulotomy is a benefit when not performed with a joint surgery.

9.2.17 * Cardiac Rehabilitation

Cardiac rehabilitation is a physician-supervised program that furnishes physician-prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment. Cardiac rehabilitation programs must include all of the following:

- Physician-prescribed exercise for each day on which cardiac rehabilitation items and services are furnished
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to a client's individual needs
- Psychosocial assessment
- Outcomes assessment
- An individual treatment plan that specifies how components are used for a client and that is reviewed and signed by the prescribing physician every 30 days

Cardiac rehabilitation procedure codes 93797 and 93798 are benefits of Texas Medicaid.

The appropriate procedure code must be billed with one of the following diagnosis codes:

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|-------|-------|-------|--------|--------|--------|--------|
| I110 | I160 | I161 | I169 | I201 | I208 | I209 | I2101 |
| I2102 | I2109 | I2111 | I2119 | I2121 | I2129 | I213 | I214 |
| I219 | I21A1 | I21A9 | I220 | I221 | I222 | I228 | I229 |
| I2720 | I2721 | I2722 | I2723 | I2724 | I2729 | I2783 | I501 |
| I5020 | I5021 | I5022 | I5023 | I5030 | I5031 | I5032 | I5033 |
| I5040 | I5041 | I5042 | I5043 | I50810 | I50811 | I50812 | I50813 |
| I50814 | I5082 | I5083 | I5084 | I5089 | I509 | I5A | Z941 |
| Z943 | Z951 | Z952 | Z953 | Z954 | Z955 | Z9861 | Z98890 |

Coverage of cardiac rehabilitation programs is considered reasonable and necessary only for clients for whom there is documentation of any of the following conditions within the 12 months immediately preceding the beginning of the program:

- Acute myocardial infarction
- Coronary artery bypass surgery (CABG)
- Percutaneous transluminal coronary angioplasty or coronary stenting
- Heart valve repair or replacement
- Major pulmonary surgery
- Sustained ventricular tachycardia or fibrillation
- Class III or class IV congestive heart failure
- Chronic stable angina

Note: A cardiac rehabilitation program in which the cardiac monitoring is done using telephonically transmitted electrocardiograms (ECGs) to a remote site is not a benefit of Texas Medicaid.

Cardiac rehabilitation must be provided in a facility that has the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment (e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator) available for immediate use.

Cardiac rehabilitation is limited to 2 one-hour sessions per day for 18 weeks per rolling year and can not exceed 36 sessions.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions if the client has another documented cardiac event or if the prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. To confirm that a continuation of cardiac rehabilitation is at the request of or is coordinated with the prescribing physician, the medical record must include evidence of communication between the cardiac rehabilitation staff and the prescribing physician. If the physician responsible for such follow-up is the medical director, then the physician's notes must be evident in each client's chart.

Additional cardiac rehabilitation sessions must be prior authorized and must not exceed a total of 36 sessions for 52 weeks from the date of authorization of additional sessions.

If no clinically-significant arrhythmia is documented during the first three weeks of the program, the physician may give the order for the client to complete the remaining portion of the cardiac rehabilitation without telemetry monitoring.

Although cardiac rehabilitation may be considered a form of physical therapy, it is a specialized program that is conducted by personnel who are not physicians but are trained in both basic and advanced cardiac life support techniques and exercise therapy for coronary disease and who provide the services under the direct supervision of a physician.

Direct supervision of a physician means that a physician must be immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under cardiac rehabilitation programs.

9.2.17.1 Prior Authorization for Cardiac Rehabilitation

Prior authorization is not required for the initial 36 sessions of cardiac rehabilitation.

Cardiac rehabilitation may be considered medically necessary beyond 36 sessions in the following circumstances:

- The medical record must support the client has had another cardiac event; or
- The prescribing physician documents that a continuation of cardiac rehabilitation is medically necessary. Documentation must include the following:
 - Progress made from the beginning of cardiac rehabilitation period to the current service request date, including progress towards previous goals.
 - Information that supports the client's capability of continued measurable progress.
 - A proposed treatment plan for the requested extension dates with specific goals related to the client's individual needs.

Requests for prior authorization for additional sessions that exceed a total of 36 sessions in 52 weeks will not be granted. Prior authorization must be obtained through the TMHP Special Medical Prior Authorization (SMPA) Department.

9.2.17.2 Reimbursement

The evaluation provided by the cardiac rehabilitation team at the beginning of each cardiac rehabilitation session is not considered a separate service and will be included in the reimbursement for the cardiac rehabilitation session. Evaluation and management (E/M) services unrelated to cardiac rehabilitation may be billed with modifier 25 appended to the E/M code when a separately identifiable E/M service was provided on the same day by the provider that rendered cardiac rehabilitation. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Physical and occupational therapy will not be reimbursed when furnished in addition to cardiac rehabilitation exercise program services unless there is also a diagnosis of a non-cardiac condition that requires such therapy, e.g., a client who is recuperating from an acute phase of heart disease and may have had a stroke that requires physical and/or occupational therapy.

Client education services, such as formal lectures and counseling on diet, nutrition, and sexual activity, that help a client adjust living habits because of the cardiac condition; will not be separately reimbursed when the services are provided as part of the cardiac rehabilitation program.

9.2.18 Casting, Splinting, and Strapping

Casting, splinting, and strapping are subject to global surgery fee guidelines. The following procedure codes for casting, splinting, and strapping are a benefit of Texas Medicaid:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 29000 | 29010 | 29015 | 29035 | 29040 | 29044 | 29046 | 29049 | 29055 | 29058 |
| 29065 | 29075 | 29085 | 29086 | 29105 | 29125 | 29126 | 29130 | 29131 | 29200 |

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 29240 | 29260 | 29280 | 29305 | 29325 | 29345 | 29355 | 29358 | 29365 | 29405 |
| 29425 | 29435 | 29440 | 29445 | 29450 | 29505 | 29515 | 29520 | 29530 | 29540 |
| 29550 | 29580 | 29799 | | | | | | | |

The following procedure codes for cast removal, windowing, wedging, or repair may be reimbursed to a provider other than the provider who applied the initial cast, splint, or strap:

| Procedure Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 29700 | 29705 | 29710 | 29720 | 29730 | 29740 | 29750 | 29799 |

Authorization is not required for casting, splinting, or strapping services.

9.2.19 Cardiopulmonary Resuscitation (CPR)

CPR (procedure code 92950) is a benefit of Texas Medicaid and may be reimbursed when medical necessity is documented in the client's medical record. Only the primary provider performing CPR may be reimbursed for procedure code 92950. CPR billed as an ambulance service by an ambulance provider will be denied.

CPR may be billed with the same date of service as critical care when reported as a separately identifiable procedure. The time spent performing CPR must not be included in the time reported as critical care.

9.2.20 Circumcisions

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54161. Circumcisions performed on clients who are 1 year of age and older must be documented with medical necessity.

Referto: Subsection 9.2.44.1, "Circumcisions for Newborns" in this handbook for additional benefit information.

9.2.21 Closure of Wounds

The repair of wounds is defined as simple, intermediate, or complex. Simple repair involves the dermis and subcutaneous tissue and requires a one-layer closure. Intermediate repair requires some layered closure of deeper layers of subcutaneous tissue and superficial fascia. Complex repair involves more layered closure, debridement, extensive undermining, stints, or retention sutures.

Wound closures may use sutures, staples, or tissue adhesives. Wounds closed with adhesive strips must not be reported using wound closure procedure codes. When adhesive strips are the only wound closure material used, providers must report the most appropriate E/M visit procedure code on their claim.

Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is considered inclusive to the wound closure and will not be reimbursed separately.

The lengths of multiple closures of wounds must be added together and billed as one procedure code if they meet at least one of the following criteria:

- The closures have the same CPT classification (see "Repair [Closure]" in the CPT manual).
- The closures are in anatomic sites that are grouped together in the same procedure code descriptor.

Providers must submit the procedure code that represents the total length of the repairs. Lengths of repairs from different CPT classifications or groupings of anatomic sites must be billed as separate procedure codes.

Wound closures must be billed using the following procedure codes:

| Procedure Codes | | | | | | | | | |
|---------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Repair Simple | | | | | | | | | |
| 12001 | 12002 | 12004 | 12005 | 12006 | 12007 | 12011 | 12013 | 12014 | 12015 |
| 12016 | 12017 | 12018 | 12020 | 12021 | | | | | |
| Repair Intermediate | | | | | | | | | |
| 12031 | 12032 | 12034 | 12035 | 12036 | 12037 | 12041 | 12042 | 12044 | 12045 |
| 12046 | 12047 | 12051 | 12052 | 12053 | 12054 | 12055 | 12056 | 12057 | |
| Repair Complex | | | | | | | | | |
| 13100 | 13101 | 13102 | 13120 | 13121 | 13122 | 13131 | 13132 | 13133 | 13151 |
| 13152 | 13153 | 13160 | | | | | | | |

Multiple wounds on the same day will be paid the full allowed amount for the major (largest total length of the repair at the same anatomic site) wound and one-half the allowed amount for each additional laceration (total length of the repair at the same anatomic site).

No separate payment will be made for incision closures billed in addition to a surgical procedure when the closure is part of that surgical procedure.

No separate payment will be made for supplies in the office.

When the debridement is carried out separately without immediate primary closure, when gross contamination requires prolonged cleansing, or when large amounts of devitalized or contaminated tissue are removed, debridement may be reimbursed separately. Debridement rendered during the same surgical session as wound closure is considered inclusive to the closure and is not reimbursed separately.

Referto: Subsection 9.2.69.11, “Supplies, Trays, and Drugs” in this handbook for the hospital-based emergency department.

Wound suture and wound closure are considered part of any surgical procedure performed on the same area, except for excision of benign or malignant lesion procedure codes that require more than simple closure. Providers may be reimbursed for the appropriate intermediate or complex closure procedure code. Multiple surgery guidelines apply.

The exceptions listed above apply to the following excision and closure procedure codes:

| Excision of Benign Lesion Procedure Code | | | | | | | | | |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 11400 | 11401 | 11402 | 11403 | 11404 | 11406 | 11420 | 11421 | 11422 | 11423 |
| 11424 | 11426 | 11440 | 11441 | 11442 | 11443 | 11444 | 11446 | | |

| Excision of Malignant Lesion Procedure Codes | | | | | | | | | |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 11600 | 11601 | 11602 | 11603 | 11604 | 11606 | 11620 | 11621 | 11622 | 11623 |
| 11624 | 11626 | 11640 | 11641 | 11642 | 11643 | 11644 | 11646 | | |

| Intermediate Closure Procedure Codes | | | | | | | | | |
|--------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 12031 | 12032 | 12034 | 12035 | 12036 | 12037 | 12041 | 12042 | 12044 | 12045 |
| 12046 | 12047 | 12051 | 12052 | 12053 | 12054 | 12055 | 12056 | 12057 | |

| Complex Closure Procedure Codes | | | | | | | | | |
|---------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 13100 | 13101 | 13102 | 13120 | 13121 | 13122 | 13131 | 13132 | 13133 | 13151 |

Complex Closure Procedure Codes

| | | |
|-------|-------|-------|
| 13152 | 13153 | 13160 |
|-------|-------|-------|

9.2.22 Cochlear Implants

Cochlear implants, when medically indicated, are benefits of Texas Medicaid with prior authorization. A cochlear implant device (procedure code 69930) is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn externally to capture and amplify sound. These devices are available in single and multichannel models. Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

Referto: Subsection 3.2.1, “Cochlear Implants” in the *Vision and Hearing Services Handbook (Vol. 2, Provider Handbooks)* for additional information on benefit and authorization requirements for cochlear implants.

9.2.23 Continuous Glucose Monitoring (CGM)

CGM (procedure codes 95250 and 95251) is a benefit of Texas Medicaid with prior authorization.

Procedure codes 95250 and 95251 are limited to once per 12 calendar months by any provider.

The rental or purchase of a continuous glucose monitoring system (CGMS) is considered part of the CGM and is not reimbursed separately.

9.2.23.1 Prior Authorization for Continuous Glucose Monitoring

CGM requires prior authorization and must be prescribed by a physician performing the glucose monitoring.

CGM may be prior authorized for clients with Type I diabetes or diabetes during pregnancy, including gestational diabetes. The client must be compliant with his or her current medical regimen, use insulin injections three or more times per day or be on an insulin pump, and have documented self-blood glucose monitoring at least four times per day. At least one or more of the following conditions must also be present:

- Frequent unexplained hypoglycemic episodes
- Unexplained large fluctuations in daily, preprandial blood glucose
- Episodes of ketoacidosis or hospitalization for uncontrolled glucose

Additional CGM services may be considered with documentation of medical necessity that indicates the client meets the criteria above and has a change in condition that would warrant a second procedure within 12 calendar months.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested services. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the use of CGM.

9.2.24 Developmental Screening and Testing and Aphasia Assessment

The following types of developmental screening and testing and aphasia assessment are benefits of Texas Medicaid when medically necessary:

- Developmental screening when performed outside of a Texas Health Steps (THSteps) medical checkup (procedure code 96110)
- Developmental testing (procedure codes 96112 and 96113 [add-on procedure code must be submitted with primary procedure code 96112])

- Assessment of aphasia (procedure code 96105)

Re-evaluations are a benefit of Texas Medicaid only to address a clinical need, to provide the documentation needed to measure a client's status over time, and to direct the plan of care.

Procedure codes 96105, 96110, 96112, and 96113 are used to report medically necessary aphasia assessment, developmental screening, and testing.

Prior authorization is not required for developmental screening, developmental testing, and aphasia assessment.

9.2.24.1 Developmental Screening

Developmental screening requiring the use of a standardized, validated screening tool (procedure code 96110) is a benefit of Texas Medicaid for clients who are birth through 6 years of age.

Developmental screening is limited to once per rolling year, any provider, outside of a THSteps medical checkup when medically necessary. This screening should only be completed for a diagnosis of suspected developmental delay or to evaluate a change in the client's developmental status outside of a THSteps medical checkup.

Developmental screening should be used to identify clients who are birth through 6 years of age and who may need a more comprehensive evaluation. Results of developmental screening may guide or identify the need for further testing. Clients with abnormal screening results must be referred to an appropriate provider for further testing. Clients who are birth through 35 months of age who have suspected developmental delay must be referred to Texas Early Childhood Intervention (ECI) within 7 days after the child has been identified.

Referto: Subsection 2.8, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for additional information on the Texas ECI program.

Subsection 4.3.11.1.2, "Developmental Surveillance or Screening" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for additional information on developmental screening for THSteps checkups.

9.2.24.2 Developmental Testing

Developmental testing (procedure codes 96112 and 96113) is a benefit of Texas Medicaid for clients who are birth through 20 years of age.

Developmental testing consists of an extended evaluation and requires the use of a standardized norm-referenced tool. Developmental testing is medically necessary when there is suspected developmental delay supported by clinical evidence. Developmental testing is only medically indicated when clinical evidence suggests the following:

- Suspected developmental delay or atypical development when the diagnosis cannot be clearly identified through clinical interview or standardized screening tool alone.
- Retesting of a client to evaluate a change in developmental status that results in a change of treatment plan.

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

Developmental testing performed when a development delay or a change in the client's developmental status is not suspected is not a benefit of Texas Medicaid.

Developmental testing is not a benefit when completed for the purposes of entering day care, Head Start, or a school setting.

Providers cannot bill the client for developmental testing that better fits the description of developmental screening.

The physician must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports the medical necessity of the service. The following information is required at least every six months to establish medical necessity:

- The physician's prescription that includes a description of the specific service being prescribed
- The treatment plan that includes a copy of the current evaluation and documented age of the child at the time of the evaluation

9.2.24.3 Assessment of Aphasia

Aphasia assessment (procedure code 96105) is a benefit of Texas Medicaid when medically necessary and is limited to the following diagnosis codes:

| Diagnosis codes | | | | |
|-----------------|-------|------|-------|-------|
| R4701 | R4702 | R471 | R4781 | R4789 |

Procedure code 96105 is limited to two services per rolling year, any provider.

9.2.24.4 12-Hour Limitation for Procedure Codes 96110, 96112, and 96113

APRNs, PAs, and psychologists are limited to a maximum, combined total of 12 hours per day for developmental screening and testing, and inpatient and outpatient mental health services.

Because physicians (M.D. and D.O.) can delegate and may submit claims for services in excess of 12 hours per day, they are not subject to the 12-hour system limitation.

Developmental screening and testing are included in the 12-hour per day, per provider, system limitation. The following table lists the procedure codes that are included in the 12-hour per day system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

| Procedure Code | Time Applied by System |
|----------------|------------------------|
| 96110 | 30 Minutes |
| 96112 | 60 Minutes |
| 96113 | 30 minutes |

Referto: Subsection 4.5, "Twelve Hour System Limitation" in the *Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks)* for more information about procedure codes included in the 12-hour system limitation.

All providers, including physicians and all providers to whom they delegate services, are subject to retrospective review. HHSC and TMHP routinely perform retrospective reviews of all providers. All providers are subject to retrospective review for the total hours of services performed and billed in excess of 12 hours per day. Retrospective review may include:

- All E/M procedure codes, including those listed in the Evaluation and Management Section of the *CPT Manual*, billed with a diagnosis listed in the diagnosis table above under Neurobehavioral Testing
- All developmental screening and testing procedure codes included in the 12-hour system limitation

Note: *Developmental screening and testing procedure codes and mental health procedure codes are included in the review. If a provider provides developmental and neurological assessment and testing at more than one location, any of these services may be retrospectively reviewed.*

9.2.25 Diagnostic Tests

9.2.25.1 Blood Pressure Monitoring

Blood pressure monitoring by either self-measured blood pressure monitoring or ambulatory blood pressure monitoring is a benefit of Texas Medicaid when used as a diagnostic tool to assist a physician in diagnosing hypertension in individuals whose blood pressure is either elevated, or inconclusive when evaluated in the office alone.

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring may also be used for the following:

- Clients who are under treatment for established hypertension
- Evaluating refractory or treatment-resistant blood pressure
- Evaluating symptoms such as light-headedness corresponding with blood pressure changes
- Evaluating nighttime blood pressure
- Examining diurnal patterns of blood pressure

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for the evaluation of one of the following conditions:

- White coat hypertension, which is defined as the following:
 - Blood pressure measurements taken in the clinic or office are greater than 140/90 mm Hg on at least three separate visits, with two separate measurements made at each visit.
 - At least two separately documented blood pressure measurements taken outside of the clinic or office that are less than 140/90 mm Hg.
 - There is no evidence of end-organ damage.
- Resistant hypertension
- Hypotensive symptoms as a response to hypertension medications
- Nocturnal angina
- Episodic hypertension
- Syncope

Self-measured blood pressure monitoring and ambulatory blood pressure monitoring are indicated for initial diagnosis of hypertension and should not be used for maintenance monitoring.

Self-measured blood pressure monitoring may also be indicated for re-evaluation of clients previously diagnosed with hypertension.

Providers must document that the self-measured blood pressure monitoring was performed for at least 24 hours.

Procedure code 99473 is limited to one service per year, any provider. Procedure code 99473 may be considered for reimbursement more than once per year when the following documentation of medical necessity is submitted with the claim:

- Documentation of erroneous blood pressure readings-excessively high or low blood pressure, blood pressure readings excessively inconsistent with those measured professionally
- Documentation of erroneous blood pressure logs-day of the week, time of day, setting or location, or timing of medication administration inconsistent with prior professional instruction
- Documentation of poor health literacy, developmental, or intellectual challenges that may require repeated client education

- Client purchase or receipt of new blood pressure device

Procedure code 99474 is limited to four services per year, any provider, and may be reimbursed only if a claim for procedure code 99473 has been submitted within 12 rolling months.

Only one method of blood pressure monitoring (self-measured or ambulatory) may be reimbursed within a rolling 12-month period. Self-measured blood pressure monitoring submitted within the same rolling 12-month period as ambulatory blood pressure monitoring will be denied.

Use procedure codes 93784, 93786, 93788, and/or 93790 to bill in 24-hour increments for ambulatory blood pressure monitoring. Ambulatory blood pressure monitoring is limited to two services per lifetime, any provider. Ambulatory blood pressure monitoring performed more than twice per lifetime may be considered when documentation of medical necessity is submitted with the claim.

9.2.25.2 Ambulatory and Long-Term Electroencephalogram (Ambulatory EEG)

Ambulatory EEG monitoring is a covered benefit for clients in whom a seizure diathesis is suspected but not defined by history, physical, and resting EEG.

The EEG technical component procedure codes are limited to 3 studies for each physician for the same client per 6 months when medically necessary.

The following procedure codes should be submitted when billing for the EEG technical component:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95705 | 95706 | 95707 | 95708 | 95709 | 95710 | 95711 | 95712 | 95713 | 95714 |
| 95715 | 95716 | | | | | | | | |

Procedure code 95700 will be limited to three units per six months for each physician for the same client.

Professional component procedure codes are limited to three studies per six months for each physician for the same client, when medically necessary.

Technical component procedure codes are limited to three studies per six months for each physician for the same client, when medically necessary.

Note: A study includes one unit of procedure code 95700 (set-up, education, and takedown) and any appropriate combination of the corresponding technical and professional procedure codes.

The following procedure codes should be submitted when billing for the EEG professional component:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95717 | 95718 | 95719 | 95720 | 95721 | 95722 | 95723 | 95724 | 95725 | 95726 |

The procedure codes in the tables above may be reimbursed when they are submitted with the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|---------|---------|---------|
| F05 | F060 | F068 | G253 | G3101 | G3109 | G3183 | G40001 |
| G40009 | G40011 | G40019 | G40101 | G40109 | G40111 | G40119 | G40201 |
| G40209 | G40211 | G40219 | G40301 | G40309 | G40311 | G40319 | G40401 |
| G40409 | G40411 | G40419 | G40501 | G40509 | G40801 | G40802 | G40803 |
| G40804 | G40811 | G40812 | G40813 | G40814 | G4089 | G40901 | G40909 |
| G40911 | G40919 | G40A11 | G40A19 | G40B01 | G40B09 | G40B11 | G40B19 |
| G912 | O99351 | O99352 | O99353 | O99354 | O99355 | P90 | P912 |
| R410 | R4182 | R5601 | R561 | R569 | S060X1A | S060X1D | S060X1S |

Z052

Other diagnosis codes may be considered on appeal with supporting medical documentation to the TMHP Medical Director.

9.2.25.3 Bone Marrow Aspiration, Biopsy

Physicians may bill procedure code 85097 if interpretation is for smear interpretation, or procedure code 88305 if interpretation is for preparation and interpretation of cell block. If both procedure codes 85097 and 88305 are billed, procedure code 88305 is paid and procedure code 85097 is denied.

Physicians may bill procedure code 85097 or 88305 for preparation and interpretation of the specimen.

9.2.25.4 Cytopathology Studies—Other Than Gynecological

Procurement and handling of the specimen for cytopathology of sites other than vaginal, cervical, or uterine is considered part of the client's E/M and will not be reimbursed separately.

Procedure codes 88160, 88161, and 88162 are reimbursed according to the POS where the cytopathology smear is interpreted.

Procedure code 88177 is limited to three services per day by the same provider.

9.2.25.5 * Echoencephalography

Echoencephalography (procedure code 76506) is medically indicated for the following conditions or diagnosis codes:

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|
| A066 | A170 | A171 | A1781 | A1782 | A1789 | C410 | C6961 |
| C6962 | C700 | C710 | C711 | C712 | C713 | C714 | C715 |
| C716 | C717 | C718 | C719 | C7221 | C7222 | C7231 | C7232 |
| C7241 | C7242 | C7259 | C729 | C751 | C752 | C768 | C7931 |
| C7932 | C7940 | C7949 | C7951 | C7952 | C7989 | D075 | D098 |
| D164 | D3161 | D3162 | D320 | D329 | D330 | D331 | D332 |
| D333 | D3500 | D3501 | D3502 | D420 | D421 | D429 | D432 |
| D433 | D434 | D438 | D439 | D47Z1 | D47Z2 | D480 | D487 |
| D492 | D496 | D497 | F0390 | G060 | G062 | G07 | G08 |
| G132 | G138 | G232 | G300 | G301 | G308 | G309 | G3101 |
| G3109 | G311 | G312 | G3183 | G3184 | G3185 | G3189 | G319 |
| G910 | G911 | G912 | G930 | G932 | G9340 | G9341 | G9349 |
| G935 | G936 | G937 | G9381 | G9389 | G939 | G94 | G988 |
| G998 | H35361 | H4600 | H4601 | H4602 | H4603 | H4610 | H4611 |
| H4612 | H4613 | H462 | H463 | H468 | H469 | H47011 | H47012 |
| H47013 | H47019 | H47021 | H47022 | H47023 | H47029 | H47031 | H47032 |
| H47033 | H47039 | H47091 | H47092 | H47093 | H47099 | H4710 | H4711 |
| H4712 | H4713 | H47141 | H47142 | H47143 | H47149 | H4720 | H47211 |
| H47212 | H47213 | H47219 | H4722 | H47231 | H47232 | H47233 | H47239 |
| H47291 | H47292 | H47293 | H47299 | H47311 | H47312 | H47313 | H47319 |
| H47321 | H47322 | H47323 | H47329 | H47331 | H47332 | H47333 | H47339 |
| H47391 | H47392 | H47393 | H47399 | H4741 | H4742 | H4743 | H4749 |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|
| H47511 | H47512 | H47519 | H47521 | H47522 | H47529 | H47531 | H47532 |
| H47539 | H47611 | H47612 | H47619 | H47621 | H47622 | H47629 | H47631 |
| H47632 | H47639 | H47641 | H47642 | H47649 | I6000 | I6001 | I6002 |
| I6010 | I6011 | I6012 | I602 | I6030 | I6031 | I6032 | I604 |
| I6050 | I6051 | I6052 | I606 | I607 | I608 | I609 | I610 |
| I611 | I612 | I613 | I614 | I615 | I616 | I618 | I619 |
| I6200 | I6201 | I6202 | I6203 | I621 | I629 | I6330 | I63311 |
| I63312 | I63319 | I63321 | I63322 | I63323 | I63333 | I63329 | I63331 |
| I63332 | I63339 | I6339 | I6340 | I63411 | I63412 | I63419 | I63421 |
| I63422 | I63429 | I63431 | I63432 | I63439 | I6349 | I6350 | I63511 |
| I63512 | I63513 | I63519 | I63521 | I63522 | I63523 | I63529 | I63531 |
| I63532 | I63533 | I63539 | I63543 | I6381 | I6389 | I6601 | I6602 |
| I6603 | I6609 | I6611 | I6612 | I6613 | I6619 | I6621 | I6622 |
| I6623 | I6629 | I668 | I669 | I671 | I6781 | I6782 | I6783 |
| I67850 | I67858 | I6789 | I680 | I69098 | I6921 | I69210 | I69211 |
| I69212 | I69213 | I69214 | I69215 | I69218 | I69219 | I69220 | I69221 |
| I69222 | I69223 | I69269 | I69290 | I69291 | I69292 | I69293 | I69298 |
| O99411 | O99412 | O99413 | O99419 | O9942 | O9943 | P0082 | P0700 |
| P0701 | P0702 | P0703 | P0710 | P0714 | P0715 | P0716 | P0717 |
| P100 | P101 | P102 | P103 | P104 | P108 | P109 | P112 |
| P119 | P120 | P121 | P122 | P123 | P124 | P1281 | P1289 |
| P129 | P150 | P151 | P152 | P153 | P154 | P155 | P156 |
| P158 | P352 | P370 | P371 | P372 | P373 | P374 | P378 |
| P520 | P521 | P5221 | P5222 | P523 | P524 | P525 | P526 |
| P528 | P529 | P90 | P912 | P91811 | P91819 | P91821 | P91822 |
| P91823 | P91829 | P9188 | Q010 | Q011 | Q012 | Q018 | Q02 |
| Q030 | Q031 | Q038 | Q040 | Q041 | Q042 | Q045 | Q046 |
| Q048 | Q050 | Q051 | Q052 | Q054 | Q0701 | Q0702 | Q0703 |
| Q282 | Q283 | R220 | R221 | R5600 | R569 | S0190XA | S0190XD |
| S0190XS | S060X0A | S060X0D | S060X0S | S060X1A | S060X1D | S060X1S | S060X9A |
| S060X9D | S060X9S | S061X0A | S061X0D | S061X0S | S061X1A | S061X1D | S061X1S |
| S061X2A | S061X2D | S061X2S | S061X3A | S061X3D | S061X3S | S061X4A | S061X4D |
| S061X4S | S061X5A | S061X5D | S061X5S | S061X6A | S061X6D | S061X6S | S061X7A |
| S061X8A | S061X9A | S061X9D | S061X9S | S06305A | S06305D | S06305S | S06306A |
| S06306D | S06306S | S06307A | S06308A | S06310A | S06310D | S06310S | S06311A |
| S06311D | S06311S | S06312A | S06312D | S06312S | S06313A | S06313D | S06313S |
| S06314A | S06314D | S06314S | S06315A | S06315D | S06315S | S06316A | S06316D |
| S06316S | S06317A | S06318A | S06319A | S06319D | S06319S | S06320A | S06320D |
| S06320S | S06321A | S06321D | S06321S | S06322A | S06322D | S06322S | S06323A |
| S06323D | S06323S | S06324A | S06324D | S06324S | S06325A | S06325D | S06325S |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|
| S06326A | S06326D | S06326S | S06327A | S06328A | S06329A | S06329D | S06329S |
| S06330A | S06330D | S06330S | S06331A | S06331D | S06331S | S06332A | S06332D |
| S06332S | S06333A | S06333D | S06333S | S06334A | S06334D | S06334S | S06335A |
| S06335D | S06335S | S06336A | S06336D | S06336S | S06337A | S06338A | S06339A |
| S06339D | S06339S | S06340A | S06340D | S06340S | S06341A | S06341D | S06341S |
| S06342A | S06342D | S06342S | S06343A | S06343D | S06343S | S06344A | S06344D |
| S06344S | S06345A | S06345D | S06345S | S06346A | S06346D | S06346S | S06347A |
| S06348A | S06349A | S06349D | S06349S | S06350A | S06350D | S06350S | S06351A |
| S06351D | S06351S | S06352A | S06352D | S06352S | S06353A | S06353D | S06353S |
| S06354A | S06354D | S06354S | S06355A | S06355D | S06355S | S06356A | S06356D |
| S06356S | S06357A | S06358A | S06359A | S06359D | S06359S | S06360A | S06360D |
| S06360S | S06361A | S06361D | S06361S | S06362A | S06362D | S06362S | S06363A |
| S06363D | S06363S | S06364A | S06364D | S06364S | S06365A | S06365D | S06365S |
| S06366A | S06366D | S06366S | S06367A | S06368A | S06369A | S06369D | S06369S |
| S06370A | S06370D | S06370S | S06371A | S06371D | S06371S | S06372A | S06372D |
| S06372S | S06373A | S06373D | S06373S | S06374A | S06374D | S06374S | S06375A |
| S06375D | S06375S | S06376A | S06376D | S06376S | S06377A | S06378A | S06379A |
| S06379D | S06379S | S06380A | S06380D | S06380S | S06381A | S06381D | S06381S |
| S06382A | S06382D | S06382S | S06383A | S06383D | S06383S | S06384A | S06384D |
| S06384S | S06385A | S06385D | S06385S | S06386A | S06386D | S06386S | S06387A |
| S06388A | S06389A | S06389D | S06389S | S064X0A | S064X0D | S064X0S | S064X1A |
| S064X1D | S064X1S | S064X2A | S064X2D | S064X2S | S064X3A | S064X3D | S064X3S |
| S064X4A | S064X4D | S064X4S | S064X5A | S064X5D | S064X5S | S064X6A | S064X6D |
| S064X6S | S064X7A | S064X8A | S064X9A | S064X9D | S064X9S | S065X0A | S065X0D |
| S065X0S | S065X1A | S065X1D | S065X1S | S065X2A | S065X2D | S065X2S | S065X3A |
| S065X3D | S065X3S | S065X4A | S065X4D | S065X4S | S065X5A | S065X5D | S065X5S |
| S065X6A | S065X6D | S065X6S | S065X7A | S065X8A | S065X9A | S065X9D | S065X9S |
| S066X0A | S066X0D | S066X0S | S066X1A | S066X1D | S066X1S | S066X2A | S066X2D |
| S066X2S | S066X3A | S066X3D | S066X3S | S066X4A | S066X4D | S066X4S | S066X5A |
| S066X5D | S066X5S | S066X6A | S066X6D | S066X6S | S066X7A | S066X8A | S066X9A |
| S066X9D | S066X9S | S06890A | S06890D | S06890S | S06891A | S06891D | S06891S |
| S06892A | S06892D | S06892S | S06893A | S06893D | S06893S | S06894A | S06894D |
| S06894S | S06895A | S06895D | S06895S | S06896A | S06896D | S06896S | S06897A |
| S06898A | S06899A | S06899D | S06899S | S069X0A | S069X0D | S069X0S | S069X1A |
| S069X1D | S069X1S | S069X2A | S069X2D | S069X2S | S069X3A | S069X3D | S069X3S |
| S069X4A | S069X4D | S069X4S | S069X5A | S069X5D | S069X5S | S069X6A | S069X6D |
| S069X6S | S069X7A | S069X8A | S069X9A | S069X9D | S069X9S | S06A0XA | S06A0XD |
| S06A0XS | S06A1XA | S06A1XD | S06A1XS | S0990xA | S0990xD | S0990xS | |

9.2.25.6 Electrocardiogram (ECG)

Electrocardiograms (ECG) are a benefit of Texas Medicaid when used for the evaluation and management (E/M) of a confirmed or suspected primary disease of the heart, pericardium, and coronary arteries or when necessary for management of diseases that are not primarily cardiac, but can affect the heart directly or indirectly.

ECGs are limited to six treatments for each client, by any provider per benefit period.

For ECGs, a benefit period is defined as 12 consecutive months, beginning with the month the client receives the first ECG.

The following procedure codes may be reimbursed for ECGs: 93000, 93005, 93010, 93040, 93041, and 93042.

Claims that are denied for exceeding the six-ECG limitation may be appealed with documentation supporting medical necessity. The documentation must include the following:

- Diagnosis
- Treatment history
- Documentation of why additional ECGs are needed

The report of the professional component (the interpretation) for the ECG must be a complete written report that includes relevant findings and appropriate comparisons.

The interpretation may appear on the actual tracing.

When the ECG is performed in conjunction with the performance of an evaluation and management (E/M) service, the interpretation may appear with a progress note or other report of the E/M service; however, if the ECG is billed as a separate service from the E/M service, the interpretation should contain the same information as a report made upon the tracing itself.

A simple notation of “ECG/EKG normal” without an accompanying tracing will not suffice as documentation of a separately payable interpretation.

Appropriate documentation, which includes a copy of the ECG tracing, must be kept in the client’s medical record. Documentation must support the medical necessity of the ECG. Documentation may appear on the actual tracing or with a progress note or report. Documentation is subject to retrospective review.

Only an ECG interpretation that directly contributes to the diagnosis and treatment of a client may be considered for reimbursement. Services, such as routine admission ECGs performed without medical indications, that do not directly contribute to the diagnosis and treatment of an individual client are not considered medically necessary.

9.2.25.6.1 Prior Authorization for ECG

Prior authorization is not required for ECGs performed in the emergency room or inpatient hospital setting.

Prior authorization is required for more than six ECGs in a rolling 12-month period.

Requests for additional ECGs must be submitted on the Special Medical Prior Authorization (SMPA) Request Form along with documentation of medical necessity.

Providers may request a prior authorization up to 12 months in advance. When requesting retroactive authorization, a provider must submit the request no later than 14 calendar days after the ECG is completed.

Before submitting a prior authorization request for an ECG, a provider must have a completed SMPA Request Form that has been signed and dated by a physician who is familiar with the client. The completed SMPA Request Form must include the procedure codes and numerical quantities for the services requested. The completed SMPA Request Form with the original dated signature must be maintained by the prescribing physician in the client's medical record.

The SMPA Request Form must include all of the following information, which is related to medical necessity:

- Procedure requested (CPT)
- Diagnosis
- Treatment history
- Treatment plan

Prior authorization requests submitted by paper, must be faxed or mailed with the completed SMPA Request Form to the SMPA department and a copy of the signed and dated form must be retained in the client's medical record at the provider's place of business. Requests may be faxed or mailed to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

9.2.25.7 Esophageal pH Probe Monitoring

Esophageal pH monitoring uses an indwelling pH microelectrode positioned just above the esophageal sphincter. The pH electrode and skin reference electrode are connected to a battery-powered pH meter and transmitter worn as a shoulder harness. The esophageal pH is monitored continuously and a strip chart is used to record the pH determinations. The patient is usually monitored for a 24-hour period. Esophageal pH monitoring is a medically appropriate adjunct procedure to help establish the presence or absence of gastroesophageal reflux.

Esophageal pH probe monitoring should be coded with procedure codes 91034, 91035, and 78262.

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) are limited to two services per rolling year, same procedure, any provider.

Claims that are denied for exceeding two services per rolling year may be considered on appeal with documentation of one of the following:

- The client is new and the provider has been unsuccessful in obtaining the client's previous records from a different provider.
- The provider is not aware that the client received previous esophageal testing.

Only one appeal will be considered per client, for the same provider. Providers must request prior authorization for any additional esophageal testing performed after the appealed service.

9.2.25.7.1 Prior Authorization

Esophageal pH probe testing (procedure codes 78262, 91034, and 91035) require prior authorization for services that exceed two per rolling year.

Requests for additional testing may be considered when submitted with documentation of medical necessity that supports, but is not limited to, the following:

- Adult's unintentional weight loss is more than 5 percent of their normal body weight in a span of 12 months or less
- Child's weight loss is 3 to 5 percent of their body mass in less than 30 days
- Symptoms of gastroesophageal reflux disease (GERD) that include heartburn and regurgitation that do not respond to treatment with medication
- Atypical symptoms of GERD, such as chest pain, coughing, wheezing, hoarseness, and sore throat

Prior authorization requests must be submitted to the Special Medical Prior Authorization Department using the Special Medical Prior Authorization (SMPA) Request Form. The completed prior authorization request form must be maintained by the requesting provider and the prescribing physician. The original, signed copy must be kept by the physician in the client's medical record.

9.2.25.8 Helicobacter Pylori (H. pylori)

Initial testing for H. pylori may be performed using the following tests:

- Serology testing (procedure codes 83009 and 86677)
- Stool testing (procedure code 87338 with modifier QW)
- Breath testing (procedure codes 78267, 78268, 83013, and 83014)

Serology testing for H. pylori is a noninvasive diagnostic procedure that is preferred for initial diagnosis but is not indicated after a diagnosis has been made. Serology testing is not indicated or covered for monitoring a response to therapy.

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.

Urea breath tests (UBTs) and fecal antigen tests provide reliable means of identifying active H. pylori infection before antibiotic therapy. UBTs are the most reliable non-endoscopic test to document eradication of H. pylori infection.

H. pylori is accepted as an etiologic factor in duodenal ulcers, peptic ulcer disease, gastric carcinoma, and primary B cell gastric lymphoma. H. pylori testing may be indicated for symptomatic clients who have a documented history of chronic/recurrent duodenal ulcer, gastric ulcer, or chronic gastritis. The history must delineate the failed conservative treatment for the condition.

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

- New onset uncomplicated dyspepsia.
- New onset dyspepsia responsive to conservative treatment (e.g., withdrawal of nonsteroidal anti-inflammatory drugs [NSAID] and/or use of antisecretory agents). If the treatment does not prove successful in eliminating the symptoms, further testing may be indicated to determine the presence of H. pylori.
- Screening for H. pylori in asymptomatic clients.
- Dyspeptic clients requiring endoscopy and biopsy.

H. pylori testing is not indicated under the following circumstances:

- There has been a negative endoscopy in the previous 90 days.
- An endoscopy is planned.
- H. pylori is of new onset and still being treated.

H. pylori testing will be denied if it is performed within 90 days of an upper gastrointestinal endoscopy. Procedure codes 87338 (with modifier QW), 78267, 78268, 83013, and 83014 may be reimbursed within the 90 days if the provider submits documentation that indicates the client was tested for eradication after treatment.

If a follow-up breath or stool test is used to document eradication of H. pylori, the medical record documentation must verify the history of the following previous complication(s):

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

Testing for H. pylori eradication after the completion of antibiotic therapy (procedure codes 87338 [with modifier QW], 78267, 78268, 83013, and 83014) will be denied if billed less than 35 days after the initial test.

Procedure code 87339 is not a benefit of Texas Medicaid.

9.2.25.9 Myocardial Perfusion Imaging

Referto: Subsection 3.2.1, “Cardiac Nuclear Imaging” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

9.2.25.10 * Pediatric Pneumogram

A pediatric pneumogram (procedure code 94772) is a 12-hour to 24-hour recording of breathing effort, heart rate, oxygen level, and airflow to the lungs during sleep. The study is useful in identifying abnormal breathing patterns, with or without bradycardia, especially in premature infants.

The following diagnosis codes may be reimbursed for a pediatric pneumogram in infants from birth through 11 months of age:

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|-------|-------|-------|-------|-------|-------|-------|
| K200 | K2080 | K2081 | K2090 | K2091 | K2100 | K2101 | K219 |
| K220 | P0082 | P220 | P228 | P270 | P271 | P278 | P282 |
| P283 | P284 | P285 | P2881 | P2889 | P84 | R0600 | R0609 |
| R062 | R063 | R0681 | R0682 | R0683 | R0689 | R6813 | |

A pediatric pneumogram is limited to two services per lifetime without prior authorization when submitted with one of the diagnosis codes listed above. Additional studies may be considered under CCP with documentation of medical necessity, and will require prior authorization.

Referto: Section 2, “Medicaid Children’s Services Comprehensive Care Program (CCP)” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

EMGs, polysomnography, EEGs, and ECGs are denied when billed on the same day as a pediatric pneumogram.

Pediatric pneumograms are reimbursed on the same day as an apnea monitor (rented monthly) if documentation supports the medical necessity.

Pneumogram supplies are considered part of the technical component and are denied if billed separately.

9.2.26 Diagnostic Doppler Sonography

Diagnostic Doppler sonography is a benefit of Texas Medicaid when treatment decisions depend on the results. Authorization is not required for diagnostic Doppler services.

Doppler sonography uses a transducer that transmits and receives the returned sound waves as vibrations. The transducer turns the vibrations into electrical pulses that travel to the ultrasonic scanner where they are processed and transformed into a digital image. It is used to study blood flow throughout the body.

A vascular diagnostic study may be personally performed by a physician or by a technologist. The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and physician performing and interpreting the study. Consequently, the physician who performs and/or interprets the study must be able to document training through recent residency training or post-graduate continuing medical education and experience and must maintain that documentation for post-payment review.

If noninvasive vascular diagnostic studies are performed by a technologist, the technologist must have demonstrated competency in ultrasound by receiving one of the following credentials in vascular ultrasound technology:

- Registered Vascular Specialist (RVS) provided by Cardiovascular Credentialing International (CCI)
- Registered Vascular Technologist (RVT) provided by the American Registry of Diagnostic Medical Sonographers (ARDMS)
- Vascular Sonographer (VS) provided by the American Registry of Radiologic Technologists (ARRT), Sonography

Alternately, such studies must be performed in a facility or vascular laboratory accredited by one of the following nationally recognized accreditation organizations. If a vascular laboratory or facility is accredited, the technologists performing noninvasive cerebrovascular arterial studies in that laboratory are considered to have demonstrated competency in cerebrovascular ultrasound:

- American College of Radiology (ACR) Vascular Ultrasound Accreditation Program
- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)

9.2.26.1 Cerebrovascular Doppler Studies

Cerebrovascular Doppler sonography includes both extracranial and transcranial (intracranial) studies. This group of Doppler studies is used to investigate cerebral hemodynamics (e.g., blood flow, vasculitis, cerebral fluid collection/hydrocephalus, cerebral vascular disorders,). Cerebrovascular Doppler sonography should not be used when treatment decisions will not be affected by the findings.

Cerebrovascular Doppler studies for the diagnosis of migraine are considered experimental and are not a benefit of Texas Medicaid.

Extracranial arterial Doppler (procedure codes 93880 and 93882) are limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|--|-------|-------|-------|-------|-------|-------|--------|
| D446 | D447 | D7821 | D7822 | G450 | G451 | G452 | G453 |
| G454 | G458 | G459 | G460 | G461 | G462 | G463 | G464 |
| G465 | G466 | G467 | G468 | G8101 | G8102 | G8103 | G8104 |
| G8111 | G8112 | G8113 | G8114 | G8191 | G8192 | G8193 | G8194 |
| G830 | G8311 | G8312 | G8313 | G8314 | G8321 | G8322 | G8323 |
| G8324 | G8331 | G8332 | G8333 | G8334 | G9751 | G9752 | G9761 |
| G9762 | H3401 | H3402 | H3403 | H3411 | H3412 | H3413 | H34211 |
| * Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency | | | | | | | |
| ** Use R221 to report pulsatile neck mass | | | | | | | |
| *** Use R0989 to report carotid bruit | | | | | | | |

| Diagnosis Codes | | | | | | | |
|--|----------|---------|---------|---------|---------|---------|---------|
| H34212 | H34213 | H34231 | H34232 | H34233 | H3582 | H5311 | H53121 |
| H53122 | H53123 | H53131 | H53132 | H53133 | H59311 | H59312 | H59313 |
| H59319 | H59321 | H59322 | H59323 | H59329 | H59331 | H59332 | H59333 |
| H59339 | H59341 | H59342 | H59343 | H59349 | H9541 | H9542 | H9551 |
| H9552 | I2510 | I340 | I341 | I342 | I350 | I351 | I352 |
| I610 | I611 | I612 | I613 | I614 | I615 | I616 | I618 |
| I619 | I6300 | I63011 | I63012 | I63013 | I6302 | I63031 | I63032 |
| I63033 | I6309 | I6310 | I63111 | I63112 | I63113 | I6312 | I63131 |
| I63132 | I63133 | I6319 | I6320 | I63211 | I63212 | I63213 | I63219 |
| I6322 | I63231 | I63232 | I63233 | I6329 | I63311 | I63312 | I63313 |
| I63321 | I63322 | I63323 | I63331 | I63332 | I63333 | I63341 | I63342 |
| I63343 | I6339 | I63411 | I63412 | I63413 | I63421 | I63422 | I63423 |
| I63431 | I63432 | I63433 | I63441 | I63442 | I63443 | I6349 | I63511 |
| I63512 | I63513 | I63521 | I63522 | I63523 | I63531 | I63532 | I63533 |
| I63541 | I63542 | I63543 | I6359 | I636 | I6501 | I6502 | I6503 |
| I651 | I6521 | I6522 | I6523 | I658 | I6601 | I6602 | I6603 |
| I6611 | I6612 | I6613 | I6621 | I6622 | I6623 | I663 | I668 |
| I671 | I672 | I676 | I6781 | I6782 | I67841 | I67848 | I67850 |
| I67858 | I6789 | I680 | I69031 | I69032 | I69033 | I69034 | I69041 |
| I69042 | I69043 | I69044 | I69051 | I69052 | I69053 | I69054 | I69131 |
| I69132 | I69133 | I69134 | I69141 | I69142 | I69143 | I69144 | I69151 |
| I69152 | I69153 | I69154 | I69231 | I69232 | I69233 | I69234 | I69241 |
| I69242 | I69243 | I69244 | I69251 | I69252 | I69253 | I69254 | I69331 |
| I69332 | I69333 | I69334 | I69341 | I69342 | I69343 | I69344 | I69351 |
| I69352 | I69353 | I69354 | I69831 | I69832 | I69833 | I69834 | I69841 |
| I69842 | I69843 | I69844 | I69851 | I69852 | I69853 | I69854 | I69931 |
| I69932 | I69933 | I69934 | I69941 | I69942 | I69943 | I69944 | I69951 |
| I69952 | I69953 | I69954 | I720 | I749 | I76 | I771 | I772 |
| I773 | I776 | I7771 | I7789 | I97610 | I97611 | I97618 | I97620 |
| I97621 | I97630 | I97631 | I97638 | J95830 | J95831 | J95860 | J95861 |
| K9161 | K91840 | K91841 | K91870 | K91871 | L7621 | L7622 | L7631 |
| L7632 | M96830 | M96831 | M96840 | M96841 | N99820 | N99821 | N99840 |
| N99841 | R0989*** | R221** | R260 | R261 | R295 | R29810 | R4701 |
| R4702 | R471 | R4781 | R4789 | R55* | S15011A | S15011D | S15011S |
| S15012A | S15012D | S15012S | S15021A | S15021D | S15021S | S15022A | S15022D |
| S15022S | S15091A | S15091D | S15091S | S15092A | S15092D | S15092S | S15111A |
| S15111D | S15111S | S15112A | S15112D | S15112S | S15121A | S15121D | S15121S |
| S15122A | S15122D | S15122S | S15191A | S15191D | S15191S | S15192A | S15192D |
| * Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency | | | | | | | |
| ** Use R221 to report pulsatile neck mass | | | | | | | |
| *** Use R0989 to report carotid bruit | | | | | | | |

| Diagnosis Codes | | | | | | | |
|--|---------|---------|---------|---------|---------|---------|---------|
| S15192S | S25111A | S25111D | S25111S | S25112A | S25112D | S25112S | S25121A |
| S25121D | S25121S | S25122A | S25122D | S25122S | S25191A | S25191D | S25191S |
| S25192A | S25192D | S25192S | T82817A | T82817D | T82817S | T82818A | T82818D |
| T82818S | T82827A | T82827D | T82827S | T82828A | T82828D | T82828S | T82837A |
| T82837D | T82837S | T82838A | T82838D | T82838S | T82847A | T82847D | T82847S |
| T82848A | T82848D | T82848S | T82857A | T82857D | T82857S | T82858A | T82858D |
| T82858S | T82867A | T82867D | T82867S | T82868A | T82868D | T82868S | T8381XA |
| T8381XD | T8381XS | T8382XA | T8382XD | T8382XS | T8383XA | T8383XD | T8383XS |
| T8384XA | T8384XD | T8384XS | T8385XA | T8385XD | T8385XS | T8386XA | T8386XD |
| T8386XS | T85818A | T85818D | T85818S | T85828A | T85828D | T85828S | T85838A |
| T85838D | T85838S | T85848A | T85848D | T85848S | T85858A | T85858D | T85858S |
| T85868A | T85868D | T85868S | T85898A | T85898D | T85898S | Z09 | Z98890 |
| * Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency | | | | | | | |
| ** Use R221 to report pulsatile neck mass | | | | | | | |
| *** Use R0989 to report carotid bruit | | | | | | | |

Transcranial Doppler (procedure codes 93886, 93888, 93890, 93892, and 93893) are limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|--|--------|--------|--------|--------|--------|--------|--------|
| D7821 | D7822 | G450 | G452 | G453 | G454 | G458 | G459 |
| G460 | G461 | G462 | G9382 | G9389* | G9731 | G9732 | G9748 |
| G9749 | G9751 | G9752 | G9761 | G9762 | H59311 | H59312 | H59313 |
| H59319 | H59321 | H59322 | H59323 | H59329 | H59331 | H59332 | H59333 |
| H59339 | H59341 | H59342 | H59343 | H59349 | H9541 | H9542 | H9551 |
| H9552 | I6011 | I6012 | I602 | I6031 | I6032 | I604 | I6051 |
| I6052 | I606 | I608 | I610 | I611 | I613 | I614 | I615 |
| I616 | I618 | I63011 | I63012 | I63013 | I6302 | I63031 | I63032 |
| I63033 | I6309 | I63111 | I63112 | I63113 | I6312 | I63131 | I63132 |
| I63133 | I6319 | I63211 | I63212 | I63213 | I6322 | I63231 | I63232 |
| I63233 | I6329 | I63311 | I63312 | I63313 | I63321 | I63322 | I63323 |
| I63331 | I63332 | I63333 | I63341 | I63342 | I63343 | I6339 | I63411 |
| I63412 | I63413 | I63421 | I63422 | I63423 | I63431 | I63432 | I63433 |
| I63441 | I63442 | I63443 | I6349 | I63511 | I63512 | I63513 | I63521 |
| I63522 | I63523 | I63531 | I63532 | I63533 | I63541 | I63542 | I63543 |
| I6359 | I636 | I6381 | I6389 | I639 | I6501 | I6502 | I6503 |
| I651 | I6521 | I6522 | I6523 | I658 | I6601 | I6602 | I6603 |
| I6611 | I6612 | I6613 | I6621 | I6622 | I6623 | I663 | I668 |
| I671 | I672 | I677 | I6781 | I6782 | I67841 | I67848 | I67850 |
| I67858 | I6789 | I679 | I726 | I749** | I76 | I97610 | I97611 |
| * Use G9389 to identify assessment of suspected brain death | | | | | | | |
| ** Use I749 to report paradoxical cerebral embolism | | | | | | | |
| *** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency | | | | | | | |

| Diagnosis Codes | | | | | | | |
|--|---------|---------|---------|---------|---------|---------|---------|
| I97618 | I97620 | I97621 | I97630 | I97631 | I97638 | J95830 | J95831 |
| J95860 | J95861 | K9161 | K91840 | K91841 | K91870 | K91871 | L7621 |
| L7622 | L7631 | L7632 | M96830 | M96831 | M96840 | M96841 | N99820 |
| N99821 | N99840 | N99841 | Q282 | Q283 | R260 | R261 | R2681 |
| R2689 | R295 | R29810 | R4701 | R4702 | R471 | R4781 | R4789 |
| R55*** | S090XXA | S090XXD | S090XXS | S15111A | S15111D | S15111S | S15112A |
| S15112D | S15112S | S15121A | S15121D | S15121S | S15122A | S15122D | S15122S |
| S15191A | S15191D | S15191S | S15192A | S15192D | S15192S | T82818A | T82818D |
| T82818S | T82828A | T82828D | T82828S | T82838A | T82838D | T82838S | T82848A |
| T82848D | T82848S | T82858A | T82858D | T82858S | T82868A | T82868D | T82868S |
| Z09 | | | | | | | |
| * Use G9389 to identify assessment of suspected brain death | | | | | | | |
| ** Use I749 to report paradoxical cerebral embolism | | | | | | | |
| *** Use R55 when symptomatology indicates a strong clinical suspicion of vertebrobasilar insufficiency | | | | | | | |

In addition to the diagnosis codes listed in the table above, procedure codes 93886 and 93888 are benefits for clients who are 2 through 16 years of age with sickle cell disease to evaluate the risk of stroke when submitted with the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|------|-------|--------|--------|-------|--------|
| D5700 | D5702 | D571 | D5720 | D57212 | D57219 | D5780 | D57812 |
| D57819 | | | | | | | |

9.2.26.2 Peripheral Doppler Studies

Peripheral Doppler sonography is used to determine vascular impedance and evaluate peripheral masses and peripheral nerve continuity.

9.2.26.3 Peripheral Arterial Doppler Studies

Noninvasive peripheral arterial examinations that are performed to establish the level and degree of arterial occlusive disease are reasonable and necessary if significant signs or symptoms of possible limb ischemia are present, and the client is a candidate for invasive therapeutic procedures.

Peripheral arterial Doppler (procedure codes 93922, 93923, 93924, 93925, 93926, 93930, and 93931) are limited to the following diagnosis codes (unless otherwise indicated):

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| E0851 | E0852 | E0859 | E0951 | E0952 | E0959 | E1051 | E1052 |
| E1059 | E1151 | E1152 | E1159 | E1351 | E1352 | E1359 | G9751 |
| G9752 | I2583 | I670 | I700 | I70218 | I70228 | I7025 | I70268 |
| I70298 | I70418 | I70428 | I7045 | I70468 | I70498 | I70518 | I70528 |
| I7055 | I70568 | I70598 | I70618 | I70628 | I7065 | I70668 | I70698 |
| I70718 | I70728 | I7075 | I70768 | I70798 | I7092 | I7101 | I7102 |
| I7103 | I711 | I712 | I713 | I714 | I715 | I716 | I723 |
| I728 | I7300 | I7301 | I731 | I7389 | I739 | I7401 | I7409 |
| I7411 | I7419 | I745 | I748 | I770 | I771 | I772 | I773 |
| I775 | I7771 | I7772 | I7773 | I7774 | I7779 | I77810 | I77811 |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| I77812 | I7789 | I790 | I791 | I798 | I96 | I97410 | I97411 |
| I97418 | I9742 | I9751 | I9752 | I97610 | I97611 | I97618 | J9561 |
| J9562 | J9571 | J9572 | J95830 | J95831 | K9161 | K9162 | K9171 |
| K9172 | K91840 | K91841 | L7601 | L7602 | L7611 | L7612 | L7621 |
| L7622 | L89112 | L89113 | L89114 | L89116 | L89122 | L89123 | L89124 |
| L89126 | L89132 | L89133 | L89134 | L89136 | L89142 | L89143 | L89144 |
| L89146 | L89152 | L89153 | L89154 | L89156 | L89216 | L89226 | L89316 |
| L89326 | L8946 | L89812 | L89813 | L89814 | L89892 | L89893 | L89894 |
| L89896 | L98421 | L98422 | L98423 | L98424 | L98425 | L98426 | L98428 |
| L98429 | M314 | M315 | M316 | M318 | M79609 | M96810 | M96811 |
| M96820 | M96821 | M96830 | M96831 | N184 | N185 | N186 | N9961 |
| N9962 | N9971 | N9972 | N99820 | N99821 | R0989 | R1901 | R1902 |
| R1903 | R1904 | R1905 | R1906 | R1907 | R1909 | R200 | R201 |
| R202 | R203 | T801XXA | T801XXD | T801XXS | T8131XA | T8131XD | T8131XS |
| T8132XA | T8132XD | T8132XS | T81718A | T81718D | T81718S | T8172XA | T8172XD |
| T8172XS | T8189XA | T8189XD | T8189XS | T82310A | T82310D | T82310S | T82311A |
| T82311D | T82311S | T82312A | T82312D | T82312S | T82318A | T82318D | T82318S |
| T82320A | T82320D | T82320S | T82321A | T82321D | T82321S | T82322A | T82322D |
| T82322S | T82328A | T82328D | T82328S | T82330A | T82330D | T82330S | T82331A |
| T82331D | T82331S | T82332A | T82332D | T82332S | T82338A | T82338D | T82338S |
| T82390A | T82390D | T82390S | T82391A | T82391D | T82391S | T82392A | T82392D |
| T82392S | T82398A | T82398D | T82398S | T8241XA | T8241XD | T8241XS | T8242XA |
| T8242XD | T8242XS | T8243XA | T8243XD | T8243XS | T8249XA | T8249XD | T8249XS |
| T82510A | T82510D | T82510S | T82511A | T82511D | T82511S | T82513A | T82513D |
| T82513S | T82514A | T82514D | T82514S | T82515A | T82515D | T82515S | T82518A |
| T82518D | T82518S | T82520A | T82520D | T82520S | T82521A | T82521D | T82521S |
| T82523A | T82523D | T82523S | T82524A | T82524D | T82524S | T82525A | T82525D |
| T82525S | T82528A | T82528D | T82528S | T82530A | T82530D | T82530S | T82531A |
| T82531D | T82531S | T82533A | T82533D | T82533S | T82534A | T82534D | T82534S |
| T82535A | T82535D | T82535S | T82538A | T82538D | T82538S | T82590A | T82590D |
| T82590S | T82591A | T82591D | T82591S | T82593A | T82593D | T82593S | T82594A |
| T82594D | T82594S | T82595A | T82595D | T82595S | T82598A | T82598D | T82598S |
| T827XXA | T827XXD | T827XXS | T82817A | T82817D | T82817S | T82818A | T82818D |
| T82818S | T82827A | T82827D | T82827S | T82828A | T82828D | T82828S | T82837A |
| T82837D | T82837S | T82838A | T82838D | T82838S | T82847A | T82847D | T82847S |
| T82848A | T82848D | T82848S | T82856A | T82856D | T82856S | T82857A | T82857D |
| T82857S | T82858A | T82858D | T82858S | T82867A | T82867D | T82867S | T82868A |
| T82868D | T82868S | T82897A | T82897D | T82897S | T82898A | T82898D | T82898S |
| T8381XA | T8381XD | T8381XS | T8382XA | T8382XD | T8382XS | T8383XA | T8383XD |
| T8383XS | T8384XA | T8384XD | T8384XS | T8385XA | T8385XD | T8385XS | T8386XA |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T8386XD | T8386XS | T8389XA | T8389XD | T8389XS | T8481XA | T8481XD | T8481XS |
| T8482XA | T8482XD | T8482XS | T8483XA | T8483XD | T8483XS | T8484XA | T8484XD |
| T8484XS | T8485XA | T8485XD | T8485XS | T8486XA | T8486XD | T8486XS | T8489XA |
| T8489XD | T8489XS | T85810A | T85810D | T85810S | T85818A | T85818D | T85818S |
| T85860A | T85860D | T85860S | T85868A | T85868D | T85868S | T8601 | T8602 |
| T8603 | T8609 | T8611 | T8612 | T8613 | T8619 | T8621 | T8622 |
| T8623 | T86290 | T86298 | T8631 | T8632 | T8633 | T8639 | T8641 |
| T8642 | T8643 | T8649 | T86810 | T86811 | T86812 | T86818 | T86830 |
| T86831 | T86832 | T86838 | T86850 | T86851 | T86852 | T86858 | T86890 |
| T86891 | T86892 | T86898 | T872 | T888XXA | Z09 | Z4803 | Z48812 |
| Z4889 | Z951 | Z955 | Z95820 | Z95828 | Z9861 | | |

| Diagnosis Codes for Upper Extremity Conditions | | | | | | | |
|--|---------|---------|---------|---------|---------|---------|---------|
| I721 | I742 | I75011 | I75012 | I75013 | I7776 | L89012 | L89013 |
| L89014 | L89016 | L89022 | L89023 | L89024 | L89026 | M79A11 | M79A12 |
| Q2731 | S45011A | S45011D | S45011S | S45012A | S45012D | S45012S | S45091A |
| S45091D | S45091S | S45092A | S45092D | S45092S | S45111A | S45111D | S45111S |
| S45112A | S45112D | S45112S | S45191A | S45191D | S45191S | S45192A | S45192D |
| S45192S | S45211A | S45211D | S45211S | S45212A | S45212D | S45212S | S45219A |
| S45219D | S45219S | S45291A | S45291D | S45291S | S45292A | S45292D | S45292S |
| S45311A | S45311D | S45311S | S45312A | S45312D | S45312S | S45391A | S45391D |
| S45391S | S45392A | S45392D | S45392S | S45811A | S45811D | S45811S | S45812A |
| S45812D | S45812S | S45891A | S45891D | S45891S | S45892A | S45892D | S45892S |
| S55011A | S55011D | S55011S | S55012A | S55012D | S55012S | S55091A | S55091D |
| S55091S | S55092A | S55092D | S55092S | S55111A | S55111D | S55111S | S55112A |
| S55112D | S55112S | S55191A | S55191D | S55191S | S55192A | S55192D | S55192S |
| S55211A | S55211D | S55211S | S55212A | S55212D | S55212S | S55291A | S55291D |
| S55291S | S55292A | S55292D | S55292S | S55811A | S55811D | S55811S | S55812A |
| S55812D | S55812S | S55891A | S55891D | S55891S | S55892A | S55892D | S55892S |
| S65011A | S65011D | S65011S | S65012A | S65012D | S65012S | S65091A | S65091D |
| S65091S | S65092A | S65092D | S65092S | S65111A | S65111D | S65111S | S65112A |
| S65112D | S65112S | S65191A | S65191D | S65191S | S65192A | S65192D | S65192S |
| S65211A | S65211D | S65211S | S65212A | S65212D | S65212S | S65291A | S65291D |
| S65291S | S65292A | S65292D | S65292S | S65311A | S65311D | S65311S | S65312A |
| S65312D | S65312S | S65391A | S65391D | S65391S | S65392A | S65392D | S65392S |
| S65411A | S65411D | S65411S | S65412A | S65412D | S65412S | S65491A | S65491D |
| S65491S | S65492A | S65492D | S65492S | S65510A | S65510D | S65510S | S65511A |
| S65511D | S65511S | S65512A | S65512D | S65512S | S65513A | S65513D | S65513S |
| S65514A | S65514D | S65514S | S65515A | S65515D | S65515S | S65516A | S65516D |
| S65516S | S65517A | S65517D | S65517S | S65518A | S65518D | S65518S | S65590A |

| Diagnosis Codes for Upper Extremity Conditions | | | | | | | |
|--|---------|---------|---------|---------|---------|---------|---------|
| S65590D | S65590S | S65591A | S65591D | S65591S | S65592A | S65592D | S65592S |
| S65593A | S65593D | S65593S | S65594A | S65594D | S65594S | S65595A | S65595D |
| S65595S | S65596A | S65596D | S65596S | S65597A | S65597D | S65597S | S65598A |
| S65598D | S65598S | S65811A | S65811D | S65811S | S65812A | S65812D | S65812S |
| S65891A | S65891D | S65891S | S65892A | S65892D | S65892S | T870X1 | T870X2 |

| Diagnosis Codes for Lower Extremity Conditions | | | | | | | |
|--|--------|--------|--------|--------|--------|--------|--------|
| I70211 | I70212 | I70213 | I70221 | I70222 | I70223 | I70231 | I70232 |
| I70233 | I70234 | I70235 | I70238 | I70241 | I70242 | I70243 | I70244 |
| I70245 | I70248 | I70261 | I70262 | I70263 | I70291 | I70292 | I70293 |
| I70411 | I70412 | I70413 | I70421 | I70422 | I70423 | I70431 | I70432 |
| I70433 | I70434 | I70435 | I70438 | I70441 | I70442 | I70443 | I70444 |
| I70445 | I70448 | I70461 | I70462 | I70463 | I70491 | I70492 | I70493 |
| I70511 | I70512 | I70513 | I70521 | I70522 | I70523 | I70531 | I70532 |
| I70533 | I70534 | I70535 | I70538 | I70541 | I70542 | I70543 | I70544 |
| I70545 | I70548 | I70561 | I70562 | I70563 | I70591 | I70592 | I70593 |
| I70611 | I70612 | I70613 | I70621 | I70622 | I70623 | I70631 | I70632 |
| I70633 | I70634 | I70635 | I70638 | I70641 | I70642 | I70643 | I70644 |
| I70645 | I70648 | I70661 | I70662 | I70663 | I70691 | I70692 | I70693 |
| I70711 | I70712 | I70713 | I70721 | I70722 | I70723 | I70731 | I70732 |
| I70733 | I70734 | I70735 | I70738 | I70741 | I70742 | I70743 | I70744 |
| I70745 | I70748 | I70761 | I70762 | I70763 | I70791 | I70792 | I70793 |
| I724 | I743 | I75021 | I75022 | I75023 | I7777 | I83011 | I83012 |
| I83013 | I83014 | I83015 | I83018 | I83021 | I83022 | I83023 | I83024 |
| I83025 | I83028 | L89212 | L89213 | L89214 | L89222 | L89223 | L89224 |
| L89312 | L89313 | L89314 | L89322 | L89323 | L89324 | L8942 | L8943 |
| L8944 | L89512 | L89513 | L89514 | L89516 | L89522 | L89523 | L89524 |
| L89526 | L89612 | L89613 | L89614 | L89616 | L89622 | L89623 | L89624 |
| L89626 | L97111 | L97112 | L97113 | L97114 | L97115 | L97116 | L97118 |
| L97119 | L97121 | L97122 | L97123 | L97124 | L97125 | L97126 | L97128 |
| L97129 | L97205 | L97206 | L97208 | L97209 | L97211 | L97212 | L97213 |
| L97214 | L97215 | L97216 | L97218 | L97219 | L97221 | L97222 | L97223 |
| L97224 | L97305 | L97306 | L97308 | L97309 | L97311 | L97312 | L97313 |
| L97314 | L97315 | L97316 | L97318 | L97319 | L97321 | L97322 | L97323 |
| L97324 | L97325 | L97326 | L97328 | L97329 | L97411 | L97412 | L97413 |
| L97414 | L97415 | L97416 | L97418 | L97419 | L97421 | L97422 | L97423 |
| L97424 | L97425 | L97426 | L97428 | L97429 | L97511 | L97512 | L97513 |
| L97514 | L97521 | L97522 | L97523 | L97524 | L97811 | L97812 | L97813 |
| L97814 | L97816 | L97818 | L97819 | L97821 | L97822 | L97823 | L97824 |
| L98411 | L98412 | L98413 | L98414 | L98415 | L98416 | L98418 | L98419 |

| Diagnosis Codes for Lower Extremity Conditions | | | | | | | |
|--|---------|---------|---------|---------|---------|---------|---------|
| M79A21 | M79A22 | Q2732 | S75011A | S75011D | S75011S | S75012A | S75012D |
| S75012S | S75021A | S75021D | S75021S | S75022A | S75022D | S75022S | S75091A |
| S75091D | S75091S | S75092A | S75092D | S75092S | S75111A | S75111D | S75111S |
| S75112A | S75112D | S75112S | S75121A | S75121D | S75121S | S75122A | S75122D |
| S75122S | S75191A | S75191D | S75191S | S75192A | S75192D | S75192S | S75211A |
| S75211D | S75211S | S75212A | S75212D | S75212S | S75221A | S75221D | S75221S |
| S75222A | S75222D | S75222S | S75291A | S75291D | S75291S | S75292A | S75292D |
| S75292S | S75811A | S75811D | S75811S | S75812A | S75812D | S75812S | S75891A |
| S75891D | S75891S | S75892A | S75892D | S75892S | S85011A | S85011D | S85011S |
| S85012A | S85012D | S85012S | S85091A | S85091D | S85091S | S85092A | S85092D |
| S85092S | S85141A | S85141D | S85141S | S85142A | S85142D | S85142S | S85151A |
| S85151D | S85151S | S85152A | S85152D | S85152S | S85171A | S85171D | S85171S |
| S85172A | S85172D | S85172S | S85181A | S85181D | S85181S | S85182A | S85182D |
| S85182S | S85211A | S85211D | S85211S | S85212A | S85212D | S85212S | S85291A |
| S85291D | S85291S | S85292A | S85292D | S85292S | S85311A | S85311D | S85311S |
| S85312A | S85312D | S85312S | S85391A | S85391D | S85391S | S85392A | S85392D |
| S85392S | S85411A | S85411D | S85411S | S85412A | S85412D | S85412S | S85491A |
| S85491D | S85491S | S85492A | S85492D | S85492S | S85511A | S85511D | S85511S |
| S85512A | S85512D | S85512S | S85591A | S85591D | S85591S | S85592A | S85592D |
| S85592S | S85811A | S85811D | S85811S | S85812A | S85812D | S85812S | S85891A |
| S85891D | S85891S | S85892A | S85892D | S85892S | S95011A | S95011D | S95011S |
| S95012A | S95012D | S95012S | S95091A | S95091D | S95091S | S95092A | S95092D |
| S95092S | S95111A | S95111D | S95111S | S95112A | S95112D | S95112S | S95191A |
| S95191D | S95191S | S95192A | S95192D | S95192S | S95211A | S95211D | S95211S |
| S95212A | S95212D | S95212S | S95291A | S95291D | S95291S | S95292A | S95292D |
| S95292S | S95811A | S95811D | S95811S | S95812A | S95812D | S95812S | S95891A |
| S95891D | S95891S | S95892A | S95892D | S95892S | T871X1 | T871X2 | |

9.2.26.4 Peripheral Venous Doppler Studies

Non-invasive vascular diagnostic studies utilize ultrasonic Doppler and physiologic principles to assess irregularities in blood flow in the venous system.

Peripheral venous Doppler (procedure codes 93970 and 93971) are limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| I2601 | I2602 | I2609 | I2690 | I2692 | I2693 | I2694 | I2699 |
| I749 | I8001 | I8002 | I8003 | I8011 | I8012 | I8013 | I80211 |
| I80212 | I80213 | I80221 | I80222 | I80223 | I80231 | I80232 | I80233 |
| I80241 | I80242 | I80243 | I80251 | I80252 | I80253 | I80291 | I80292 |
| I80293 | I808 | I821 | I82220 | I82411 | I82412 | I82413 | I82421 |
| I82422 | I82423 | I82431 | I82432 | I82433 | I82441 | I82442 | I82443 |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| I82451 | I82452 | I82453 | I82461 | I82462 | I82463 | I82491 | I82492 |
| I82493 | I82511 | I82512 | I82513 | I82521 | I82522 | I82523 | I82531 |
| I82532 | I82533 | I82541 | I82542 | I82543 | I82551 | I82552 | I82553 |
| I82561 | I82562 | I82563 | I82591 | I82592 | I82593 | I82611 | I82612 |
| I82613 | I82621 | I82622 | I82623 | I82711 | I82712 | I82713 | I82721 |
| I82722 | I82723 | I82A11 | I82A12 | I82A13 | I82A21 | I82A22 | I82A23 |
| I82C11 | I82C12 | I82C13 | I82C21 | I82C22 | I82C23 | I82811 | I82812 |
| I82813 | I82890 | I82891 | I83011 | I83012 | I83013 | I83014 | I83015 |
| I83018 | I83021 | I83022 | I83023 | I83024 | I83025 | I83028 | I8311 |
| I8312 | I83211 | I83212 | I83213 | I83214 | I83215 | I83218 | I83221 |
| I83222 | I83223 | I83224 | I83225 | I83228 | I83811 | I83812 | I83813 |
| I83891 | I83892 | I83893 | I87001 | I87002 | I87003 | I87011 | I87012 |
| I87013 | I87021 | I87022 | I87023 | I87031 | I87032 | I87033 | I87091 |
| I87092 | I87093 | I871 | I872 | I87311 | I87312 | I87313 | I87321 |
| I87322 | I87323 | I87331 | I87332 | I87333 | I87391 | I87392 | I87393 |
| I96 | J80 | J9600 | J9601 | J9602 | J9690 | L89016 | L89026 |
| L89116 | L89126 | L89136 | L89146 | L89156 | L89216 | L89226 | L89316 |
| L89326 | L8946 | L97111 | L97112 | L97113 | L97114 | L97115 | L97116 |
| L97118 | L97119 | L97121 | L97122 | L97123 | L97124 | L97125 | L97126 |
| L97128 | L97129 | L97211 | L97212 | L97213 | L97214 | L97215 | L97216 |
| L97218 | L97219 | L97221 | L97222 | L97223 | L97224 | L97225 | L97226 |
| L97228 | L97229 | L97311 | L97312 | L97313 | L97314 | L97315 | L97316 |
| L97318 | L97319 | L97321 | L97322 | L97323 | L97324 | L97325 | L97326 |
| L97328 | L97329 | L97411 | L97412 | L97413 | L97414 | L97415 | L97416 |
| L97418 | L97419 | L97421 | L97422 | L97423 | L97424 | L97425 | L97426 |
| L97428 | L97429 | L97511 | L97512 | L97513 | L97514 | L97515 | L97516 |
| L97518 | L97519 | L97521 | L97522 | L97523 | L97524 | L97525 | L97526 |
| L97528 | L97529 | L97811 | L97812 | L97813 | L97814 | L97815 | L97816 |
| L97818 | L97819 | L97821 | L97822 | L97823 | L97824 | L97825 | L97826 |
| L97828 | L97829 | M7121 | M7122 | M79601 | M79602 | M79604 | M79605 |
| M79621 | M79622 | M79631 | M79632 | M79641 | M79642 | M79644 | M79645 |
| M79651 | M79652 | M79661 | M79662 | M79671 | M79672 | M79674 | M79675 |
| O2221 | O2222 | O2223 | O2231 | O2232 | O2233 | O870 | O871 |
| O88211 | O88212 | O88213 | O8822 | O8823 | Q2731 | Q2732 | Q278 |
| R042 | R0600 | R0602 | R0609 | R0682 | R071 | R0781 | R0782 |
| R0789 | R079 | R2231 | R2232 | R2233 | R2241 | R2242 | R2243 |
| R600 | R601 | R609 | T800XXA | T801XXA | T8172XA | T82817A | T82818A |
| T82827A | T82828A | T82837A | T82838A | T82847A | T82848A | T82857A | T82858A |
| T82867A | T82868A | T8381XA | T8382XA | T8383XA | T8384XA | T8385XA | T8386XA |
| T85818A | T85828A | T85838A | T85848A | T85858A | T85868A | T85898A | |

In addition to the diagnosis codes listed in the table above, procedure code 93971 is also a benefit when submitted with diagnosis code Z01810, Z01818, or Z09.

Doppler echocardiography color flow velocity mapping (procedure code 93325) must be billed with one of the corresponding procedure codes in column B to be considered for reimbursement:

| Column A Procedure Code | Column B Procedure Codes |
|-------------------------|--|
| 93325 | 76825, 76826, 76827, 76828, 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, or 93351 |

9.2.26.5 Limitations for Diagnostic Doppler Sonography

Documentation of medical necessity for the diagnostic Doppler study must be maintained by the ordering provider in the client's medical record.

Procedure codes described as complete bilateral studies are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Diagnostic Doppler procedure codes are limited to one study per day, same provider.

When medically necessary, multiple Doppler procedures (e.g., studies of extracranial arteries and intracranial arteries) billed on the same day by the same provider will be reimbursed at full fee for the first study and one-half fee for each additional study, regardless of the number of services billed.

The use of transcranial Doppler studies performed for the assessment of stroke risk in clients who are 2 through 16 years of age who have sickle cell anemia should be limited to once every 6 months.

The use of a simple hand-held or other Doppler device that does not produce hard copy output or that does not permit analysis of bidirectional vascular flow is considered part of the physical examination of the vascular system and is not separately reported.

9.2.27 Evoked Response Tests and Neuromuscular Procedures

The following services are a benefit of Texas Medicaid:

- Autonomic function test (AFT)
- Electromyography (EMG)
- Nerve conduction studies (NCS)
- Evoked potential (EP) testing
- Motion analysis studies

9.2.27.1 Autonomic Function Tests

AFTs are a benefit of Texas Medicaid when submitted with procedure codes 95921, 95922, 95923, 95924, and 95943.

Procedure codes 95921, 95922, 95923, 95924, and 95943 are limited to once per date of service, by the same provider.

Autonomic disorders may be congenital or acquired (primary or secondary). Some of the conditions under which autonomic function testing may be appropriate include, but are not limited to, the following:

- Amyloid neuropathy
- Diabetic autonomic neuropathy
- Distal small fiber neuropathy
- Excessive sweating

- Gastrointestinal dysfunction
- Idiopathic neuropathy
- Irregular heart rate
- Multiple system atrophy
- Orthostatic symptoms
- Pure autonomic failure
- Reflex sympathetic dystrophy or causalgia (sympathetically maintained pain)
- Sjogren's syndrome

The reason for the referral, the specific autonomic function being tested, and a clear diagnostic impression must be documented in the client's medical record for each AFT performed.

The client's medical records must clearly document the medical necessity for the AFT. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for reevaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence that the client's condition is changing rapidly, supported by the following:
 - Diagnosis
 - Current clinical signs and symptoms
 - Prior clinical condition
 - Expected clinical disease course
- Clinical benefit of additional studies.

The client's medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.27.2 * Electromyography and Nerve Conduction Studies

Electromyography (EMG) and nerve conduction studies (NCS), collectively known as electrodiagnostic (EDX) testing, must be medically indicated and may be reimbursed with the diagnosis codes listed below. Testing must be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnoses are not a benefit of Texas Medicaid.

| [Revised] Diagnosis Codes | | | | | | | |
|----------------------------------|-------|-------|--------|-------|-------|-------|--------|
| C701 | C720 | C721 | E0842 | E0942 | E1041 | E1042 | E10610 |
| E1141 | E1142 | E1144 | E11610 | E1342 | E5111 | E5112 | E512 |
| E518 | E519 | E560 | E568 | E7281 | E7289 | E7841 | E7849 |
| E786 | E851 | E852 | E853 | E8581 | E8582 | E8589 | E859 |
| G120 | G121 | G1221 | G1222 | G1223 | G1224 | G1225 | G1229 |
| G128 | G129 | G130 | G243 | G2589 | G26 | G320 | G360 |
| G370 | G375 | G501 | G510 | G511 | G512 | G5131 | G5132 |
| G5133 | G5139 | G514 | G518 | G519 | G522 | G523 | G527 |
| G528 | G540 | G541 | G542 | G543 | G544 | G545 | G548 |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|
| G549 | G5601 | G5602 | G5603 | G5611 | G5612 | G5613 | G5621 |
| G5622 | G5623 | G5631 | G5632 | G5633 | G5641 | G5642 | G5643 |
| G5681 | G5682 | G5683 | G5691 | G5692 | G5693 | G5701 | G5702 |
| G5703 | G5711 | G5712 | G5713 | G5721 | G5722 | G5723 | G5731 |
| G5732 | G5733 | G5741 | G5742 | G5743 | G5751 | G5752 | G5753 |
| G5761 | G5762 | G5763 | G5771 | G5772 | G5773 | G5781 | G5782 |
| G5783 | G5791 | G5792 | G5793 | G587 | G588 | G589 | G59 |
| G600 | G601 | G602 | G603 | G608 | G609 | G610 | G6181 |
| G6182 | G6189 | G619 | G620 | G621 | G622 | G6281 | G6282 |
| G629 | G63 | G650 | G651 | G652 | G7000 | G7001 | G701 |
| G702 | G7081 | G7089 | G709 | G7100 | G7101 | G7102 | G7109 |
| G7111 | G7112 | G7113 | G7114 | G7119 | G7120 | G7121 | G71220 |
| G71228 | G7129 | G713 | G718 | G719 | G721 | G722 | G723 |
| G7241 | G7249 | G7281 | G7289 | G729 | G731 | G733 | G737 |
| G800 | G801 | G802 | G803 | G804 | G808 | G809 | G8311 |
| G8312 | G8313 | G8314 | G8321 | G8322 | G8323 | G8324 | G834 |
| G8381 | G8382 | G8383 | G8384 | G8389 | G839 | G9009 | G902 |
| G904 | G9050 | G90511 | G90512 | G90513 | G90519 | G90521 | G90522 |
| G90523 | G90529 | G9059 | G909 | G950 | G9511 | G9519 | G9520 |
| G9529 | G9581 | G9589 | G959 | G990 | G992 | I776 | I951 |
| J3800 | J3801 | J3802 | K5902 | K5903 | K5904 | K5909 | K592 |
| K594 | K624 | K6289 | M05411 | M05412 | M05421 | M05422 | M05431 |
| M05432 | M05441 | M05442 | M05451 | M05452 | M05461 | M05462 | M05471 |
| M05472 | M0549 | M05511 | M05512 | M05521 | M05522 | M05531 | M05532 |
| M05541 | M05542 | M05551 | M05552 | M05561 | M05562 | M05571 | M05572 |
| M0559 | M05711 | M05712 | M05721 | M05722 | M05731 | M05732 | M05741 |
| M05742 | M05751 | M05752 | M05761 | M05762 | M05769 | M05771 | M05772 |
| M05779 | M0579 | M057A | M05811 | M05812 | M05821 | M05822 | M05831 |
| M05832 | M05841 | M05842 | M05851 | M05852 | M05861 | M05862 | M05871 |
| M05872 | M0589 | M058A | M06011 | M06012 | M06021 | M06022 | M06031 |
| M06032 | M06041 | M06042 | M06051 | M06052 | M06061 | M06062 | M06071 |
| M06072 | M0608 | M0609 | M060A | M06811 | M06812 | M06821 | M06822 |
| M06831 | M06832 | M06841 | M06842 | M06852 | M06861 | M06862 | M06871 |
| M06872 | M0688 | M0689 | M068A | M069 | M21271 | M21272 | M21331 |
| M21332 | M21511 | M21512 | M216X1 | M216X2 | M21831 | M21832 | M21931 |
| M21932 | M320 | M3210 | M3211 | M3212 | M3213 | M3214 | M3215 |
| M3219 | M328 | M329 | M3300 | M3301 | M3302 | M3309 | M3310 |
| M3311 | M3312 | M3319 | M3320 | M3321 | M3322 | M3329 | M3390 |
| M3391 | M3392 | M3399 | M340 | M341 | M342 | M3481 | M3482 |
| M3483 | M3489 | M3505 | M3506 | M3507 | M3508 | M350A | M350B |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|
| M350C | M3581 | M3589 | M360 | M4321 | M4322 | M4323 | M4324 |
| M4325 | M4326 | M4327 | M4328 | M436 | M438X9 | M4644 | M4645 |
| M4646 | M4647 | M4711 | M4712 | M4713 | M4714 | M4715 | M4716 |
| M4721 | M4722 | M4723 | M4724 | M4725 | M4726 | M4727 | M4728 |
| M47811 | M47812 | M47813 | M47814 | M47815 | M47816 | M47817 | M47818 |
| M47891 | M47892 | M47893 | M47894 | M47895 | M47896 | M47897 | M47898 |
| M4801 | M4802 | M4803 | M4804 | M4805 | M48062 | M4807 | M4808 |
| M5000 | M5001 | M50020 | M50021 | M50022 | M50023 | M5003 | M5011 |
| M50120 | M50121 | M50122 | M50123 | M5013 | M5020 | M5021 | M50220 |
| M50221 | M50222 | M50223 | M5023 | M5030 | M5031 | M50320 | M50321 |
| M50322 | M50323 | M5033 | M5080 | M5081 | M50820 | M50821 | M50822 |
| M50823 | M5083 | M5091 | M50920 | M50921 | M50922 | M50923 | M5093 |
| M5104 | M5105 | M5106 | M5124 | M5125 | M5126 | M5127 | M5134 |
| M5135 | M5136 | M5137 | M5184 | M5185 | M5186 | M5187 | M5410 |
| M5411 | M5412 | M5413 | M5414 | M5415 | M5416 | M5417 | M5431 |
| M5432 | M5450 | M5451 | M5459 | M546 | M5489 | M60011 | M60012 |
| M60021 | M60022 | M60031 | M60032 | M60041 | M60042 | M60044 | M60051 |
| M60052 | M60061 | M60062 | M60070 | M60071 | M60073 | M60074 | M60076 |
| M60077 | M6008 | M6009 | M60111 | M60112 | M60121 | M60122 | M60131 |
| M60132 | M60141 | M60142 | M60151 | M60152 | M60161 | M60162 | M60171 |
| M60172 | M6018 | M6019 | M609 | M6250 | M62511 | M62512 | M62519 |
| M62521 | M62522 | M62529 | M62531 | M62532 | M62539 | M62541 | M62542 |
| M62549 | M62551 | M62552 | M62559 | M62561 | M62562 | M62569 | M62571 |
| M62572 | M62579 | M6258 | M6259 | M6281 | M6284 | M629 | M7910 |
| M7911 | M7912 | M7918 | M792 | M79601 | M79602 | M79604 | M79605 |
| M79621 | M79622 | M79631 | M79632 | M79641 | M79642 | M79651 | M79652 |
| M79661 | M79662 | M79671 | M79672 | M797 | M961 | N393 | N3941 |
| N3942 | N3943 | N3944 | N3945 | N3946 | N39490 | N39491 | N39492 |
| N39498 | N94819 | R150 | R151 | R152 | R159 | R200 | R201 |
| R202 | R203 | R208 | R209 | R260 | R261 | R2681 | R2689 |
| R269 | R290 | R295 | R29701 | R29702 | R29703 | R29704 | R29705 |
| R29706 | R29707 | R29708 | R29709 | R29710 | R29711 | R29712 | R29713 |
| R29714 | R29715 | R29716 | R29717 | R29718 | R29719 | R29720 | R29721 |
| R29722 | R29723 | R29724 | R29725 | R29726 | R29727 | R29728 | R29729 |
| R29730 | R29731 | R29732 | R29733 | R29734 | R29735 | R29736 | R29737 |
| R29738 | R29739 | R29740 | R29741 | R29742 | R32 | R3914 | R39191 |
| R39192 | R39198 | R4702 | R471 | R4781 | R4789 | R498 | R6884 |
| S14101A | S14101D | S14101S | S14102A | S14102D | S14102S | S14103A | S14103D |
| S14103S | S14104A | S14104D | S14104S | S14105A | S14105D | S14105S | S14106A |
| S14106D | S14106S | S14107A | S14107D | S14107S | S14108A | S14108D | S14108S |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|
| S14109A | S14109D | S14109S | S14111A | S14111D | S14111S | S14112A | S14112D |
| S14112S | S14113A | S14113D | S14113S | S14114A | S14114D | S14114S | S14115A |
| S14115D | S14115S | S14116A | S14116D | S14116S | S14117A | S14117D | S14117S |
| S14118A | S14118D | S14118S | S14121A | S14121D | S14121S | S14122A | S14122D |
| S14122S | S14123A | S14123D | S14123S | S14124A | S14124D | S14124S | S14125A |
| S14125D | S14125S | S14126A | S14126D | S14126S | S14127A | S14127D | S14127S |
| S14128A | S14128D | S14128S | S14131A | S14131D | S14131S | S14132A | S14132D |
| S14132S | S14133A | S14133D | S14133S | S14134A | S14134D | S14134S | S14135A |
| S14135D | S14135S | S14136A | S14136D | S14136S | S14137A | S14137D | S14137S |
| S14138A | S14138D | S14138S | S14141A | S14141D | S14141S | S14142A | S14142D |
| S14142S | S14143A | S14143D | S14143S | S14144A | S14144D | S14144S | S14145A |
| S14145D | S14145S | S14146A | S14146D | S14146S | S14147A | S14147D | S14147S |
| S14148A | S14148D | S14148S | S14151A | S14151D | S14151S | S14152A | S14152D |
| S14152S | S14153A | S14153D | S14153S | S14154A | S14154D | S14154S | S14155A |
| S14155D | S14155S | S14156A | S14156D | S14156S | S14157A | S14157D | S14157S |
| S14158A | S14158D | S14158S | S142XXA | S142XXD | S142XXS | S143XXA | S143XXD |
| S143XXS | S144XXA | S144XXD | S144XXS | S145XXA | S145XXD | S145XXS | S148XXA |
| S148XXD | S148XXS | S149XXA | S149XXD | S149XXS | S24101A | S24101D | S24101S |
| S24102A | S24102D | S24102S | S24103A | S24103D | S24103S | S24104A | S24104D |
| S24104S | S24109A | S24109D | S24109S | S24111A | S24111D | S24111S | S24112A |
| S24112D | S24112S | S24113A | S24113D | S24113S | S24114A | S24114D | S24114S |
| S24113A | S24131D | S24131S | S24132A | S24132D | S24132S | S24133A | S24133D |
| S24133S | S24134A | S24134D | S24134S | S24141A | S24141D | S24141S | S24142A |
| S24142D | S24142S | S24143A | S24143D | S24143S | S24144A | S24144D | S24144S |
| S24151A | S24151D | S24151S | S24152A | S24152D | S24152S | S24153A | S24153D |
| S24153S | S24154A | S24154D | S24154S | S242XXA | S242XXD | S242XXS | S243XXA |
| S243XXD | S243XXS | S244XXA | S244XXD | S244XXS | S248XXA | S248XXD | S248XXS |
| S249XXA | S249XXD | S249XXS | S34109A | S34109D | S34109S | S34111A | S34111D |
| S34111S | S34112A | S34112D | S34112S | S34113A | S34113D | S34113S | S34114A |
| S34114D | S34114S | S34115A | S34115D | S34115S | S34121A | S34121D | S34121S |
| S34122A | S34122D | S34122S | S34123A | S34123D | S34123S | S34124A | S34124D |
| S34124S | S34125A | S34125D | S34125S | S34131A | S34131D | S34131S | S34132A |
| S34132D | S34132S | S34139A | S34139D | S34139S | S3421XA | S3421XD | S3421XS |
| S3422XA | S3422XD | S3422XS | S343XXA | S343XXD | S343XXS | S344XXA | S344XXD |
| S344XXS | S345XXA | S345XXD | S345XXS | S4400XA | S4400XD | S4400XS | S4401XA |
| S4401XD | S4401XS | S4402XA | S4402XD | S4402XS | S4410XA | S4410XD | S4410XS |
| S4411XA | S4411XD | S4411XS | S4412XA | S4412XD | S4412XS | S4420XA | S4420XD |
| S4420XS | S4421XA | S4421XD | S4421XS | S4422XA | S4422XD | S4422XS | S4430XA |
| S4430XD | S4430XS | S4431XA | S4431XD | S4431XS | S4432XA | S4432XD | S4432XS |
| S4440XA | S4440XD | S4440XS | S4441XA | S4441XD | S4441XS | S4442XA | S4442XD |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|
| S4442XS | S4450XA | S4450XD | S4450XS | S4451XA | S4451XD | S4451XS | S4452XA |
| S4452XD | S4452XS | S448X1A | S448X1D | S448X1S | S448X2A | S448X2D | S448X2S |
| S448X9A | S448X9D | S448X9S | S4491XA | S4491XD | S4491XS | S4492XA | S4492XD |
| S4492XS | S5400XA | S5400XD | S5400XS | S5401XA | S5401XD | S5401XS | S5402XA |
| S5402XD | S5402XS | S5410XA | S5410XD | S5410XS | S5411XA | S5411XD | S5411XS |
| S5412XA | S5412XD | S5412XS | S5420XA | S5420XD | S5420XS | S5421XA | S5421XD |
| S5421XS | S5422XA | S5422XD | S5422XS | S5430XA | S5430XD | S5430XS | S5431XA |
| S5431XD | S5431XS | S5432XA | S5432XD | S5432XS | S5490XA | S5490XD | S5490XS |
| S5491XA | S5491XD | S5491XS | S5492XA | S5492XD | S5492XS | S6400XA | S6400XD |
| S6400XS | S6401XA | S6401XD | S6401XS | S6402XA | S6402XD | S6402XS | S6410XA |
| S6410XD | S6410XS | S6411XA | S6411XD | S6411XS | S6412XA | S6412XD | S6412XS |
| S6420XA | S6420XD | S6420XS | S6421XA | S6421XD | S6421XS | S6422XA | S6422XD |
| S6422XS | S6430XA | S6430XD | S6430XS | S6431XA | S6431XD | S6431XS | S6432XA |
| S6432XD | S6432XS | S64490A | S64490D | S64490S | S64491A | S64491D | S64491S |
| S64492A | S64492D | S64492S | S64493A | S64493D | S64493S | S64494A | S64494D |
| S64494S | S64495A | S64495D | S64495S | S64496A | S64496D | S64496S | S64497A |
| S64497D | S64497S | S64498A | S64498D | S64498S | S648X1A | S648X1D | S648X1S |
| S648X2A | S648X2D | S648X2S | S648X9A | S648X9D | S648X9S | S6490XA | S6490XD |
| S6490XS | S6491XA | S6491XD | S6491XS | S6492XA | S6492XD | S6492XS | S7401XA |
| S7401XD | S7401XS | S7402XA | S7402XD | S7402XS | S7411XA | S7411XD | S7411XS |
| S7412XA | S7412XD | S7412XS | S7421XA | S7421XD | S7421XS | S7422XA | S7422XD |
| S7422XS | S748X1A | S748X1D | S748X1S | S748X2A | S748X2D | S748X2S | S7491XA |
| S7491XD | S7491XS | S7492XA | S7492XD | S7492XS | S8401XA | S8401XD | S8401XS |
| S8402XA | S8402XD | S8402XS | S8411XA | S8411XD | S8411XS | S8412XA | S8412XD |
| S8412XS | S8421XA | S8421XD | S8421XS | S8422XA | S8422XD | S8422XS | S84801A |
| S84801D | S84801S | S84802A | S84802D | S84802S | S8491XA | S8491XD | S8491XS |
| S8492XA | S8492XD | S8492XS | S9421XA | S9421XD | S9421XS | S9422XA | S9422XD |
| S9422XS | S9431XA | S9431XD | S9431XS | S9432XA | S9432XD | S9432XS | S948X1A |
| S948X1D | S948X1S | S948X2A | S948X2D | S948X2S | S948X9A | S948X9D | S948X9S |
| S9490XA | S9490XD | S9490XS | S9491XA | S9491XD | S9491XS | S9492XA | S9492XD |
| S9492XS | T85840A | T85840D | T85840S | | | | |

Any EDX testing procedures may be reimbursed up to four different dates of service per calendar year, same provider. Any E/M service will be denied as part of another service when billed for the same date of service as EMG or NCS service by the same provider.

Claims for nerve conduction studies that are denied for exceeding the maximum number of studies allowed per day, may be appealed with supporting medical record documentation.

The reason for the referral, the specific site(s) tested, and a clear diagnostic impression must be documented in the client's medical record for each NCS or EMG study performed.

The client's medical records must clearly document the medical necessity for the NCS and EMG testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis. Examples may include suspected:
 - Peripheral nerve entrapment syndromes
 - Other neuropathies (traumatic, metabolic, or demyelinating)
 - Neuromuscular junction disorders (myasthenia gravis, botulism)
 - Myopathies (dermatomyositis, congenital myopathies)
 - Unexplained symptoms suggestive of peripheral nerve, muscle or neuromuscular junction pathology, manifested by muscle weakness, muscle atrophy, loss of dexterity, spasticity, sensory deficits, swallowing dysfunction, diplopia, or dysarthria
- The client's diagnosis could not be confirmed on previous studies, although suspected.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
 - Diagnosis
 - Current clinical signs and symptoms
 - Prior clinical condition
 - Expected clinical disease course
- There is clinical benefit of additional electrodiagnostic studies.

The client's medical records are subject to retrospective review. NCS hard copies of the wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.27.2.1 EMG

The following EMG procedure codes may be reimbursed for one service per day, each procedure, by the same provider:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 51784 | 51785 | 95860 | 95861 | 95863 | 95864 | 95865 | 95867 | 95868 | 95869 |
| 95872 | 95875 | | | | | | | | |

Procedure code 95866 may be reimbursed up to two services per day, same provider. Procedure code 95870 may be reimbursed in multiple quantities if specific muscles are documented.

The needle EMG examination must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.

Surface or macro-EMG testing is considered experimental and is not a benefit of the Texas Medicaid.

9.2.27.2.2 NCS

NCS are reimbursed by Texas Medicaid with documentation of medical necessity using the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95885 | 95886 | 95887 | 95905 | 95907 | 95908 | 95909 | 95910 | 95911 | 95912 |
| 95913 | 95933 | 95937 | | | | | | | |

NCS must be performed by one of the following:

- A physician
- A trained individual under the direct supervision of a physician. (Direct supervision means that the physician is in close physical proximity to the electrodiagnostic laboratory while testing is underway, immediately available to provide the trained individual with assistance and direction, and responsible for selecting the appropriate NCS to be performed.)

When the same studies are performed on unique sites by the same provider for the same date of service, studies for the first site must be billed without a modifier and studies for each additional site must be billed with modifier XE, XP, XS, or XU, indicating a distinct procedural service. Modifier 59 should be used when modifier XE, XP, XS, or XU is not appropriate.

Procedure codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 may be reimbursed only once when multiple sites on the same nerve are stimulated or recorded.

Prior authorization is required when the anticipated number of nerve conduction studies planned for an evaluation exceeds the following maximum number of studies:

| Procedure Code | Limitation |
|---------------------|---|
| 95885, 95886 | Reimbursed once per extremity up to 4 units, using any combination of procedure codes, per day, any provider. |
| 95885, 95886, 95887 | Must be billed with one of the primary procedure codes 95907, 95908, 95909, 95910, 95911, 95912, or 95913. |
| 95937 | Up to 3 studies per day, per procedure, same provider without prior authorization. |

Requests for prior authorization must be submitted to the Special Medical Prior Authorization department (SMPA) using the Special Medical Prior Authorization (SMPA) Request Form.

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of evoked response tests and neuromuscular procedures on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number blocks are required.*

Requests must include documentation supporting medical necessity for the number of studies requested, and they must be received on or before the requested DOS. Requests received after the services are performed will be denied for DOS that occurred before the date the request was received.

Medical record documentation must establish medical necessity for the additional studies, including one or more of the following:

- Other diagnosis in the differential that require consideration should include provider notes about both of the following:
 - The additional diagnoses considered.
 - The clinical signs, symptoms, or electrodiagnostic findings that necessitated the inclusion.
- If multiple diagnoses have been established by nerve conduction studies and the recommendations in the table above for a single diagnostic category do not apply, then the provider should document all diagnoses established as a result of EDX testing.
- Testing of an asymptomatic contralateral limb to establish normative values for an individual client (particularly the elderly, diabetic, and clients with a history of ethyl alcohol [ETOH] usage).
- Comorbid clinical conditions are identified. The clinical condition must be one that may cause sensory or motor symptoms, for example:

- Underlying metabolic disease (such as thyroid condition or diabetes mellitus)
- Nutritional deficiency (alcoholism)
- Malignant disease
- Inflammatory disorder (including but not limited to lupus, sarcoidosis or Sjögren's syndrome)

9.2.27.3 Evoked Potential Testing

Evoked potential (EP) tests are a benefit of Texas Medicaid when medically necessary. The most common EP tests are:

- Brainstem auditory evoked potentials (BAEPs)
- Motor evoked potentials (MEPs)
- Somatosensory evoked potentials (SEPs)
- Visual evoked potentials (VEPs)

Each EP test (procedure codes 92650, 92651, 92652, 92653, 95925, 95926, 95927, 95928, 95929, 95930, 95938, or 95939) is considered a bilateral procedure and is limited to once per date of service any provider regardless of modifiers that indicate multiple sites were tested.

EP tests may be reimbursed up to four services per rolling year, any combination of services by any provider. Claims that exceed the limitation of four services per rolling year may be considered for reimbursement on appeal with documentation that supports the medical necessity.

Intraoperative neurophysiology monitoring (procedure codes 95940 and 95941) is a benefit when performed in addition to each evoked potential test on the same day.

The documentation for the intraoperative neurophysiology monitoring must include the time for which each test is performed.

Procedure codes 95940 and 95941 are limited to a maximum of two hours per date of service, per client, same procedure, any provider.

Procedure codes 95940 and 95941 must be billed in conjunction with one of the following procedure codes or the service will be denied:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 92653 | 95822 | 95860 | 95861 | 95863 | 95864 | 95865 | 95866 | 95867 | 95868 |
| 95869 | 95870 | 95907 | 95908 | 95909 | 95910 | 95911 | 95912 | 95913 | 95925 |
| 95926 | 95927 | 95928 | 95929 | 95930 | 95933 | 95937 | 95938 | 95939 | |

Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

The reason for the referral, the specific nerve evoked potential being tested, and a clear diagnostic impression must be documented in the client's medical record for each EP study performed.

The client's medical records must clearly document the medical necessity for the EP testing. The medical record documentation must reflect the actual results of specific tests (such as latency and amplitude).

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
 - Diagnosis

- Current clinical signs and symptoms
- Prior clinical condition
- Expected clinical disease course
- There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review. Wave form recordings obtained during the testing will aid documentation requirements in cases where a review becomes necessary.

9.2.27.3.1 Visual Evoked Potentials

Some of the conditions under which VEP testing (procedure code 95930) may be appropriate include, but are not limited to, the following:

- Identification of persons at increased risk for developing clinically definite multiple sclerosis.
- Diagnosing, monitoring, and assessing treatment response in multiple sclerosis.
- Localizing the cause of a visual field defect not explained by lesions seen on CT or MRI, or by metabolic disorders or infectious disease.
- Evaluating the signs and symptoms of visual loss in persons who are unable to communicate (e.g., unresponsive persons, non-verbal persons).
- Evaluating clients who experience double vision, blurred vision, loss of vision, eye injuries, head injuries, or weakness of the eyes, arms, or legs.

9.2.27.4 Motion Analysis Studies

Motion analysis studies (procedure codes 96000, 96001, 96002, and 96003) are a benefit of Texas Medicaid for clients who are 3 through 20 years of age.

Procedure codes 96000, 96001, 96002, and 96003 are limited to one per date of service by the same provider and two per rolling year, any provider.

In the following table, the procedure codes in Column A will be denied when they are submitted on the same date of service by the same provider as the procedure codes in Column B:

| Column A (Denied) | Column B |
|---|----------------|
| 96000 | 96001 |
| 95860, 95861, 95863, 95864, 95865, 95866, 95869, 95870, 95872 | 96002 or 96003 |

Documentation must include the following information that indicates the client meets all the requirements for motion analysis studies. The client must be:

- Ambulatory for a minimum of ten consecutive steps, with or without assistive devices.
- At least three years of age.
- Physically able to tolerate up to three hours of testing.

The reason for the referral and a clear diagnostic impression must be documented in the client's medical record for each motion analysis study performed.

The client's medical records must clearly document the medical necessity for the motion analysis study. The medical record documentation must reflect the actual results of specific tests.

Medical necessity for re-evaluation of a client (beyond the initial consultation and testing) must be clearly documented in the client's medical record. Supporting documentation includes, but is not limited to, the following:

- The client has new symptoms unrelated to those previously evaluated, suggestive of a new diagnosis.
- Evidence exists that the client's condition is changing rapidly, supported by the following:
 - Diagnosis
 - Current clinical signs and symptoms
 - Prior clinical condition
 - Expected clinical disease course
- There is clinical benefit of additional studies.

The client's medical records are subject to retrospective review.

9.2.28 Extracorporeal Membrane Oxygenation (ECMO)

ECMO may be effective on a short-term basis for clients with life-threatening respiratory and/or cardiac insufficiency.

ECMO may be reimbursed for clients who have the following clinical indications (this is not an all-inclusive list):

- Persistent pulmonary hypertension
- Meconium aspiration syndrome
- Respiratory distress syndrome
- Adult respiratory distress syndrome
- Congenital diaphragmatic hernia
- Sepsis
- Pneumonia
- Preoperative and postoperative congenital heart disease or heart transplantation
- Reversible causes of cardiac failure
- Cardiomyopathy
- Myocarditis
- Aspiration pneumonia
- Pulmonary contusion
- Pulmonary embolism

The following procedure codes may be used when billing ECMO:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 33946 | 33947 | 33948 | 33949 | 33951 | 33952 | 33953 | 33954 | 33955 | 33956 |
| 33957 | 33958 | 33959 | 33962 | 33963 | 33964 | 33965 | 33966 | 33969 | 33984 |
| 33985 | 33986 | 33987 | 33988 | 33989 | | | | | |

Terminal disease with expectation of short survival, advanced multiple organ failure syndrome, irreversible central nervous system injury and severe immunosuppression are contraindications to ECMO. Claims for ECMO services may be recouped if the services are provided in the presence of these conditions.

The initial 24 hours of veno-venous (VV) ECMO should be submitted using procedure code 33946. Procedure code 33948 should be used for each additional 24 hours. Procedure code 33946 is denied as part of procedure code 33948 if submitted with the same date of service. Procedure codes 33946 and 33948 are limited to one per day when billed by any provider.

The initial 24 hours of veno-arterial (VA) ECMO should be submitted using procedure code 33947. Procedure code 33949 should be used for each additional 24 hours. Procedure code 33947 is denied as part of procedure code 33949 if submitted with the same date of service. Procedure codes 33947 and 33949 are limited to one per day when billed by any provider.

If insertion of VV cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33946 or 33948, the insertion of the cannula is denied, and the ECMO (procedure code 33946 or 33948) is considered for reimbursement.

If insertion of VA cannula (procedure codes 33951, 33952, 33953, 33954, 33955, and 33956) for prolonged extracorporeal circulation for cardiopulmonary insufficiency is submitted by the same provider with the same date of service as procedure code 33947 or 33949, the insertion of the cannula is denied, and the ECMO (procedure code 33947 and 33949) is considered for reimbursement.

9.2.29 Family Planning

Physicians, PAs, NPs, CNSs, and CNMs are encouraged to provide family planning services to Texas Medicaid clients, especially pregnant and postpartum clients. No separate enrollment is required. Providers are reimbursed for family planning services through Texas Medicaid (Title XIX) or through the DSHS Family Planning Program.

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

Section 2, “Healthy Texas Women (HTW) Program Overview” in the *Healthy Texas Women Program Handbook (Vol. 2, Provider Handbooks)*.

The *Health and Human Services Commission Family Planning Program Services Handbook (Vol. 2, Provider Handbooks)*.

9.2.30 Gynecological Health Services

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

Referto: Section 6, “Gynecological Health Services” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for information about contraception, sterilizations, and family planning annual examinations.

9.2.31 Hospital Visits

Referto: Subsection 9.2.56, “Physician Evaluation and Management (E/M) Services” in this handbook.

9.2.32 Hyperbaric Oxygen Therapy (HBOT)

Physicians who bill for the professional component of HBOT must use procedure code 99183. Hospital providers who bill for the chamber time must use procedure code G0277 with revenue code 413.

Note: Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, or other device, or applied topically is not considered hyperbaric treatment in itself.

Texas Medicaid recognizes the following indications for HBOT, as approved by the Undersea and Hyperbaric Medical Society (UHMS):

- Air or gas embolism
- Carbon monoxide poisoning
- Central retinal artery occlusion
- Compromised skin grafts and flaps
- Crush injuries, compartment syndrome, and other acute traumatic ischemias
- Decompression sickness
- Delayed radiation injury (soft tissue and bony necrosis)
- Diabetic foot ulcer
- Severe anemia
- Clostridial myositis and myonecrosis (gas gangrene)
- Intracranial abscess
- Necrotizing soft tissue infections
- Refractory osteomyelitis
- Acute thermal burn injuries

HBOT is not a replacement for other standard successful therapeutic measures.

Texas Medicaid considers HBOT experimental and investigational for any indications other than the ones approved by UHMS and outlined in this section. Non-covered indications include, but are not limited to, autism and traumatic brain injury.

Oxygen administered outside of a hyperbaric chamber, by any means, is not considered hyperbaric treatment.

The physician must be in constant attendance of hyperbaric oxygen therapy during compression and decompression of the chamber and may not delegate the rendering of the service. Both the facility's medical record and the client's medical record must contain documentation to support that there was a physician in attendance who provided direct supervision of the compression and decompression phases of the HBOT treatment. All documentation pertaining to HBOT is subject to retrospective review.

9.2.32.1 Prior Authorization for HBOT

HBOT procedure codes 99183 and G0277 require prior authorization. Prior authorization requests submitted for procedure code G0277 must also include revenue code 413. When requesting prior authorization, providers should use the [Special Medical Prior Authorization \(SMPA\) Request Form](#) on the TMHP website at www.tmhp.com.

Referto: "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for detailed information about prior authorization requirements.

The prior authorization request must include documentation that supports medical necessity and is specific to each appropriate covered indication as listed in the following table:

| Covered Indication | Total 30-Minute Intervals Allowed for Procedure Code G0277 | Total Professional Sessions Allowed for Procedure Code 99183 | Medical Necessity Documentation of the Following is Required |
|--|---|---|---|
| Air or gas embolism | 6 | 2 | Evidence that gas bubbles are detectable by ultrasound, Doppler or other diagnostics |
| Carbon monoxide poisoning - initial authorization | 15 | 5 | Persistent neurological dysfunction secondary to carbon monoxide inhalation |
| Carbon monoxide poisoning - one subsequent authorization | 9 | 3 | Evidence of continuing improvement in cognitive functioning |
| Central retinal artery occlusion | 36 | 6 | Evidence of central retinal artery occlusion with treatment initiated within 24 hours of the occlusion |
| Compromised skin grafts and flaps - initial authorization | 80 | 10 | Evidence the flap or graft is failing because tissue is/has been compromised by irradiation or there is decreased perfusion or hypoxia |
| Compromised skin grafts and flaps - one subsequent authorization | 40 | 5 | Evidence of stabilization of graft or flap |
| Crush injury, compartment syndrome and other acute traumatic ischemias | 36 | 12 | Adjunct to standard medical and surgical interventions |
| Decompression sickness | 28 | 1 | Diagnosis based on signs and/or symptoms of decompression sickness after a dive or altitude exposure |
| Diabetic foot ulcer - initial authorization | 60 | 30 | After at least 30 days of standard medical wound therapy, with a wound pO ₂ less than 40 mmHg AND wound classified as Wagner grade 3 or higher. * |
| Diabetic foot ulcer - two subsequent authorizations | 60 | 20 | Evidence of continuing healing and wound pO ₂ less than 40 mmHg |
| Severe anemia | 50 | 10 | Hgb less than 6.0 sustained secondary to hemorrhage, hemolysis, or aplasia, when the client is unable to be cross matched or refuses transfusion because of religious beliefs |
| Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications: Grade 1: Superficial diabetic ulcer Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis) Grade 3: Deep ulcer with abscess or osteomyelitis Grade 4: Gangrene to portion of forefoot Grade 5: Extensive gangrene of foot | | | |

| Covered Indication | Total 30-Minute Intervals Allowed for Procedure Code G0277 | Total Professional Sessions Allowed for Procedure Code 99183 | Medical Necessity Documentation of the Following is Required |
|--|--|--|---|
| Clostridial myositis and myonecrosis (gas gangrene) | 39 | 13 | Evidence of unsuccessful medical and/or surgical wound treatment and positive Gram-stained smear of the wound fluid |
| Necrotizing soft tissue infections - initial authorization | 36 | 12 | Evidence of unsatisfactory response to standard medical and surgical treatment and advancement of dying tissue |
| Necrotizing soft tissue infections - two subsequent authorizations | 15 | 5 | Evidence that advancement of dying tissue has slowed |
| Delayed radiation injury (soft tissue and bony necrosis) -initial authorization | 40 | 10 | Evidence of unsatisfactory clinical response to conventional treatment |
| Delayed radiation injury - one subsequent authorization | 40 | 10 | Evidence of improvement demonstrated by clinical response |
| Refractory osteomyelitis - initial authorization | 40 | 10 | Evidence of unsatisfactory clinical response to conventional multidisciplinary treatment |
| Refractory osteomyelitis - one subsequent authorization | 15 | 5 | Evidence of improvement demonstrated by clinical response |
| Acute thermal burn injury - initial authorization | 45 | 15 | Partial or full thickness burns covering greater than 20% of total body surface area OR with involvement of the hands, face, feet or perineum |
| Acute thermal burn injury - three subsequent authorizations | 30 | 10 | Evidence of continuing improvement demonstrated by clinical response |
| Intracranial abscess - initial authorization | 15 | 5 | Adjunct to standard medical and surgical interventions when one or more of the following conditions exist: Multiple abscesses Abscesses in a deep or dominant location Compromised host Surgery contraindicated or client is a poor surgical risk |
| Intracranial abscess - one subsequent authorization | 15 | 5 | Evidence of improvement demonstrated by clinical response and radiological findings |
| Note: The following Wagner wound classification grades apply only to the diabetic foot ulcer indications: Grade 1: Superficial diabetic ulcer Grade 2: Ulcer extension - involves ligament, tendon, joint capsule or fascia (No abscess or osteomyelitis) Grade 3: Deep ulcer with abscess or osteomyelitis Grade 4: Gangrene to portion of forefoot Grade 5: Extensive gangrene of foot | | | |

Procedure code 99183 is authorized according to the number of professional sessions (total HBOT treatments), and procedure code G0277 is authorized according to the number of 30-minute intervals of chamber time. The units in the columns for procedure codes 99183 and G0277 represent the maximum number of sessions and intervals that are allowed for that procedure code per authorization.

Limitations beyond those listed in the table above are considered experimental and investigational.

In emergency situations, the prior authorization request must be submitted no later than three business days after the date the service is rendered. Providers must not submit a claim until the prior authorization request has been approved. If the request has not been approved, the claim will be denied.

9.2.33 Ilizarov Device and Procedure

Providers must use procedure codes 20692, 20693, 20694, and 20999 when submitting claims for the Ilizarov procedure. A global fee payment methodology is applied to the Ilizarov device procedure codes. Procedure codes 20692, 20693, 20694, and 20999 include the preconstruction, surgical application, adjustments to the device for up to 6 months, and the removal of the device.

Providers who bill for other external fixator devices, such as the Monticelli device, should continue to use procedure codes 20690 or 20692, where applicable, when billing for the surgical applications.

9.2.34 Immunization Guidelines and Administration

Texas Medicaid reimburses immunizations (vaccines and toxoids) that the Advisory Committee on Immunization Practices (ACIP) recommends as routine.

Providers must follow the most current ACIP recommendations unless they conflict with guidelines from the Texas Vaccines for Children (TVFC) Program, in which case providers must follow TVFC guidelines. Providers must also provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC). VISs explain the benefits and risks of the vaccines and toxoids administered.

Note: Administered vaccines and toxoids must be reported to DSHS. After obtaining consent, DSHS submits all reported vaccines and toxoids to a centralized repository of immunization histories. This lifespan registry is known in Texas as ImmTrac2.

9.2.34.1 Administration Fee

An administration fee may be reimbursed for all covered vaccines and toxoids that are administered according to the ACIP. The following procedure codes may be reimbursed when billed for vaccine and toxoid administration:

| Procedure Code | | | | | |
|----------------|-------|-------|-------|-------|-------|
| 90460 | 90461 | 90471 | 90472 | 90473 | 90474 |

Procedure codes 90460 and 90461 are benefits for services rendered to clients who are birth through 18 years of age when counseling is provided for the immunization administered.

Procedure codes 90471, 90472, 90473, and 90474 are benefits when counseling is not provided for the immunization administered. Procedure codes 90471 and 90472 may be reimbursed for services rendered to clients of any age. Procedure codes 90473 and 90474 are restricted to clients who are 20 years of age and younger.

The administration fee may be reimbursed when the procedure code for the vaccine or toxoid administered (regardless of the source of the vaccine or toxoid) and the administration fee procedure code are billed on the same claim with the same date of service. Only one administration fee may be reimbursed to any provider for each vaccine or toxoid administered per day.

The following vaccines and toxoids procedure codes are a benefit of Texas Medicaid for clients based on the number of recognized components as follows:

| Procedure Code | Number of Recognized Components** | Procedure Code | Number of Recognized Components** |
|----------------|-----------------------------------|----------------|-----------------------------------|
| 90620* | 1 | 90621* | 1 |
| 90630 | 1 | 90632 | 1 |
| 90633* | 1 | 90636 | 2 |
| 90644 | 2 | 90647* | 1 |
| 90648* | 1 | 90651* | 1 |
| 90654 | 1 | 90655* | 1 |
| 90656* | 1 | 90657* | 1 |
| 90658* | 1 | 90660* | 1 |
| 90661 | 1 | 90670* | 1 |
| 90672* | 1 | 90673 | 1 |
| 90674 | 1 | 90680* | 1 |
| 90681* | 1 | 90682 | 1 |
| 90685* | 1 | 90686* | 1 |
| 90687* | 1 | 90688* | 1 |
| 90696* | 4 | 90698* | 5 |
| 90700* | 3 | 90702* | 2 |
| 90707* | 3 | 90710* | 4 |
| 90713* | 1 | 90714* | 2 |
| 90715* | 3 | 90716* | 1 |
| 90723* | 5 | 90732* | 1 |
| 90733 | 1 | 90734* | 1 |
| 90743 | 1 | 90744* | 1 |
| 90746 | 1 | 90748* | 2 |
| 90749 | 1 | 90756* | 1 |
| 90758 | 2 | | |

* TVFC-distributed vaccine/toxoid

** The number of components applies if counseling is provided and procedure codes 90460 and 90461 are submitted.

Each vaccine or toxoid and its administration must be submitted on the claim in the following sequence: the vaccine procedure code immediately followed by the applicable immunization administration procedure code(s). All of the immunization administration procedure codes that correspond to a single vaccine or toxoid procedure code must be submitted on the same claim as the vaccine or toxoid procedure code.

Each vaccine or toxoid procedure code must be submitted with the appropriate “administration with counseling” procedure code(s) (procedure codes 90460 and 90461) or the most appropriate “administration without counseling” procedure code (procedure code 90471, 90472, 90473, or 90474). If an “administration with counseling” procedure code is submitted with an “administration without counseling” procedure code for the same vaccine or toxoid, the second administration of the vaccine or toxoid will be denied.

Administration with Counseling

Providers must submit claims for immunization administration procedure codes 90460 or 90461 based on the number of components per vaccine. Providers must specify the number of components per vaccine by billing 90460 and 90461 as defined by the procedure code descriptions:

- Procedure code 90460 is submitted for the administration of the first component.
- Procedure code 90461 is submitted for the administration of each additional component identified in the vaccine.

Procedure code 90461 will be denied if procedure code 90460 has not been submitted on the same claim for the same vaccine or toxoid.

The necessary counseling that is conducted by a physician or other qualified health-care professional must be documented in the client's medical record.

The following is an example of how to submit claims for immunization administration procedure codes when counseling is provided:

| Procedure Code | Quantity Billed |
|--|-----------------|
| Vaccine or toxoid procedure code with 1 component | 1 |
| 90460 (1st component) | 1 |
| Vaccine or toxoid procedure code with 3 components | 1 |
| 90460 (1st component) | 1 |
| 90461 (2nd and 3rd components) | 2 |

Note: The term “components” refers to the number of antigens that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.

Administration without Counseling

Procedure codes 90471, 90472, 90473, and 90474 may be reimbursed per vaccine based on the route of administration.

The following is an example of how to submit claims for injection administration procedure codes when counseling is not provided:

| Procedure Code | Quantity Billed |
|----------------------------------|-----------------|
| Vaccine or toxoid procedure code | 1 |
| 90471 (Injection administration) | 1 |
| Vaccine or toxoid procedure code | 1 |
| 90472 (Injection administration) | 1 |
| Vaccine or toxoid procedure code | 1 |
| 90472 (Injection administration) | 1 |

9.2.34.2 Documentation

Providers must document the following information in the client's medical record, which is subject to retrospective review to determine appropriate utilization and reimbursement of this service:

- The vaccine or toxoid given
- The date of the vaccine or toxoid administration (day, month, year)
- The name of the vaccine or toxoid manufacturer and the vaccine or toxoid lot number

- The signature and title of the person administering the vaccine or toxoid
- The organization's name and address
- The publication date of the VIS issued to the client, parent, or guardian
- The site at which the vaccine was given (recommended)

9.2.34.3 Vaccine Adverse Event Reporting System (VAERS)

VAERS encourages providers to report any adverse event that occurs after the administration of any vaccine in the United States, even if it's unclear whether a vaccine caused it. The *National Childhood Vaccine Injury Act* (NCVIA) requires health-care providers to report:

- Any adverse event listed by the vaccine manufacturer as a contraindication to subsequent doses of the vaccine.
- Any reaction listed in the VAERS Reportable Events Table that occurs within the specified time period after vaccination.

Clinically significant adverse events should be reported even if it is unclear whether a vaccine caused the event.

Documentation of the injection site is recommended but not required.

A copy of the Reportable Events Table can be obtained by calling VAERS at 1-800-822-7967 or by downloading it from vaers.hhs.gov/docs/VAERS_Table_of_Reportable_Events_Following_Vaccination.pdf.

9.2.35 Immunizations for Clients Birth through 20 Years of Age

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of THSteps when provided as part of a THSteps medical checkup. A THSteps provider who bills vaccines and toxoids with diagnosis or age restrictions is subject to those restrictions. In addition to the age appropriate diagnosis for the THSteps preventive care medical checkup, providers must bill the claim with the diagnosis code that indicates the condition that necessitates the vaccine or toxoid.

If an immunization is administered as part of the preventive care medical checkup, diagnosis code Z23 may also be included on the claim, in addition to the age-appropriate diagnosis.

If an immunization is the only service provided during an office visit, providers may submit only diagnosis code Z23 on the claim.

Administration of vaccines and toxoids to clients who are birth through 20 years of age may be a benefit of CCP when the vaccine or toxoid is provided as part of an acute medical visit outside of a THSteps medical checkup.

Referto: Section 4, "THSteps Medical" in the *Children's Services Handbook* (Vol. 2, *Provider Handbooks*) for more information on THSteps age related diagnosis codes.

9.2.35.1 Vaccine Coverage Through the TVFC Program

Providers may refer to the TVFC web site at www.dshs.texas.gov/immunize/tvfc/default.shtm for information about the program and for a list of vaccines available through the program.

Note: *All vaccines and toxoids recommended by Advisory Committee on Immunization Practices (ACIP) are available from the TVFC Program to enrolled clinic sites. Clinics participating in the TVFC Program have agreed to administer all ACIP-recommended vaccines to the eligible populations that are served.*

When a single antigen vaccine or toxoid or a comparable antigen vaccine or toxoid is available through TVFC, but the provider chooses to use a different ACIP-recommended product, the administration fee will be reimbursed but the vaccine or toxoid will not be reimbursed.

Although Texas Medicaid does not mandate that providers enroll in TVFC, Texas Medicaid will not reimburse providers when the vaccine is available through TVFC. Only the administration fee will be reimbursed through Texas Medicaid when the vaccine or toxoid procedure code is identified on the claim. Clients may not be billed for vaccines and toxoids that are available through TVFC.

If a vaccine or toxoid meets the definition of “not available” through TVFC, it may be separately reimbursed through CCP when billed with modifier U1. Modifier U1 may be used in the following situations:

- The TVFC, based on their federal resolution (distribution/guidelines), does not distribute an HHSC-approved vaccine or toxoid following the ACIP recommendation, and the provider purchases vaccine to administer to all ACIP-recommended ages or risk groups.
- A new vaccine or toxoid approved by the ACIP with established guidelines, but has not been negotiated or added to a TVFC contract
- Funding for new vaccine or toxoid has not been established by TVFC
- Insufficient vaccine and toxoid supply due to national supply or distribution issues, as reported to HHSC by TVFC

HHSC will notify providers if a vaccine or toxoid meets the definition of “not available” from TVFC and when the provider’s privately purchased vaccine or toxoid may be billed with modifier U1. Modifier U1 must not be used due to a provider’s failure to enroll in TVFC or to maintain sufficient TVFC vaccine or toxoid inventory.

Referto: Subsection 4.1.3, “Texas Vaccines for Children (TVFC) Program” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for additional information about TVFC and immunizations for infants and children.

9.2.35.2 Vaccine and Toxoid Procedure Codes

The following vaccine and toxoid procedure codes may be reimbursed for Texas Medicaid clients who are birth through 20 years of age:

| Procedure Codes | | | | |
|---|-------|--------|-------|--------|
| Bacillus Calmette-Guérin (BCG) | | | | |
| Refer to: Subsection 9.2.9, “Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer” in this handbook. | | | | |
| Ebola Virus | | | | |
| 90758 | | | | |
| Procedure code 90758 is limited to clients who are 18 years of age and older. | | | | |
| Hepatitis A and B | | | | |
| 90630 | 90632 | 90633* | 90636 | 90723* |
| 90740 | 90743 | 90744* | 90746 | 90747 |
| 90748* | | | | |
| Providers must document in the client’s medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. | | | | |
| Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747. | | | | |
| Providers are expected to follow the ACIP recommendations for administration. | | | | |
| * Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational. | | | | |

| Procedure Codes | | | | |
|---|--------|--------|--------|--------|
| Hepatitis B Immune Globulin | | | | |
| 90371 | 96372 | 96374 | J1571 | J1573 |
| Providers must document in the client’s medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. | | | | |
| Intramuscular hepatitis B immune globulin (HBIG) may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIG is not provided through TVFC. | | | | |
| Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205, Z206, or Z20828. | | | | |
| Only one HBIG procedure code will be paid if billed with the same date of service by any provider as any other HBIG procedure code. | | | | |
| Procedure codes 96372 and 96374 may be reimbursed for HBIG administration. Providers are expected to follow the ACIP recommendations for administrations. | | | | |
| Hib | | | | |
| 90647* | 90648* | | | |
| Human Papilloma (HPV) | | | | |
| 90651* | | | | |
| Influenza | | | | |
| 90654 | 90655* | 90656* | 90657* | 90658* |
| 90660* | 90661 | 90672* | 90673 | 90674 |
| 90682 | 90685* | 90686* | 90687* | 90688* |
| 90756* | | | | |
| Influenza vaccine is a benefit of Texas Medicaid for high-risk clients who are not covered by THSteps or TVFC or when the vaccine is not declared available through the TVFC. | | | | |
| Texas Medicaid considers the influenza season in the United States to be October through the end of May. | | | | |
| Procedure codes 90655, 90657, 90685, and 90687 are limited to clients who are 6 through 35 months of age. | | | | |
| Procedure codes 90656 and 90658 are limited to clients who are 3 years of age and older. | | | | |
| Procedure codes 90686 and 90688 are limited to clients who are 6 months of age and older. | | | | |
| Procedure code 90682 is limited to clients who are 18 years of age and older. | | | | |
| Procedure code 90756 is limited to clients who are 4 years of age and older. | | | | |
| Measles, Mumps, Rubella Vaccine (MMR) | | | | |
| 90707* | | | | |
| Measles, Mumps, Rubella, and Varicella Vaccine (MMRV) | | | | |
| 90710* | | | | |
| Pneumococcal and Meningococcal | | | | |
| 90620* | 90621* | 90644 | 90670* | 90732* |
| 90733 | 90734* | | | |
| * Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational. | | | | |

| Procedure Codes | | | | |
|--|--------|--------|--------|--------|
| The pneumococcal polysaccharide vaccine (procedure code 90732) is a benefit for Texas Medicaid clients who are not covered by the THSteps or TVFC programs | | | | |
| The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. For high-risk clients, revaccination is recommended once in a lifetime five years after the initial dose. Revaccination after a second dose is not a benefit of Texas Medicaid. | | | | |
| Pneumococcal polysaccharide vaccine is not recommended for children who are birth through 23 months of age. | | | | |
| Providers are expected to follow the ACIP recommendations for administrations. | | | | |
| Poliovirus (IPV) | | | | |
| 90713* | | | | |
| Rotavirus | | | | |
| 90680* | 90681* | | | |
| Tetanus and Diphtheria | | | | |
| 90696* | 90698* | 90700* | 90702* | 90714* |
| 90715* | 90723* | | | |
| Unlisted | | | | |
| 90749 | | | | |
| Varicella Virus | | | | |
| 90716* | | | | |
| * Indicates a vaccine or toxoid distributed through TVFC. Vaccines and toxoids available through TVFC for clients who are birth through 18 years of age will not be reimbursed through Texas Medicaid. These vaccines and toxoids will be processed as informational. | | | | |

9.2.36 Immunizations for Clients Who Are 21 Years of Age and Older

Vaccines and toxoids may be reimbursed through Texas Medicaid at a fee determined by HHSC when the vaccine is medically necessary. Providers are expected to follow the ACIP recommendations for administration.

The following immunizations are identified and recommended by the ACIP for clients who are 21 years of age and older (this list is not all-inclusive):

| Immunization Procedure Codes | | | |
|---|-------|-------|-------|
| BCG | | | |
| Refer to: Subsection 9.2.9, “Bacillus Calmette-Guérin (BCG) Intravesical for Treatment of Bladder Cancer” in this handbook. | | | |
| Ebola Virus | | | |
| 90758 | | | |
| Procedure code 90758 is limited to clients who are 18 years of age and older. | | | |
| Hepatitis A and B | | | |
| 90632 | 90740 | 90746 | 90747 |
| Providers must document in the client’s medical record the indication for the hepatitis B vaccine, for dialysis patients. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. | | | |
| Procedure codes 96372 and 96374 may be reimbursed for the administration of hepatitis B vaccine procedure codes 90740 and 90747. | | | |

| Immunization Procedure Codes | | | | |
|--|-------|-------|-------|-------|
| Hepatitis B Immune Globulin | | | | |
| 90371 | 96372 | 96374 | J1571 | J1573 |
| Providers must document in the client's medical record the indication for the immunoglobulin. These records are subject to retrospective review to determine appropriate utilization of and reimbursement for this service. | | | | |
| Intramuscular HBIG may be reimbursed when medically necessary to provide coverage for acute exposure to the hepatitis B virus. HBIG is not provided through TVFC. | | | | |
| Procedure codes 90371, J1571, and J1573 must be billed with diagnosis code Z205, Z206, or Z20828. | | | | |
| Only one HBIG procedure code will be paid if billed with the same date of service by any provider as any other HBIG procedure code. | | | | |
| Procedure codes 96372 and 96374 may be reimbursed for HBIG administration. | | | | |
| Hepatitis A and B | | | | |
| 90636 | | | | |
| Human Papilloma (HPV) | | | | |
| 90651 | | | | |
| Influenza | | | | |
| 90630 | 90654 | 90656 | 90658 | 90661 |
| 90662 | 90673 | 90674 | 90682 | 90686 |
| 90688 | 90756 | | | |
| Influenza vaccine is a benefit of Texas Medicaid for all clients. | | | | |
| Texas Medicaid considers the influenza season in the United States to be October through the end of May. The optimal time to receive influenza vaccine is as early in the season as it is available. However, clients should continue to receive influenza vaccine through March. The vaccine may be administered one time per influenza season. | | | | |
| Procedure code 90682 is limited to clients who are 18 years of age and older. | | | | |
| MMR | | | | |
| 90707 | | | | |
| Pneumococcal and Meningococcal | | | | |
| 90620 | 90621 | 90670 | 90732 | |
| The initial pneumococcal polysaccharide vaccine is limited to one per client per lifetime. Revaccination is recommended five years (not interpreted to mean every five years) after the initial dose for high-risk individuals. | | | | |
| Revaccination after a second dose is not reimbursed. | | | | |
| Shingles | | | | |
| 90736 | 90750 | | | |
| Procedure code 90736 is limited to clients who are 60 years of age and older. Procedure code 90750 is limited to clients who are 50 years of age and older. | | | | |
| Tetanus | | | | |
| 90714 | | | | |
| Tetanus, Diphtheria, and Acellular Pertussis Vaccine (Tdap) | | | | |
| 90715 | | | | |

The specific diagnosis necessitating the vaccine or toxoid is required when billing the administration fee procedure code in combination with the appropriate vaccine procedure code. Diagnosis code Z23 may also be included. The type of immunization given will be identified by the procedure code.

9.2.37 Postexposure Prophylaxis for Rabies

Postexposure prophylaxis for rabies procedure codes 90375, 90376, 90377, and 90675 is a benefit of Texas Medicaid. Rabies vaccine for pre-exposure procedure code 90676 is not a benefit of Texas Medicaid.

Postexposure rabies vaccine is limited to clients with diagnosis code Z203.

Animal bites to people must be reported as soon as possible to the Local Rabies Control Authority (LRCA).

Postexposure prophylaxis for rabies is not necessary following exposure to an animal that tests negative for the rabies virus.

An exposed person who has never received a complete pre- or postexposure rabies vaccine series will first receive a dose of rabies immune globulin (HRIG). This is a blood product that contains antibodies against rabies and gives immediate, short-term protection. The injection should be given in or near the wound area.

HRIG that is not administered when vaccination begins can be administered up to seven days after the administration of the first dose of vaccine. Beyond the seventh day, HRIG is not recommended since an antibody response to the vaccine is presumed to have occurred, and HRIG may inhibit the immune response to the vaccine.

The recommended dose of HRIG is 20 IU/kg body weight. This formula is applicable to all age groups, including children.

The postexposure treatment will also include five doses of rabies vaccine (1.0 ml. intramuscular). The first dose should be given as soon as possible after the exposure (day 0). Additional doses should be given on days 3, 7, 14, and 28 after the first shot. For an exposed person who has previously been vaccinated with a complete pre- or postexposure vaccine series, two doses of rabies vaccine should be given on days 0 and 3.

Health care providers, who determine their client requires the preventative rabies vaccination series after valid rabies exposure, may obtain the biologicals directly from the manufacturer or through one of the DSHS depots around the state.

Injection administration is a benefit for administration of rabies vaccine for post exposure.

9.2.37.1 Prior Authorization for Postexposure Rabies Vaccine

Prior authorization is not required for postexposure rabies vaccine. The physician must maintain documentation of the exposure in the client's medical record.

9.2.37.2 Limitations for Postexposure Rabies Vaccine

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

Reimbursement for postexposure rabies vaccine is limited to 5 occurrences per 90 rolling days. Claims billed for any vaccine given beyond 90 rolling days will be denied.

9.2.37.2.1 Obtaining Rabies Vaccine and HRIG from DSHS for PEP Use

Providers may obtain the vaccine and HRIG directly from the manufacturer. If a provider is not able to obtain the vaccine and/or HRIG directly, providers may contact DSHS local or state public health professionals.

For each potential rabies exposure, providers must consult with their local health department or the DSHS regional ZC program office that serves their area. Requests for consultations made to DSHS after-hours or on holidays should be directed to the DSHS On-Call Physician at 1-888-963-7111.

Local public health professionals or regional ZC staff will help providers determine whether or not the exposure situation warrants PEP. If the exposure situation is determined to be valid, providers will be given detailed information about how to obtain rabies vaccine and HRIG for the patient.

Providers can refer to the following DSHS web pages for the contact information of local public health professionals:

- Full Service Local Health Departments and Districts of Texas at www.dshs.texas.gov/regions/lhds.shtm
- Zoonosis Control Branch at www.dshs.texas.gov/idcu/health/zoonosis/contact/
- Use of a Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies, Recommendations of the Advisory Committee on Immunization Practices March 19, 2010 www.cdc.gov/mmwr/pdf/rr/rr5902.pdf
- DSHS rabies website at www.dshs.texas.gov/idcu/disease/Rabies/
- Regional DSHS ZC offices
- “Human Rabies Prevention—United States, 2008 Recommendations of the Advisory Committee on Immunization Practices”
- CDC rabies website at www.cdc.gov/rabies/

9.2.38 Implantable Infusion Pumps

Implantable infusion pump (IIPs) are intended to provide long-term, continuous, or intermittent drug infusion. They may be medically necessary in the following circumstances:

- Administration of intrathecal or epidural antispasmodic drugs to treat refractory intractable spasticity
- Administration of Intrathecal, epidural, or central venous analgesic (opioid or non-opioid) drugs for treatment of severe chronic intractable pain
- Administration of intrahepatic chemotherapy for primary liver cancer or metastatic cancer with metastases limited to the liver
- Administration of intra-arterial chemotherapy in head and neck cancers

An implantable infusion pump is not a benefit for the following uses:

- Continuous insulin infusion for diabetes
- Continuous heparin infusion for recurrent thromboembolic disease
- Continuous intralesional infusion for severe chronic intractable pain
- Continuous intra-arterial infusion
- Continuous intra-articular infusion for severe chronic intractable pain
- Administration of antibiotics for osteomyelitis

All supplies associated with an IIP are included with the reimbursement for the surgery to implant the infusion pump and are not reimbursed separately.

Providers may be reimbursed for implantable infusion pumps using procedure codes E0782, E0783, and E0786. If procedure codes E0782 and E0783 are billed with the same date of service, only one may be reimbursed.

9.2.38.0.1 Prior Authorization for Implantable Infusion Pumps

Implantable infusion pumps (procedure codes E0782, E0783, and E0786) require prior authorization.

Prior authorization is not required for the physician services associated with the insertion, revision, removal, refilling, or maintenance of the IIP.

Providers must request prior authorization through the Special Medical Prior Authorization (SMPA) department. The ASC or DME provider may submit a request for prior authorization using the Special Medical Prior Authorization (SMPA) Form, which must be completed and signed by a physician.

The completed, signed and dated SMPA form must be maintained by the provider and the prescribing physician in the client's medical record.

The completed SMPA Form must include the procedure code and quantity for the services that are requested. Documentation that is submitted with the prior authorization request must indicate whether the IIP will be provided by the ASC or the DME provider.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the requested IIP. The requesting provider may be asked for additional information to clarify or complete a request for the IIP.

Documentation submitted with the prior authorization request must indicate the client or caregiver has:

- The ability to provide a return demonstration performance.
- The attention, desire, interest, flexibility, and independence.
- An understanding of cause and effect and object permanence.

As indicated in the following sections, supporting documentation that is based on the type of IIP requested must be included with the request for prior authorization. All of the documentation listed under the specific type of IIP must be included with the request for prior authorization.

9.2.38.0.2 IIP for Administration of Anti-spasmodic Drug to Treat Severe Refractory Spasticity

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
- Degree of spasticity
- Affected muscle groups
- Functional impact
- Duration of symptoms
- Any recent hospitalizations (within past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- Treatment history of self-administration with evidence of:
- A minimum of six weeks of non-invasive methods of spasticity control, including, but not limited to, oral antispasmodics, that either:
- Failed to adequately control the spasticity, or
- Produced intolerable side effects
- The role, participation, and compliance of the family or client that demonstrate the following:
- The ability to provide a return demonstration performance

- Attentiveness, desire, interest, flexibility, and independence
- An understanding of cause and effect and object permanence
- Favorable response to a trial intrathecal dose of the antispasmodic
- No contraindications to implantation exist, including, but not limited to, the following:
 - Coagulopathy
 - Infection
- Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
- Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
 - Antispasmodic to be infused
 - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
 - Expected outcome
 - Treatment goals

9.2.38.1 IIP for Administration of Analgesic (Opioid or Nonopioid) Drug for Treatment of Severe Intractable Pain

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Symptoms:
- Severity of pain
- Functional impact
- Source of pain or location, including whether pain is malignant or non-malignant
- Duration of symptoms
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- A life expectancy of at least three months

Note: *The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*

For malignant pain, the following documentation is required for prior authorization:

- Treatment history with evidence of a favorable response to a trial intrathecal dose of the analgesic drug, defined as a minimum of 50 percent reduction in pain
- Failure of more conservative methods of pain control, including, but not limited to, oral analgesics, surgery, or therapy, that were ineffective due to one of the following:
- Failed to adequately control the pain, or

- Produced intolerable side effects

Note: *The standard of care for treatment of severe intractable pain for a client with a life expectancy of less than three months is to use less invasive techniques such as an external infusion pump.*

For nonmalignant pain, the following documentation is required for prior authorization:

- A minimum of six months of more conservative methods of pain control, including but not limited to oral analgesics, surgery, attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated pain reaction, that were ineffective due to one of the following:
 - Failed to adequately control the pain, or
 - Produced intolerable side effects

Examples of non-malignant severe intractable pain include, but are not limited to, the following:

- Complex regional pain syndrome I & II (causalgia/RSD) refractory to other treatments.
- Post herpetic neuralgia
- Failed back syndrome
- Phantom limb pain
- Arachnoiditis (proven with MRI/increased CSF protein levels)
- Spinal cord myelopathy (refractory to conservative measurements)
- The role, participation, and compliance of the family or client that demonstrate the following:
 - The ability to provide a return demonstration performance
 - Attentiveness, desire, interest, flexibility, and independence
 - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
 - Coagulopathy
 - Infection
- Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
- Tumor encroachment on the thecal sac
- Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
 - Analgesic to be infused
 - Follow-up including pump refilling, maintenance, and monitoring of changes in infusion rate
 - Expected outcome
 - Treatment goals

9.2.38.2 IIP for Administration of Intrahepatic Chemotherapy in Primary Liver Cancer or Colorectal Cancer with Liver Metastases

The following documentation is required for prior authorization:

- The initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis of one of the following:

- Primary liver cancer
- Metastatic cancer with metastases limited to the liver
- Any recent hospitalizations (within the past 12 months)
- Comorbid conditions
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family and/or client demonstrating:
 - The ability to provide a return demonstration performance
 - Attentiveness, desire, interest, flexibility, and independence
 - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
 - Coagulopathy
 - Infection
 - Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
 - Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
 - Chemotherapeutic agent to be infused. The prescribed drug must be approved by the U.S. Food and Drug Administration (FDA) for the intended use and must be compatible with the implantable device (such as floxuridine or methotrexate)
 - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
 - Expected outcome
 - Treatment goals

9.2.38.3 IIP for Administration of Intra-Arterial Chemotherapy in Head and Neck Cancers

The following documentation is required for prior authorization:

- Initial evaluation
- Type of surgical implantation and description of IIP requested
- Diagnosis and site(s) of any metastases
- Any hospitalizations (within the past 12 months) and all other diagnoses
- All pertinent laboratory and radiology results
- The role, participation, and compliance of the family or client that demonstrates the following:
 - The ability to provide a return demonstrate performance
 - Attentiveness, desire, interest, flexibility, and independence
 - An understanding of cause and effect and object permanence
- No contraindications to implantation exist, including, but not limited to, the following:
 - Coagulopathy
 - Infection

- Other implanted devices where the “crosstalk” between devices may inadvertently change the prescription
- Allergy or hypersensitivity to the drug being administered
- Treatment plan, including the following:
 - Chemotherapeutic agent to be infused
 - Follow-up, including pump refilling, maintenance, and monitoring of changes in infusion rate
 - Expected outcome
 - Treatment goals

9.2.38.4 Replacement of an IIP

An IIP is expected to last a minimum of five years. Prior authorization for replacement of an IIP is considered within five years when one of the following occurs:

- There has been a significant change in the client’s condition and the current equipment no longer meets the client’s needs.
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.
- Loss or irreparable damage to the IIP has occurred. The following must be submitted with the prior authorization request:
 - A copy of the police or fire report, when appropriate
 - A statement about the measures to be taken in order to prevent reoccurrence

Replacement of an IIP for a client who is birth through 20 years of age that does not meet the criteria above may be considered for prior authorization through CCP.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver.

The DME provider must maintain the signed and dated form in the client’s medical record.

Referto: Subsection 2.7.3.5, “DME Certification and Receipt Form” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for more information about this form.

9.2.38.5 Implantation of Catheters, Reservoirs, and Pumps

The following procedure codes may be used to bill the implantation of catheters and infusion pumps or devices for long term medication administration:

| Procedure Codes | | | | |
|-----------------|-------|-------|-------|-------|
| 62350 | 62351 | 62360 | 62361 | 62362 |

Procedure code 62350 or 62351 may be reimbursed when billed for the same date of service as procedure code 62360, 62361, or 62362.

Procedure codes 62355 and 62365 do not require prior authorization.

The following procedure codes are denied as included in the total anesthesia time when billed with the same date of service as an anesthesia procedure by the same physician:

| Procedure Codes | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|
| 62350 | 62351 | 62355 | 62360 | 62361 | 62362 | 62365 |

These procedure codes are considered for reimbursement according to multiple surgery guidelines when billed with the same date of service as another surgical procedure performed by the same physician.

Procedure codes 95990, 96521, and 96522 are considered for reimbursement when used for refilling an implantable pump.

Procedure codes 62367, 62368, 62369, and 62370 may be used to bill for electronic analysis of an implantable infusion pump.

Procedure codes 62369 and 62370 will be denied when billed for the same date of service by the same provider as procedure code 62362.

The following procedure codes may be used to bill the insertion, revision, removal, or repair associated with implantable infusion pumps:

| Procedure Codes | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|
| 36260 | 36261 | 36262 | 36563 | 36576 | 62355 | 62365 |

9.2.38.6 Drug Monitoring Services

Providers must use the most appropriate procedure codes when submitting claims for drug monitoring services that monitor prescribed medications that can be abused when used for the treatment of chronic pain. These claims are subject to retrospective review. Claims may be reprocessed and recouped if they are submitted for these drug monitoring services in the office setting using a procedure code for a quantitative test rather than a qualitative or semiquantitative test.

An enzyme immunoassay (EIA) device can be used to provide preliminary qualitative or semiquantitative test results for point-of-care monitoring purposes. EIA devices and the reagents used to perform in-office drug testing are cleared by the FDA only to obtain qualitative or semiquantitative initial screen or preliminary results.

Immunoassay and enzyme assay are tests that produce qualitative and semiquantitative results, so these tests must not be reported with procedure codes for quantitative tests. A qualitative or semiquantitative test is not a quantitative test and must not be billed as such.

The initial drug screen or preliminary result testing yields qualitative and semiquantitative results, which must be reported with an appropriate drug testing procedure code, as categorized in the CPT manual as “Drug Testing.” Only those procedure codes that are a benefit of Texas Medicaid may be reimbursed.

CPT-categorized “Chemistry” and “Therapeutic Drug Assay” procedure codes are for quantitative tests and must not be reported for an initial screen or preliminary result that was performed in the point-of-care setting.

Referto: The CPT manual for drug testing, chemistry, and therapeutic drug assay procedure codes, and to the Texas Medicaid fee schedule for procedure codes that may be reimbursed by Texas Medicaid.

Using procedure codes for quantitative tests to report preliminary qualitative or semiquantitative test results is considered systematic upcoding and may lead to administrative sanctions, civil monetary penalties, and criminal prosecution.

Providers may refer to the CMS website for more information about laboratory tests that may be rendered in the office setting. For tests that require a CLIA certificate of waiver, CMS publishes a list of all waived tests. The list is updated quarterly and includes the procedure code to use when billing a test.

9.2.39 Laboratory Services

Texas Medicaid benefits are provided for professional and technical services ordered by a physician and provided under the supervision of a physician in a setting other than a hospital (inpatient or outpatient). All laboratory services must be documented in the client's medical record as medically necessary and referenced to an appropriate diagnosis. Texas Medicaid does not reimburse baseline or screening laboratory studies.

Providers may bill only for laboratory tests that are actually provided in their office. Any test sent to an outside laboratory must not be billed on the provider's claim. Laboratories bill Texas Medicaid directly for the tests they perform.

Unless otherwise noted, interpretation of laboratory tests is considered part of the provider's professional services (hospital, office, or emergency room visits) and must not be billed separately. Modifier Q4 is required for laboratory, radiology, and ultrasound interpretations by any provider other than the attending physician.

Laboratory tests that are generally considered part of a laboratory panel (e.g., chemistries, CBCs, urinalyses [UAs]) and that are performed on the same day must be billed as a panel regardless of the method used to perform the tests (automated or manual).

Physician interpretations that are requested of a consulting pathologist and require professional reading and reporting of results may be billed to Texas Medicaid separately as a professional charge.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA cannot be reimbursed for laboratory services.

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.

Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling" in the *Radiology and Laboratory Services Handbook* (Vol. 2, *Provider Handbooks*) for claims processing instructions.

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (Vol. 2, *Provider Handbooks*).

Subsection 3.4.2, "Reimbursement" in the *Radiology and Laboratory Services Handbook* (Vol. 2, *Provider Handbooks*) for claims processing instructions.

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.

9.2.39.1 THSteps Laboratory Services

Referto: Subsection 4.3.11.6, "Laboratory Test" in the *Children's Services Handbook* (Vol. 2, *Provider Handbooks*).

9.2.39.2 Laboratory Handling Charge

The laboratory handling charge covers the expense of obtaining and packaging the specimen and sending it to a reference laboratory.

A laboratory handling charge (procedure code 99000) may be billed if the specimen is obtained by venipuncture or catheterization and sent to an outside lab. The reference laboratory name and address or provider identifier must be listed in Block 32 of the CMS-1500 claim form, and Block 20 must be completed.

The provider is required to forward the client's name, address, Medicaid ID number, and diagnosis, if appropriate, with the specimen to the reference laboratory so the laboratory may bill Texas Medicaid for its services.

A provider may bill only one laboratory handling charge per client visit unless the specimen is divided and sent to different laboratories or different specimens are collected and sent to different labs. The claim must indicate the name and/or address of each laboratory to which a specimen is sent for more than one laboratory handling fee to be paid. This laboratory handling benefit does not apply to THSteps medical checkup providers who must submit specimens to the DSHS Laboratory.

9.2.39.3 Blood Counts

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

Referto: Subsection 2.2.7, "Complete Blood Count (CBC)" in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for more information about blood counts.

9.2.39.4 Clinical Lab Panel Implementation

Referto: Subsection 2.2.5, "Automated Laboratory Tests and Laboratory Paneling" in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for more information about laboratory panels.

9.2.39.5 Clinical Pathology Consultations

Clinical pathology consultations (procedure code 80500 or 80502) are a benefit of Texas Medicaid for services rendered by a consultant who is either a clinical pathologist or a geneticist. In a clinical pathology consultation, the consultant may also help the ordering physician determine whether further study is appropriate, based on test results.

Providers may be reimbursed for clinical pathology consultations when the claim indicates the following information:

- The name and address or provider identifier of the physician who requested the consultation.
- A written narrative report describing the findings of the consultation, which will also be included in the client's medical record.

Note: *To submit claims for interpretation, the provider must document an interaction that clearly shows that the consultant interpreted the test results and made specific recommendations to the attending physicians.*

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

Note: *Geneticists who provide a pathology consultation must submit claims using their acute care provider identifier.*

Routine conversations held between a consultant and attending physicians about test orders or results are not consultations. Information that can be furnished by a non-physician laboratory specialist does not qualify as a consultation service.

9.2.39.6 * Cytogenetics Testing

Cytogenetics testing is a group of laboratory tests involving the study of chromosomes.

Clinical evidence supports the significance of cytogenetics evaluation in the diagnosis, prognosis, and treatment of acute leukemias and lymphomas, especially in children. The detection of the well-defined recurring genetic abnormalities often enables a correct diagnosis with important prognostic information that affects the treatment protocol.

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

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|---------|---------|---------|---------|---------|---------|---------|
| C8280 | C8281 | C8282 | C8283 | C8284 | C8285 | C8286 | C8287 |
| C8288 | C8289 | C8291 | C8292 | C8293 | C8294 | C8295 | C8296 |
| C8297 | C8298 | C8299 | C8310 | C8311 | C8312 | C8313 | C8314 |
| C8315 | C8316 | C8317 | C8318 | C8319 | C8380 | C8381 | C8382 |
| C8383 | C8384 | C8385 | C8386 | C8387 | C8388 | C8389 | C8440 |
| C8441 | C8442 | C8443 | C8444 | C8445 | C8446 | C8447 | C8448 |
| C8449 | C8461 | C8462 | C8463 | C8464 | C8465 | C8466 | C8467 |
| C8468 | C8469 | C8471 | C8472 | C8473 | C8474 | C8475 | C8476 |
| C8477 | C8478 | C8479 | C847A | C8581 | C8582 | C8584 | C8585 |
| C8586 | C8587 | C8588 | C8589 | C884 | C888 | 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 | E343 | E83110 | E8359 | 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 | M2600 | M2601 | M2602 | M2603 | M2604 | M2605 | M2606 |
| M2607 | M2609 | N4601 | N4611 | N6482 | N910 | N911 | N913 |
| N914 | N949 | N970 | N978 | O010 | O011 | O019 | O021 |
| O0289 | O09511 | O09512 | O09513 | O09521 | O09522 | O09523 | O350XX0 |
| O350XX1 | O350XX2 | O350XX3 | O350XX4 | O350XX5 | O350XX9 | O351XX0 | O351XX1 |
| O351XX2 | O351XX3 | O351XX4 | O351XX5 | O351XX9 | O352XX0 | O352XX1 | O352XX2 |
| O352XX3 | O352XX4 | O352XX5 | O352XX9 | 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 |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|--------|-------|-------|--------|--------|--------|--------|
| 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 | Q211 | Q212 | Q213 | Q214 | Q218 |
| Q219 | Q220 | Q221 | Q222 | Q223 | Q224 | Q225 | Q228 |
| Q230 | Q231 | Q232 | Q233 | Q234 | Q238 | 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 | 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 | Q447 | 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 | Q52120 | Q52121 | Q52122 | Q52123 |
| Q52124 | Q52129 | 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 |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|
| 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 | 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 | Q750 | 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 |
| Q858 | Q859 | Q870 | Q8711 | Q8719 | Q87410 | Q87418 | Q8742 |
| Q8743 | Q8782 | Q8901 | Q8909 | Q891 | Q892 | Q893 | Q894 |
| Q897 | Q898 | Q899 | Q900 | Q901 | Q902 | Q909 | Q910 |
| Q911 | Q912 | Q913 | Q914 | Q915 | Q916 | Q917 | Q920 |
| Q921 | Q922 | Q925 | Q9261 | Q9262 | Q927 | Q928 | Q930 |
| Q931 | Q932 | Q933 | Q934 | Q9351 | Q9359 | Q937 | Q9381 |
| Q9382 | Q9388 | Q9389 | Q950 | Q952 | Q958 | Q960 | Q961 |
| Q962 | Q963 | Q964 | Q968 | Q969 | Q970 | Q971 | Q972 |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|-------|-------|-------|-------|-------|-------|--------|
| Q973 | Q978 | Q980 | Q981 | Q984 | Q985 | Q986 | Q987 |
| Q988 | Q990 | Q991 | Q992 | Q998 | Q999 | R480 | Z31430 |
| Z31438 | Z315 | Z317 | Z360 | Z361 | Z362 | Z363 | Z364 |
| Z365 | Z3681 | Z3682 | Z3683 | Z3684 | Z3688 | Z3689 | Z368A |
| Z8279 | Z8482 | Z8489 | | | | | |

Cytogenetics testing may be reimbursed with the following procedure codes and limitations:

| Procedure Code | Quantity Allowed |
|---|-------------------------|
| Tissue Culture Procedure Codes and Limitations | |
| 88230 | 1 per day any provider |
| 88233 | 1 per day any provider |
| 88235 | 1 per day any provider |
| 88237 | 1 per day any provider |
| 88239 | 1 per day any provider |
| Chromosome Analysis Procedure Codes and Limitations | |
| 88245 | 1 per day any provider |
| 88248 | 1 per day any provider |
| 88249 | 1 per day any provider |
| 88261 | 1 per day any provider |
| 88264 | 1 per day any provider |
| 88283 | 1 per day any provider |
| 88289 | 1 per day any provider |
| Molecular Cytogenetics Procedure Codes and Limitations | |
| 88271 | 16 per provider per day |
| 88272 | 10 per provider per day |
| 88273 | 10 per provider per day |
| 88274 | 5 per provider per day |
| 88275 | 10 per provider per day |
| Interpretation and Report Procedure Code | |
| 88291 | As medically necessary |

9.2.39.7 Maternal Serum Alpha-Fetoprotein (MSAFP)

MSAFP may be reimbursed once per pregnancy per provider for all pregnant women eligible for Medicaid. For additional services, payment is allowed with documentation attached to the claim. Procedure code 82105 should be used for MSAFP.

9.2.40 Pharmacogenetics

Pharmacogenetic testing of cytochrome p450 (CYP450) metabolic pathway may be considered medically necessary only if the results of the testing are necessary to differentiate between treatment options.

The use of pharmacogenetics may be considered medically necessary once in a lifetime to determine effective response to drug therapy for the following:

| Procedure Code | Drug Treatment | Diagnosis Restriction | Prior Authorization |
|----------------|--|-----------------------|-----------------------------|
| 81225 | Clopidogrel | | Required |
| 81226 | Eliglustat | E7522 | Required for repeat testing |
| | Tetrabenzine in a dosage greater than 50mg per day | G10 | |
| 81227 | Warfarin | | Required |

9.2.40.1 Testing of Polymorphic 2C19

Pharmacogenetics testing of polymorphic 2C9 (procedure code 81227) may be considered for clopidogrel treatment and requires prior authorization and may be considered medically necessary when all of the following conditions are met:

- The client has never received genetic testing of the 2C19 alleles.
- The client has never received clopidogrel treatment.
- The clopidogrel treatment will be used for one of the following diseases or conditions:
 - ST elevated and non-ST elevated myocardial infarction (STEMI and NSTEMI)
 - Subsequent STEMI and NSTEMI
 - Dressler's syndrome
 - Unstable angina
 - Cerebral infarction due to embolism of cerebral arteries
 - Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction
 - Peripheral vascular disease, including unspecified

Note: The routine use of genetic testing to screen patients treated with clopidogrel who are undergoing percutaneous coronary intervention (PCI) is not a benefit of Texas Medicaid.

9.2.40.2 Testing of Polymorphic 2D6

Pharmacogenetics testing of polymorphic 2D6 (procedure code 81226) may be considered medically necessary when all of the following conditions are met:

- Group one:
 - The client has never received genetic testing of the 2D6 alleles
 - The client has a diagnosis of Gaucher disease type 1
 - Treatment with eliglustat (Cerdelga®) is being considered
- Group two:
 - The client has never received genetic testing of the 2D6 alleles
 - The client has a diagnosis of Huntington's disease
 - Treatment with tetrabenzine (Xenazine®) is being considered in a dosage greater than 50mg per day.

Prior authorization is not required for the initial pharmacogenetic testing of polymorphic 2D6 (procedure code 81226) that is performed on a client. Prior authorization is required for repeat testing.

9.2.40.3 Testing of Polymorphic 2C9

Pharmacogenetics testing of polymorphic 2C9 (procedure code 81227) requires prior authorization and may be considered for warfarin treatment and may be considered medically necessary when all of the following conditions are met:

- The client has never received genetic testing of the 2C9 alleles
- The client has never received warfarin (vitamin K antagonists) treatment
- The warfarin treatment will be used for one of the following diseases or conditions:
 - Irregular heartbeat or rhythm
 - Prosthetic (replacement or mechanical) heart valves
 - Myocardial infarction
 - Risk of venous thrombosis (swelling and blood clot in a vein)
 - Risk of pulmonary embolism (a blood clot in the lung)

9.2.40.4 Prior Authorization Requirements

Prior authorization is required for requests for pharmacogenetic testing for more than once in a lifetime. Prior authorization requests must be submitted on the Special Medical Prior Authorization (SMPA) Request Form. The form must be completed, signed, dated, and submitted by the prescribing or ordering provider.

Prior authorization requests from laboratories will not be processed. The requesting provider must share the prior authorization number with the laboratory submitting the claim.

The prior authorization request must include the following:

- Laboratory TPI in section D of the SMPA Request Form
- Proposed or current treatment plan, including the drug name, dosage, and frequency that support the medical necessity of the service requested
 - This information may be documented in the “Statement of medical necessity” field under Section C of the SMPA Request Form or submitted separately with the prior authorization request.
- For prior authorization of procedure code 81225, the ordering provider must include a statement on the SMPA Request Form attesting that the client has never received clopidogrel treatment.
- For prior authorization of procedure code 81227, the ordering provider must include a statement on the SMPA Request Form attesting that the client has never received warfarin treatment.

Prior authorization requests to repeat the same test (procedure code 81225, 81226, or 81227) will be reviewed by the medical director when one of the following criteria is met:

- The client has Huntington’s disease and a history of pharmacogenetic testing of 2D6 (procedure code 81226) for tetrabenzine treatment, and the new request is for the same testing of 2D6 but for eliglustat to treat Gaucher disease type 1.
- The client has Gaucher disease type 1 and a history of pharmacogenetic testing of 2D6 (procedure code 81226) for eliglustat treatment, and the new request is for the same testing of 2D6 but for tetrabenzine to treat Huntington’s disease.
- Previous test results are unavailable. Every reasonable effort must be made to obtain the test results from the client’s provider or laboratory who previously ordered or conducted testing. Documentation of these efforts must be submitted with the prior authorization request.

9.2.40.5 Exclusions

The following services are not a benefit of Texas Medicaid:

- Pharmacogenetics tests of polymorphisms in a p450 superfamily other than 2D6, 2C19, or 2C9, which are performed for the purpose of aiding in the choice of drug or dose to increase efficacy or avoid toxicity, as they are considered experimental and investigational
- The routine clinical use of genetic testing to screen patients treated with clopidogrel who are undergoing percutaneous coronary intervention (PCI)
- The use of any of the 2D6, 2C19, or 2C9 tests for the following conditions, drugs, or treatments:
 - Opioid pain medicines (codeine, oxycodone, hydrocodone, tramadol, fentanyl, and methadone)
 - Selective serotonin reuptake inhibitors (SSRIs)
 - Selective norepinephrine reuptake inhibitors (SNRIs)
 - Beta blockers
 - Selective tricyclic antidepressants
 - Selective antipsychotic drugs
 - Efavirenz and other antiretroviral therapies for human immunodeficiency virus (HIV) infection
 - Immunosuppressants for organ transplantation
 - Aricept® (donepezil) for individuals with Alzheimer's disease
 - p450 polymorphisms test panels for any of the 3 alleles 2C19, 2D6, or 2C9

9.2.41 Lung Volume Reduction Surgery (LVRS)

LVRS is a benefit for clients who are not high risk but have a presence of severe, upper-lobe emphysema (as defined by radiologist assessment of upper-lobe predominance on CT scan) or who are not high risk but have a presence of severe, non-upper-lobe emphysema with low exercise capacity.

Note: *Clients who have low exercise capacity are those whose maximal exercise capacity is at or below 25 watts for women and 40 watts for men after completion of the pre-operative therapeutic program in preparation for LVRS. Exercise capacity is measured by incremental, maximal, symptom-limited exercise with a cycle ergometer utilizing a 5- or 10-watt-per-minute ramp on 30-percent oxygen after 3 minutes of unloaded pedaling.*

LVRS must be performed in a facility that meets at least one of the following requirements:

- Certified under the Disease Specific Care Certification Program for LVRS by the Joint Commission on Accreditation of Health Care Organization
- Approved by Medicare as a lung or heart-lung transplant facility

The surgery must be both preceded and followed by a program of diagnostic and therapeutic services that are consistent with those provided in the National Emphysema Treatment Trial (NETT) and designed to maximize the client's potential to successfully undergo and recover from surgery. The program must meet all of the following requirements:

- Include a 6- to 10-week series of at least 16, and no more than 20, pre-operative sessions, each lasting a minimum of 2 hours
- Include at least 6, and no more than 10, post-operative sessions, each lasting a minimum of 2 hours, within 8 to 9 weeks after the LVRS
- Be consistent with the care plan that was developed by the treating physician following the performance of a comprehensive evaluation of the client's medical, psychosocial, and nutritional needs

- Be arranged, monitored, and performed under the coordination of the facility where the surgery takes place

Clients must have surgical clearance by a licensed cardiologist for any of the following conditions:

- Unstable angina
- Left ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram
- LVEF less than 45 percent
- Dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction
- Arrhythmia (more than 5 premature ventricular contractions (PVC) per minute)
- Cardiac rhythm other than sinus
- PVCs on electrocardiogram (EKG) at rest

For clients with cardiac ejection fraction less than 45 percent, there must be no history of congestive heart failure or myocardial infarction within six months of consideration for surgery.

Clients must have surgical clearance by a licensed pulmonologist, thoracic surgeon, and anesthesiologist after completion of pre-operative rehabilitation.

Procedure codes 32491, G0302, G0303, G0304, and G0305 are limited to one per rolling year per client for any provider.

Pre-operative pulmonary rehabilitation services for preparation for LVRS (procedure codes G0302, G0303, and G0304) and post-discharge pulmonary surgery services LVRS (procedure code G0305) will be restricted to diagnosis codes J430, J431, J432, J438, and J983.

Procedure code G0305 may be reimbursed only if a claim for LVRS (procedure code 32491) has been submitted within the past 12 months.

9.2.41.1 Prior Authorization for Lung Volume Reduction Surgery

LVRS must be prior authorized and is limited to clients who have severe emphysema, disabling dyspnea, and evidence of severe air trapping. The following documentation must be submitted with the request for prior authorization:

- The client's history and physical examination is consistent with emphysema
- BMI less than 31.1 kg/m² (men) or less than 32.3 kg/m² (women)
- Pulmonary status that is stable with less than 20 mg prednisone (or equivalent) per day
- A radiographic high resolution computer tomography (HRCT) scan has been conducted that shows evidence of bilateral emphysema.
- The forced expiratory volume in one second (FEV1) (maximum of pre- and postbronchodilator values) is less than or equal to 45 percent of the predicted value. If the client is 70 years of age and older, FEV1 is 15 percent of the predicted value or more.
- The total lung capacity (TLC) greater than 100 percent predicted postbronchodilator
- Residual volume (RV) greater than 150 percent predicted postbronchodilator found on prerehabilitation pulmonary function study.
- Arterial blood gas level (pre-rehabilitation):
 - Partial pressure of carbon dioxide (PaCO₂) less than or equal to 60 mm Hg (PaCO₂ less than or equal to 55 mm Hg if one mile above sea level)
 - Partial pressure of oxygen (PaO₂) greater than or equal to 45 mm Hg on room air (PaO₂ greater than or equal to 30 mm Hg if one mile above sea level)

- The plasma cotinine is less than or equal to 13.7 ng/ml (if the client is not using nicotine products) or the carboxyhemoglobin is less than or equal to 2.5 percent (if the client is using nicotine products).
- Nonsmoking for four months prior to initial interview and throughout evaluation for surgery
- Successful 6-minute walk test equal to or greater than 140 meters following pre-operative rehabilitation
- Successful completion of three minute unloaded pedaling in an exercise tolerance test both before and after pre-operative rehabilitation

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

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

Prior authorization is not required for the associated preoperative pulmonary surgery services for preparation for LVRS (procedure codes G0302, G0303, and G0304) or the associated postdischarge pulmonary surgery services after LVRS (procedure code G0305).

9.2.41.1.1 Noncovered Conditions

LVRS is not a benefit in any of the following clinical circumstances:

- A client with characteristics that carry a high risk for perioperative morbidity and/or mortality
- A disease that is unsuitable for LVRS
- A medical condition or other circumstance that makes it likely that the client will be unable to complete the preoperative and postoperative pulmonary diagnostic and therapeutic program required for surgery
- The client presents with FEV1 less than or equal to 20 percent of predicted value, and either a homogeneous distribution of emphysema on the CT scan or a carbon monoxide diffusing capacity of less than or equal to 20 percent of predicted value (a high-risk group identified in October 2001 by the NETT)
- The client satisfies the criteria outlined above and has severe, non-upper-lobe emphysema with a high-exercise capacity. High-exercise capacity is defined as a maximal workload at the completion of the preoperative diagnostic and therapeutic program that is above 25 watts for women or 40 watts for men (under the measurement conditions for cycle ergometry).
- A previous LVRS (laser or excision) on the same lung
- A pleural or interstitial disease which precludes surgery
- A giant bulla (greater than 1/3 the volume of the lung in which the bulla is located)
- A clinically significant bronchiectasis
- A pulmonary nodule requiring surgery
- A previous lobectomy
- Uncontrolled hypertension (systolic greater than 200 mm Hg or diastolic greater than 110 mm Hg)
- Oxygen requirement greater than 6 liters per minute during resting to keep oxygen saturation greater than or equal to 90 percent
- A history of recurrent infections with clinically significant production of sputum

- Unplanned weight loss greater than 10 percent within 3 months before the consideration of surgery
- Pulmonary hypertension, defined as the mean pulmonary artery pressure of 35 mmHg or greater on the right heart catheterization or peak systolic pulmonary artery pressure of 45 mmHg or greater. Right heart catheterization is required to rule out pulmonary hypertension if the peak systolic pulmonary artery pressure is greater than 45 mmHg on an echocardiogram
- Resting bradycardia (less than 50 beats per minute)
- Frequent multifocal premature ventricular contractions (PVCs) of complex ventricular arrhythmia or sustained supraventricular tachycardia (SVT)
- Evidence of a systemic disease or neoplasia that is expected to compromise survival

9.2.42 Diagnostic and Therapeutic Breast Procedures

Diagnostic, mastectomy, and breast reconstruction procedures are benefits of Texas Medicaid.

These are physician-directed services including, but not limited to diagnostic and surgical breast procedures provided by physicians in the office, outpatient, or inpatient hospital settings, and external breast prostheses provided by durable medical equipment (DME) providers in the home setting.

Categories of service include:

- Diagnostic breast procedures
- Mastectomy
- Reconstructive breast procedures
- Treatment of complications of breast reconstruction
- External breast prostheses

9.2.42.1 Diagnostic Procedures

Diagnostic breast procedures for a condition or malignancy of the breast may include:

- Puncture aspiration
- Mastotomy
- Injection procedure for ductogram or galactogram
- Percutaneous biopsy, with or without imaging guidance
- Incisional biopsy
- Nipple exploration
- Excision of the following:
 - Lactiferous duct fistula
 - Benign or malignant breast lesion
 - Chest wall tumor

The following procedure codes may be reimbursed for diagnostic breast procedures:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 19000 | 19001 | 19020 | 19030 | 19081 | 19082 | 19083 | 19084 | 19085 | 19086 |
| 19100 | 19101 | 19110 | 19112 | 19120 | 19125 | 19126 | 19281 | 19282 | 19283 |
| 19284 | 19285 | 19286 | 19287 | 19288 | | | | | |

The following services are not benefits of Texas Medicaid:

- Mastectomy for a diagnosis of fibrocystic disease in the absence of documented risk factors.
- Cosmetic services performed primarily to improve appearance.
- Commercial or “decorative” tattooing.
- Replacement of external breast prostheses when the damage is due to abuse or neglect by the client, client’s family, or the caregiver.

9.2.42.2 Therapeutic Procedures

9.2.42.2.1 Mastectomy Procedures

Mastectomy and partial mastectomy (e.g., lumpectomy, tylectomy, quadrantectomy, and segmentectomy) are benefits when it is medically necessary to remove a breast or portion of a breast for conditions including, but not limited to:

- Developmental abnormality
- Congenital defect
- Trauma or injury to chest wall
- Primary or secondary malignancy of the breast
- Carcinoma in situ of the breast

The following procedure codes for mastectomy are benefits of Texas Medicaid:

| Procedure Codes | | | | | |
|-----------------|-------|-------|-------|-------|-------|
| 19301 | 19302 | 19303 | 19305 | 19306 | 19307 |

Procedure codes 19301, 19302, 19303, 19305, 19306, and 19307 may be reimbursed without prior authorization for services rendered to male or female clients who are 18 years of age and older.

Prior authorization is required for services rendered to clients who are 17 years of age and younger.

Procedure codes 19303, 19305, 19306, and 19307 are limited to 1 service per breast per lifetime.

9.2.42.2.2 Prophylactic Mastectomy

Prophylactic mastectomy is a benefit after a thorough assessment of a client’s unique risk factors, health, and the level of concern. Prophylactic mastectomy is limited to clients who are at moderate- to high-risk for the development of breast cancer.

Moderate- to high-risk clients are those who meet one or more of the following criteria for development of breast cancer:

- Current or previous diagnosis of breast cancer
- Family history of breast cancer in mother, sister, or daughter, especially before the age of 50
- Presence of any of the following genetic mutations:
 - Breast cancer gene 1 (BRCA1)
 - Breast cancer gene 2 (BRCA2)
 - Tumor protein 53 (TP 53)
 - Phosphatase and tensin homolog (PTEN)
- Lobular carcinoma in situ (LCIS)
- Radiation therapy to the chest before a client reaches 30 years of age

Referto: Subsection 2.2.6, “Breast Cancer Gene 1 and 2 (BRCA) Testing” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

Documentation that supports medical necessity for prophylactic mastectomy must include the information listed above.

Documentation that as a candidate for prophylactic mastectomy, the client has undergone counseling regarding cancer risks. Counseling must include assessment of all of the following:

- The client’s ability to understand the risks and long-term implications of the surgical procedure, and
- The client’s informed choice to proceed with the surgical procedure.

9.2.42.2.3 Mastectomy for Pubertal Gynecomastia

Mastectomy for pubertal gynecomastia is a benefit with prior authorization for males who are 20 years of age and younger. Procedure code 19300 may be reimbursed for mastectomy for pubertal gynecomastia.

The following documentation must be submitted with the prior authorization request for procedure code 19300:

- The gynecomastia classification (grade II, III, or IV) as defined by the American Society of Plastic Surgeons classification.
- Evidence that puberty is near completion, as indicated by the following:
 - 95 percent of adult height based on bone age, and
 - Tanner stage V has been achieved.
- Evidence that the client has been off gynecomastia inducing drugs or other substances for a minimum of one year when this is identified as the cause of the gynecomastia.
- Evidence of resolution as supported by appropriate test results and treatment for hormonal causes, including hyperthyroidism, estrogen excess, prolactinomas, and hypogonadism, for a minimum of one year when identified as the cause of the gynecomastia.
- Evidence of a psychiatric assessment performed by a psychiatrist or psychologist.
- Client’s history and treatment plan including planned surgical procedure and timelines.
- Identification of which breast or breasts, require mastectomy.

Documentation that supports medical necessity for mastectomy for pubertal gynecomastia must be maintained in the client’s medical record, and must include the following:

- A complete medical and family history, including:
 - Gynecomastia classification
 - Bone age
 - Tanner stage
 - Use of any gynecomastia inducing drugs or substances and date last ingested
 - Hormonal causes of gynecomastia, treatment, and length of treatment
 - Psychiatric assessment performed by a psychiatrist or psychologist and outcome
 - Affected breast or breasts
- A thorough physical examination
- Medically indicated laboratory testing and any other testing including results

9.2.42.3 Breast Reconstruction

Breast reconstruction may be performed in a single stage or several stages. Breast reconstruction is a benefit when all of the following criteria are met:

- The client has a documented history of one or more of the following:
 - Mastectomy
 - Congenital defect
 - Developmental abnormality
 - Trauma or injury to the chest wall
- The client meets age and gender criteria for the requested procedure.
- The physician has documented a treatment plan in the client's medical record that addresses the recommended breast reconstruction.
- Reconstruction to attain symmetry is required and may include a surgical procedure to the contralateral breast and may be either a reduction or an augmentation.

Procedure options for breast reconstruction following a mastectomy include, but are not limited to the following:

- Superficial inferior epigastric artery (SIEA) flap
- Deep inferior epigastric artery (DIEP) flap
- Transverse rectus abdominis myocutaneous (TRAM) flap
- Breast implants (saline or silicone)
- Reduction mammoplasty
- Mastopexy
- Reconstruction of the nipple or areola (small flaps)
- Tattooing to correct color defects of the skin
- Treatment for complications of breast reconstruction

Documentation that supports medical necessity for breast reconstruction, including tattooing, must include the following:

- Diagnosis resulting in the need for breast reconstruction,
- Date of mastectomy, when appropriate,
- Date of any previous breast reconstruction procedures, when appropriate,
- Treatment plan to include planned surgical procedures and timeline for completion, and
- When appropriate, identification of the complication.

All Medicaid services, including breast reconstruction after breast cancer surgery, are covered for Medicaid Breast and Cervical Cancer (MBCC) clients who are receiving active cancer treatment. "Active treatment" is defined as medical treatment following a cancer diagnosis that is intended to cure or otherwise treat a diagnosed cancer.

Active treatment may include some or all of the following:

- Surgery
- Chemotherapy
- Radiotherapy

- Medication (e.g., ongoing hormonal treatments for estrogen and progesterone breast cancer)
- Active disease surveillance for triple negative receptor breast cancer

Reconstructive surgery (e.g., breast reconstruction) is considered “active treatment” if it is intended to permanently correct a physical condition resulting from either the diagnosed cancer or the treatment of the diagnosed cancer.

Ongoing treatment of a persistent condition resulting from a diagnosed cancer or treatment of a diagnosed cancer is not considered “active treatment” if cancer is no longer present or in need of treatment.

The following breast reconstruction procedure codes may be reimbursed without prior authorization for services rendered to clients who are 18 years of age and older:

| Procedure Codes | | | | | | | | | |
|---|-------|--------|--------|--------|--------|-------|-------|--------|-------|
| 11970 | 11971 | 19316* | 19325* | 19340* | 19342* | 19350 | 19355 | 19357* | 19361 |
| 19364 | 19367 | 19368 | 19369 | 19396* | S2068 | | | | |
| *Procedure codes are limited to females only. | | | | | | | | | |

Prior authorization is required for services rendered to clients who are 17 years of age and younger or when the client does not meet gender or age criteria.

Procedure codes 11920, 11921, and 11922 may be reimbursed when performed as part of breast reconstruction.

Breast reconstruction claims denied for no history of previous mastectomy may be appealed with supporting documentation indicating the date of mastectomy, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.42.3.1 Tattooing to Correct Color Defects of the Skin

Tattooing to correct color defects of the skin (procedure codes 11920, 11921, and 11922) are limited to two services per lifetime.

Tattooing claims denied for no history of breast reconstruction may be appealed with supporting documentation indicating the date of breast reconstruction, or the identified trauma, injury, or congenital or developmental abnormality.

9.2.42.3.2 Treatment for Complications of Breast Reconstruction

The treatment of complications related to breast reconstruction may be reimbursed using procedure codes 19328, 19330, 19370, 19371, and 19380.

Procedure codes 19328, 19330, 19370, and 19371 may be reimbursed for services rendered to female clients only.

9.2.42.3.3 Chest Wall Procedures

Excision of chest wall tumors may be reimbursed using procedure codes 21601, 21602, and 21603.

Procedure code 21603 is limited to once per lifetime.

9.2.42.3.4 External Breast Prostheses

External breast prostheses are available through a durable medical equipment (DME) provider for a female client with a history of a medically necessary mastectomy procedure.

The following procedure codes may be reimbursed for external breast prostheses services rendered to female clients of any age:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| L8000 | L8001 | L8002 | L8010 | L8015 | L8020 | L8030 | L8031 | L8032 | L8033 |
| L8035 | L8039 | | | | | | | | |

To be considered for reimbursement, an LT or RT modifier must be appropriately appended to the submitted diagnostic and therapeutic breast procedure codes or external breast prostheses procedure codes.

The external breast prosthesis procedure codes are limited as follows:

| Procedure Code | Limitation |
|----------------|----------------------------------|
| L8000 | 4 per rolling year |
| L8001 | 4 per rolling year, per modifier |
| L8002 | 4 per rolling year |
| L8010 | 8 per rolling year |
| L8015 | 2 per rolling year |
| L8020 | 1 per 6 rolling months |
| L8030 | per 2 rolling years |
| L8031 | per 2 rolling years |
| L8032 | 8 per rolling year |
| L8033 | 8 per rolling year |
| L8035 | Requires prior authorization |
| L8039 | Requires prior authorization |

Replacement of external breast prostheses may be considered at any time, through the prior authorization with documentation.

For a new or replacement external breast prosthesis procedure code outside the limitations, all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8035 (custom prosthesis), all of the following documentation must be submitted with the prior authorization request:

- The client's diagnosis
- Documentation of medical necessity for the requested prosthesis
- Documentation indicating the reason for recommending the requested prosthesis

When requesting a prior authorization for procedure code L8039 (other prosthesis), all of the following documentation must be submitted with the prior authorization request:

- A clear, concise description of the breast prosthesis requested
- Reason for recommending the requested prosthesis
- A CPT or HCPCS procedure code, which is comparable to the procedure being requested

- Documentation that this breast prosthesis is not investigational or experimental
- The provider's intended fee for the requested prosthesis

9.2.42.4 Prior Authorization Requirements for Diagnostic and Therapeutic Breast Procedures

Prior authorization is not required for the following when all of the following criteria are met:

- The procedure is a mastectomy or breast reconstruction for clients who are 18 year of age or older.
- The request is for one of the following external breast prosthesis procedure codes: L8000, L8001, L8002, L8010, L8015, L8020, or L8030.
- The procedure is for partial mastectomy procedure codes 19301 and 19302 for clients of any age.

Prior authorization is required for the following:

- Mastectomy or breast reconstruction when the client is 17 years of age or younger, or does not meet gender criteria
- Mastectomy for pubertal gynecomastia
- Procedure code 19499 (unlisted procedure)
- External breast prosthesis procedure codes L8035 (custom prosthesis) and L8039 (other prosthesis)
- Any request for new or replacement external breast prosthesis outside of the limitations

9.2.42.4.1 Unlisted Breast Procedure

All of the following documentation must be submitted for procedure code 19499 with the prior authorization request:

- A clear, concise description of the procedure to be performed
- Reason for recommending this particular procedure
- A Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code, which is comparable to the procedure being requested
- Documentation that this procedure is not investigational or experimental
- Place of service the procedure is to be performed
- The provider's intended fee for this procedure

9.2.42.4.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization Requirements" section above, the following requirements apply:

- All services are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and must support the medical necessity for the services provided.
- Services not supported by documentation are subject to recoupment.

9.2.43 Neurostimulators

Neurostimulator and neuromuscular stimulator procedures and the rental or purchase of devices and associated supplies, such as leads and form fitting conductive garments are a benefit of Texas Medicaid when medically necessary.

Neurostimulator devices are considered DME, so providers must complete both the Home Health (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX Form) to prescribe the DME and the DME Certification and Receipt Form to show receipt of the DME by the client. Both forms must be maintained in the client's medical record.

Referto: Subsection 2.2.2, “Durable Medical Equipment (DME) and Supplies” in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (Vol. 2, *Provider Handbooks*) for more information about DME.

Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

Items and/or services addressed in the sections below are either reimbursed at a maximum fee determined by HHSC or are manually priced. If an item is manually priced, the manufacturer’s suggested retail pricing (MSRP) must be submitted for consideration of rental or purchase with the appropriate procedure codes. Manually priced items are reimbursed at the MSRP minus a discount (18 percent) as determined by HHSC.

9.2.43.1 Prior Authorization for Neurostimulators

All devices and related procedures for the initial application or surgical implantation of the stimulator or neuromuscular stimulator device require prior authorization.

Requests for prior authorization must be submitted to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the requested device. Providers may use the Special Medical Prior Authorization (SMPA) Request Form when they submit requests to the SMPA department.

To avoid unnecessary denials, the physician must provide correct and complete information including documentation for medical necessity of the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record. The requesting provider may be asked for additional information to clarify or complete a request for the equipment and/or supplies. Prior authorization requests for all neurostimulators and related procedures must include the provider identifiers for both the surgeon and the facility.

A neurostimulator device that has been purchased is anticipated to last a maximum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. At that time, replacement of the device will be considered. Replacement devices require prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

9.2.43.2 Neuromuscular Electrical Stimulation (NMES)

NMES application and the rental or purchase of devices and conductive garments are a benefit of Texas Medicaid when medically necessary and prior authorized. Prior authorization requests for NMES must include documentation of a spinal cord injury or disuse atrophy that is refractory to conventional therapy.

NMES may be reimbursed using the following procedure codes:

| Procedure Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 64580 | E0731 | E0745 | E0762 | E0764 | A4556 | A4557 | A4595 |

9.2.43.2.1 NMES Rental

The rental of a NMES device may be considered before purchase and is limited to a one-month trial period with consideration for one additional month’s trial with documentation of medical necessity. Supplies are considered to be part of the rental and will not be separately reimbursed. Garments may be considered for reimbursement during the rental period when medically necessary.

9.2.43.2.2 NMES Purchase

The purchase of a NMES device is limited to once per five years, and may be reimbursed when there is documentation of successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by the following:

- A demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

Garments may be considered for reimbursement during the purchase period when medically necessary.

9.2.43.2.3 NMES for Muscle Atrophy

NMES may be reimbursed when used to treat muscle disuse atrophy when brain, spinal cord, and peripheral nerve supply to the muscle is intact, as well as other non-neurological conditions. Examples of NMES treatment for non-neurological conditions include, but are not limited to, casting or splinting of a limb, contracture due to scarring of soft tissue as in burn lesions, and hip replacement surgery until orthotic training begins.

9.2.43.2.4 NMES for Walking in Clients with Spinal Cord Injury (SCI)

The type of NMES that is used to enhance the ability to walk of SCI clients is commonly referred to as functional electrical stimulation (FES). These devices are surface units that use electrical impulses to activate paralyzed or weak muscles in precise sequence.

The use of NMES/FES is limited to SCI clients who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three months.

The trial period of physical therapy will enable the treating physician to properly evaluate the client's ability to use NMES/FES devices frequently and for the long term.

Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program. The goal of physical therapy must be to train SCI clients on the use of NMES/FES devices to achieve walking, not to reverse or retard muscle atrophy.

NMES/FES is a benefit for SCI clients who have all of the following characteristics:

- Clients with intact lower motor unit (L1 and below) (both muscle and peripheral nerve).
- Clients with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright posture while standing independently for at least three minutes.
- Clients who demonstrate brisk muscle contraction to NMES and have sensory perception electrical stimulation sufficient for muscle contraction.
- Clients who possess high motivation, commitment, and cognitive ability to use such devices for ambulation, as established by provider interview and documentation.
- Clients who can transfer independently.
- Clients who can demonstrate hand and finger function to manipulate controls.
- Clients with at least six-month post recovery spinal cord injury and restorative surgery.
- Clients with hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.

NMES and FES used for walking is not a benefit in SCI clients with any of the following:

- Cardiac pacemakers
- Severe scoliosis or severe osteoporosis

- Skin disease or cancer at area of stimulation
- Irreversible contracture
- Autonomic dysflexia

9.2.43.3 Transcutaneous Electrical Nerve Stimulation (TENS)

TENS involves the attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated.

TENS may be reimbursed for the treatment of acute postoperative pain or chronic pain that is refractory to conventional therapy.

TENS may be reimbursed using the following procedure codes:

| Procedure Codes | | | | | |
|-----------------|-------|-------|-------|-------|-------|
| E0720 | E0730 | E0731 | A4556 | A4557 | A4595 |

9.2.43.3.1 TENS Rental

Rental of a TENS device will be considered for prior authorization when there is documentation of a condition that indicates acute postoperative pain or chronic pain that is refractory to conventional therapy.

The rental of a TENS device is limited to one-month trial period with consideration for one additional month's trial with documentation of medical necessity. Supplies, such as lead wires and electrodes, are considered to be part of the rental and will not be separately reimbursed. Garments may be considered during the rental period when medically necessary.

When the TENS device is rented for a trial period rather than supplied by the provider, the combined payment made for professional services and the rental of the stimulator must not exceed the amount which would be reimbursed for the total service, including the stimulator, if furnished by the provider alone.

9.2.43.3.2 TENS Purchase

The purchase of a TENS device is limited to once every five years and may be reimbursed with prior authorization when there is documentation of the following:

- A condition that indicates chronic pain that is refractory to conventional therapy.
- A successful test stimulation (during rental or other therapeutic period) that showed improvement as measured by demonstrated increase in range of motion.
- The client's improved ability to complete activities of daily living or perform activities outside the home.

9.2.43.4 NMES and TENS Garments

The rental of the NMES/TENS garment is not covered during the trial rental period unless the client has a documented skin problem prior to the start of the trial period, and HHSC or its designee determines that use of such an item is medically necessary for the client based on the documentation submitted.

The purchase of conductive garments for NMES/TENS devices may be considered when:

- The garment has been prescribed by a physician for use in providing covered NMES/TENS treatment.
- A NMES/TENS device has been purchased for the client's use.
- The conductive garment is necessary for one of the medical indications outlined below:

- The client cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
- The client cannot manage the treatment for chronic intractable pain without the conductive garment because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
- The client has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires.

9.2.43.5 NMES and TENS Supplies

Supplies for purchased devices are limited as follows:

- If additional electrodes are required, procedure code A4556 may be considered for reimbursement at a maximum of 15 per month.
- If additional lead wires are required, procedure code A4557 may be considered for reimbursement at a maximum of 2 per month.
- Procedure code A4595 is limited to 1 per month.

Supplies are included in the rental and will not be reimbursed separately.

Supply procedure codes A4556, A4557, or A4595 may be reimbursed for clients with a purchased device and a claims history of an NMES/TENS procedure within the past five years. Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number, and purchasing entity of the device may be required.

9.2.43.6 Diaphragm-Pacing Neuromuscular Stimulation

Diaphragm-pacing neuromuscular stimulation is a benefit of Texas Medicaid when medically necessary and prior authorized.

Diaphragm-pacing neuromuscular stimulation is the electrical stimulation to one or both of the phrenic nerves or to the phrenic motor point regions of the diaphragm muscles that cause contraction of one or both of the two hemidiaphragms rhythmically to produce inspiration.

Diaphragm-pacing neuromuscular stimulation may be reimbursed when billed with procedure codes 64575 and 64590.

9.2.43.6.1 Prior Authorization for Diaphragm-Pacing Neuromuscular Stimulation

The surgical implantation of the diaphragm-pacing neuromuscular stimulator and purchase of a device are considered for prior authorization when medically necessary for individuals with severe, chronic respiratory failure that requires mechanical ventilation for any of the following reasons:

- Improvement of ventilatory function in stable, non-acute members with spinal cord injury (SCI) with high quadriplegia at or above C-3
- Alveolar hypoventilation, either primary or secondary to brainstem disorder
- Amyotrophic lateral sclerosis

All of the following criteria must be met:

- The phrenic nerves are viable
- Diaphragmatic function is sufficient to accommodate chronic stimulation
- Pulmonary function is known to be adequate
- The client has normal chest anatomy, a normal level of consciousness, and has the ability to participate in and complete the training and rehabilitation associated with the use of the device

9.2.43.7 Dorsal Column Neurostimulator (DCN)

DCN involves the surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space. The neurostimulator system stimulates pain-inhibiting nerve fibers, masking the sensation of pain with a tingling sensation (paresthesia).

DCN implantation may be reimbursed using procedure codes 63650, 63655, or 63685.

Conditions that may indicate chronic intractable pain include, but are not limited to, the following:

- Post-amputation “ghost” pain
- Cancer with bone metastasis
- Causalgia of upper/lower limb
- Herniated disc
- Radiculitis
- Spinal stenosis
- Spinal surgery
- Tic douloureux (trigeminal neuralgia)

9.2.43.7.1 Prior Authorization for Dorsal Column Neurostimulators

DCN electrode implantation and the purchase of devices is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation of DCN device may be considered for prior authorization for clients who have chronic intractable pain with documentation that indicates the following:

- Other treatment modalities, including pharmacological, surgical, physical, and/or psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and diagnosis by a multidisciplinary team prior to implantation.
- There has been evidence of pain relief during a trial period for DCN with a temporarily implanted electrode or electrodes preceding the permanent implantation.

Note: *A trial period including device and supplies is considered part of DCN procedures and will not be separately reimbursed.*

- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment, training, and the client’s follow-up are available.

9.2.43.8 Gastric Electrical Stimulation (GES)

GES involves electrical stimulation of the lower stomach (antrum) with a fully implantable system that consists of two unipolar intramuscular leads (thin wires) and a neurostimulator device.

GES is a benefit of Texas Medicaid when medically necessary and prior authorized for the treatment of chronic intractable nausea and vomiting that is secondary to gastroparesis that has proven to be refractory to medical management.

GES may be reimbursed with procedure codes 43647, 43881, and 64590.

GES is a benefit for Texas Medicaid clients with the following conditions:

- Organic obstruction or pseudo-obstruction
- A primary eating or swallowing disorder

- Chemical dependency
- Pregnancy

9.2.43.8.1 Prior Authorization for GES

The surgical implantation of a GES and purchase of a device are considered for prior authorization for chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology when all of the following criteria are met:

- Gastric emptying is significantly delayed as documented by standard scintigraphic imaging of solid food.
- Patient is refractory or intolerant of two out of three classes of prokinetic medications and two out of three antiemetic medications.
- The client's nutritional status is sufficiently low that all of the following criteria for total parenteral nutrition are met:
 - Adequate trials of dietary adjustment, oral supplements, or tube enteral nutrition have demonstrated that the patient can receive no more than 30 percent of his/her caloric needs orally and/or by tube.
 - The patient must be in a stage of wasting as indicated by all of the following:
 - Weight is significantly less than normal body weight for a patient's height and age in comparison with pre-illness weight.
 - Serum albumin is less than 3.4 grams.
 - BUN is less than 10 mg.
 - Phosphorus level is less than 2.5 mg.

9.2.43.9 Intracranial Neurostimulators

The surgical implantation, revision, and removal of intracranial deep brain stimulators (DBS) are a benefit for the relief of chronic intractable pain when more conservative methods, such as TENS, PENS, or pharmacological management have failed or were contraindicated.

Intracranial neurostimulation may be reimbursed using the following procedure codes:

| Procedure Codes | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 61781 | 61850 | 61860 | 61863 | 61864 | 61867 | 61868 | 61885 | 61886 |

9.2.43.9.1 Prior Authorization for Intracranial Neurostimulators

Intracranial neurostimulation involves the stereotactic implantation of electrodes in the brain and is a benefit of Texas Medicaid when medically necessary and prior authorized.

The surgical implantation and purchase of an intracranial neurostimulation device may be considered for prior authorization for chronic intractable pain or treatment of intractable tremors.

Requests for prior authorization must include documentation of the following:

- Other treatment modalities, including pharmacological, surgical, physical, and psychological therapies, have been tried and shown to be unsatisfactory, unsuitable, or contraindicated for the client.
- The client has undergone careful screening, evaluation, and assessment by a multidisciplinary team prior to implantation.
- The client has reported pain relief with a temporarily implanted electrode preceding the permanent implantation.

- All the facilities, equipment, and support personnel required for the proper assessment, treatment, training, and client's follow-up are available.

Prior authorization will not be given for the treatment of motor function disorders such as multiple sclerosis; however, the implantation, revision, and removal of deep brain stimulators may be reimbursed for the treatment of intractable tremors due to the following:

- Idiopathic Parkinson's disease
- Essential tremor

9.2.43.10 Pelvic Floor Stimulation

Purchase of a non-implantable pelvic floor stimulator (procedure code E0740) is a benefit of Texas Medicaid for the treatment of stress or urge incontinence in clients who have failed conservative treatment, such as Kegel exercises, behavior management, bladder training, or medication.

Purchase of the pelvic floor stimulator device is limited to once per five years. All accessories and supplies are considered part of the purchase price and are not reimbursed separately.

9.2.43.10.1 Prior Authorization for Pelvic Floor Stimulation

Prior authorization is required for the purchase of a pelvic floor stimulator device.

Documentation submitted with the prior authorization request must demonstrate that the client:

- Has a diagnosis of stress or urge incontinence.
- Has completed a six-month trial of pelvic muscles exercises with no significant clinical improvement.

9.2.43.11 Percutaneous Electrical Nerve Stimulation (PENS)

PENS is a benefit of Texas Medicaid when medically necessary and prior authorized. Devices and supplies are considered a part of the service and are not separately reimbursable.

PENS is a diagnostic procedure for the treatment of chronic pain involving the stimulation of peripheral nerves by a needle electrode inserted through the skin.

9.2.43.11.1 Prior Authorization for PENS

PENS services may be reimbursed with prior authorization for clients who meet the following criteria:

- The client has a diagnosis that indicates chronic pain, which is refractory to conventional therapy.
- Treatment with TENS has failed or is contraindicated for the client.

PENS may be reimbursed using the following procedure codes: 64553, 64555, or 64590. The revision or removal of a peripheral neurostimulator used in PENS therapy may be reimbursed without prior authorization using procedure code 64595.

9.2.43.12 Sacral Nerve Stimulators (SNS)

SNS are a benefit of Texas Medicaid when medically necessary and prior authorized. SNS implantation may be reimbursed using procedure code 64561, 64581, or 64590.

SNS involves the use of pulse generators that transmit electrical impulses to the sacral nerves through a surgically implanted wire for treatment of urinary retention, urinary frequency, and urinary/fecal incontinence.

9.2.43.12.1 Prior Authorization for SNS

The surgical implantation of SNS and purchase of a device may be considered for prior authorization with the following:

- Urinary incontinence secondary to urethral instability and/or detrusor muscle instability.

- Chronic voiding dysfunction.
- Non-obstructive urinary retention.
- Fecal incontinence.

Additionally, the medical record of the client must have documentation of the following:

- The urinary retention, urinary frequency, and urinary/fecal incontinence are refractory to conventional therapy (documented behavioral, pharmacological, and/or surgical corrective therapy).
- The client is an appropriate surgical candidate such that implantation with anesthesia can occur.

9.2.43.13 Vagal Nerve Stimulators (VNS)

VNS are a benefit of Texas Medicaid when medically necessary and prior authorized, for the treatment of intractable partial onset seizures.

VNS involves the use of devices that deliver electrical pulses to the cervical portion of the vagus nerve by an implanted generator.

9.2.43.13.1 Prior Authorization for VNS

The surgical implantation and purchase of VNS devices may be considered for prior authorization for clients with partial onset intractable seizures when there is failure, contraindication, or intolerance to all suitable medical and pharmacological management.

The surgical implantation of VNS may be reimbursed using procedure code 61885, 61886, 64553, or 64568.

VNS are not a benefit of Texas Medicaid in the following cases:

- For the treatment of clients with an absent left vagus nerve
- For the treatment of clients with depression
- For the treatment of clients with diseases or conditions with a poor prognosis or are progressively terminal in nature

Incapacities due to intellectual disabilities or cerebral palsy may confound the assessment of benefits resulting from VNS. When a diagnosis of intellectual disabilities or cerebral palsy exists, the treating physician must document in the client's medical record how VNS will measurably benefit the client in spite of intellectual disabilities or cerebral palsy.

9.2.43.14 Prior Authorization of Neurostimulator Devices Procedure Codes

The following device procedure codes may be reimbursed with prior authorization:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| L8681 | L8682 | L8683 | L8684 | L8685 | L8686 | L8687 | L8688 | L8689 | L8695 |

Neuromuscular devices and the implantation codes must be billed on the same day by any provider.

To identify the service as a VNS device, procedure code L8686 must be submitted with modifier TG. Only one similar device code may be reimbursed per date of service for any provider.

9.2.43.15 Supplies for Neurostimulators

Supply procedure codes A4290, C1883, C1897, L8680, and L8696 may be reimbursed for clients with a purchased device and a claims history of a prior neurostimulator or neuromuscular stimulator implantation within the past five years. Providers must maintain documentation in the client's medical record that a device has been purchased. Additional documentation such as the purchase date, serial number and purchasing entity of the initial implantable device may be required. Supplies for implantable devices

may be considered for reimbursement on appeal with documentation of a prior neurostimulator or a neuromuscular stimulator implantation procedure for clients with a history that is more than five years or for those who have a neurostimulator that was not received through Texas Medicaid.

To identify the service as a VNS implantable electrode, procedure code L8680 must be submitted with modifier TG.

9.2.43.16 Electrocorticogram of Implanted Neurostimulator

Electrocorticogram (procedure code 95836) is a benefit of Texas Medicaid and may be reported only once per each 30 day period.

9.2.43.17 Electronic Analysis for Neurostimulators

The following procedure codes may be reimbursed without prior authorization for the electronic analysis of the implanted neurostimulator and neuromuscular stimulation:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 95970 | 95971 | 95972 | 95976 | 95977 | 95980 | 95981 | 95982 | 95983 | 95984 |

9.2.43.18 Revision or Removal of Neurostimulator Devices

The revision or removal of implantable neurostimulators may be reimbursed without prior authorization using the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 43648 | 43882 | 61781 | 63661 | 63662 | 63663 | 63664 | 63688 | 61880 | 61888 |
| 64569 | 64570 | 64585 | 64595 | | | | | | |

9.2.43.19 Noncovered Neurostimulator Services

The following services are not a benefit of Texas Medicaid:

- VNS is not a benefit when provided for the treatment of depression.
- Neurostimulation and neuromuscular stimulation services for indications other than those outlined above.

9.2.44 Newborn Services

The newborn period is defined as the time from birth through 28 days of life. This section addresses routine newborn care, attendance at delivery, newborn resuscitation, neonatal critical care, and intensive (noncritical) low birth weight services.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

All newborn E/M procedure codes must have a newborn outcome diagnosis code included on the claim. Modifier 25 may be used to identify a significant separately identifiable E/M provided on the same day by the same physician as a procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Physician standby (procedure code 99360) is not a benefit.

Note: Some of the services addressed in this section may also be used for care beyond 28 days of life.

Referto: Subsection 9.2.56, "Physician Evaluation and Management (E/M) Services" in this handbook.

Referto: Subsection 2.2.23.13, “Cardiorespiratory Monitor (CRM)” in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook (Vol. 2, Provider Handbooks)* for authorization of cardiorespiratory monitors.

9.2.44.1 Circumcisions for Newborns

Texas Medicaid may provide reimbursement for circumcisions billed with procedure code 54150 or procedure code 54160.

9.2.44.2 Hospital Visits and Routine Care

The following procedure codes may be reimbursed for neonatal care and intensive care services:

| Service | Procedure Code(s) | Benefit(s) and Limitation(s) |
|--|---|--|
| Initial hospital E/M admission | 99221 99222 99223 | If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission. Reimbursed one per day, any provider. |
| Hospital discharge | 99238 99239 | Reimbursed for the client’s discharge from the hospital. |
| Subsequent hospital and hospital consultation services | 99251 99252 99253 99254 99255 | Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99251, 99252, 99253, 99254, and 99255). |
| Initial newborn care | 99460* | May be reimbursed once per lifetime, any provider. |
| Normal newborn care | 99461* | May be reimbursed once per lifetime, any provider. Subsequent visits must be billed using an appropriate visit code based on the place of service. |
| Subsequent hospital care | 99462 | Reimbursable once per day in the hospital and limited to a total of seven days. Restricted to clients who are birth through seven days of age. If the client is diagnosed with a condition that requires more complex care and/or must stay more than 8 days, the provider must bill subsequent neonatal and pediatric care critical or intensive care (procedure codes 99469, 99478, 99479, or 99480). If the client is readmitted, the provider must bill an initial hospital E/M admission (procedure code 99221, 99222, 99223, or 99468) and the appropriate code for inpatient neonatal critical care (procedure code 99469). Procedure code 99462 is not reimbursable in the birthing center. |
| Newborn admission and discharge, same date | 99463** | May be reimbursed once per lifetime when submitted by any provider. Reimbursed for newborns who are admitted and discharged on the same day from the hospital or birthing room setting (either hospital or birthing center). |
| Attendance at delivery | 99464 | May be reimbursed once, and only on the day of delivery, when billed by a physician other than the delivering physician. |
| <p>* Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.</p> <p>** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).</p> | | |

| Service | Procedure Code(s) | Benefit(s) and Limitation(s) |
|--|-------------------------|--|
| Newborn resuscitation | 99465 | Reimbursed for the resuscitation of the newborn. |
| Initial hospital care and initial intensive care | 99477 | Reimbursed for those neonates who require intensive observation, frequent interventions, and other intensive services. Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Initial neonatal critical and intensive care (procedure codes 99468 and 99477) may be reimbursed once per admission, any provider. Note: For subsequent admissions during the first 28 days of life, procedure codes 99468 and 99477 may be considered for reimbursement upon appeal. |
| Subsequent intensive care | 99478 99479 99480 | Non-time-based procedure codes must be billed daily irrespective of the time that the provider spends with the neonate or infant. Subsequent critical and intensive care (procedure codes 99469, 99478, 99479, and 99480) will be considered for reimbursement once per day, any provider. Services for a client who is not critically ill and unstable but who happens to be in a critical care unit must be reported using subsequent hospital codes (99478, 99479, and 99480) or hospital consultation codes (99251, 99252, 99253, 99254, and 99255). Procedure codes 99478, 99479, and 99480 must be billed for subsequent neonatal intensive (noncritical) services. The present body weight of the neonate or infant determines the appropriate procedure code that must be billed. When the present body weight of a neonate exceeds 5,000 grams, a subsequent hospital care service (procedure code 99231, 99232, or 99233) must be billed. |
| <p>* Newborn examinations billed with procedure codes 99460, 99461, and 99463 may be counted as a THSteps periodic medical checkup when all necessary components are completed and documented in the medical record.</p> <p>** If the client is readmitted within the first 28 days of life, the provider must bill an initial hospital evaluation and management (E/M) admission (procedure code 99221, 99222, or 99223).</p> | | |

Note: Services for a newborn's unsuccessful resuscitation may be billed under the mother's Texas Medicaid number using procedure code 99499.

Referto: Section 4, "THSteps Medical" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)*.

Subsection 4.3.9, "Newborn Examination" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)* for a list of the required components for an initial THSteps exam.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing a claim.

In the following table, procedure codes in Column A will be denied when billed with the same date of service by the same provider as a procedure code in Column B:

| Column A (Denied) | Column B |
|--|---------------------|
| 99238, 99239 | 99460, 99461, 99463 |
| 99462 | 99238, 99239 |
| 36410, 96361, 99292, 99307, 99354, 99355, 99356, 99357 | 99468, 99469 |

| Column A (Denied) | Column B |
|---|----------|
| 36410, 96361, 99354, 99355, 99356, 99357, 99471, 99472 | 99477 |
| 36410, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478 | 99478 |
| 36410, 94761, 96361, 99291, 99292, 99307, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479 | 99479 |
| 36410, 96361, 99291, 99292, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99354, 99355, 99356, 99357, 99471, 99472, 99478, 99479, 99480 | 99480 |

9.2.44.3 Newborn Hearing Screening

The newborn hearing screening procedure is a screening procedure, not diagnostic, and will not be reimbursed separately from the usual inpatient newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants. For more information on newborn hearing screening, providers may contact:

Texas Early Hearing Detection and Intervention
PO Box 149347, MC-1918
Austin, TX. 78714-9347
1-512-458-7111, Ext. 2600
www.dshs.texas.gov/tehdi

Referto: Section 2, “Nonimplantable Hearing Aid Devices and Related Services” in the *Vision and Hearing Services Handbook* (Vol. 2, *Provider Handbooks*).

Subsection 4.3.11.2.3, “Hearing Screening” in the *Children’s Services Handbook* (Vol. 2, *Provider Handbooks*) for additional information about hearing screenings.

9.2.45 Occupational Therapy (OT) Services

Occupational therapy (OT) is a payable benefit to physicians.

Referto: Section 4, “Therapy Services Overview” in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (Vol. 2, *Provider Handbooks*) for information about occupational therapy services provided by a physician.

9.2.46 Ophthalmology

When an ophthalmologist sees a client for a minor condition that does not require a complete eye exam, such as conjunctivitis, providers are to use the appropriate office E/M code.

Providers are to use the eye exam procedure codes with a diagnosis of ophthalmological disease or injury.

Referto: Subsection 4.3.5, “Vision Testing” in the *Vision and Hearing Services Handbook* (Vol. 2, *Provider Handbooks*).

9.2.46.1 Corneal Transplants

Corneal transplants are benefits of Texas Medicaid. Corneal transplants are subject to global surgery fee guidelines. Procedure codes 65710, 65730, 65750, 65755, 65756, and 65757 are used for this surgery.

Bioengineered cornea transplants remain investigational at this time and are not considered for reimbursement under Texas Medicaid.

Procurement of the cornea is not reimbursed separately.

9.2.46.2 Eye Surgery by Laser

Eye surgery by laser is a benefit of Texas Medicaid when medically necessary and meets the conditions and limitations stated in this section.

Authorization is not required for eye surgery by laser.

All procedure codes in this section are subject to multiple surgery guidelines. For bilateral procedures, the following modifiers must be added to the claim to indicate that the procedures were performed on the right and left eyes:

- Modifier RT to indicate the right eye
- Modifier LT to indicate the left eye

All procedures may be reimbursed only to physicians and are limited to reimbursement once every 90 days for the same eye with the exception of infants from birth through 23 months of age. Procedures performed on infants from birth through 23 months of age are not subject to any frequency restrictions.

9.2.46.2.1 Other Eye Surgery Procedures

Anterior Segment of the Eye–The Cornea

Laser surgery to the cornea by laser-assisted in situ keratomileusis (LASIK) or photorefractive keratectomy (PRK) for the purpose of correcting nearsightedness (myopia), farsightedness (hyperopia), or astigmatism is not a benefit of Texas Medicaid.

Reimbursement for laser surgery to the cornea, procedure codes 65450, 65855, and 65860 is limited to once every 90 days for the same eye.

Anterior Segment of the Eye–The Iris, Ciliary Body

Laser surgery to the anterior segment of the eye–the iris, ciliary body may be reimbursed only when billed with one of the following procedure codes:

| Procedure Codes | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|
| 66600 | 66605 | 66710 | 66711 | 66761 | 66762 | 66770 |

Reimbursement for procedure codes 66600, 66605, 66710, 66711, 66761, 66762, and 66770 is limited to once every 90 days for the same eye.

Claims for iridectomy (66600, 66605, 66625, 66630, or 66635) or iridotomy (66500 or 66505) are not reimbursed when billed for the same date of service as a trabeculectomy (66170 or 66172). These claims are considered for review when filed on appeal with documentation of medical necessity. The iridectomy is considered part of a trabeculectomy. An iridectomy billed with any other eye surgery on the same day suspends for review.

An iridectomy is also considered part of certain types of cataract extractions. An iridectomy (66600 or 66605) is not reimbursed when billed for the same date of service as the cataract surgeries listed in the following table. The iridectomy is considered part of the cataract surgery. These claims are considered for review when filed on appeal with documentation of medical necessity.

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 65920 | 66840 | 66850 | 66852 | 66920 | 66930 | 66940 | 66983 | 66984 | 66985 |
| 66986 | | | | | | | | | |

Posterior Segment of the Eye–Retina or Choroid

Laser surgery to the retina or choroid may be reimbursed only when billed with one of the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 67105 | 67107 | 67108 | 67110 | 67113 | 67145 | 67210 | 67220 | 67221 | 67225 |
| 67228 | 67229 | G0186 | | | | | | | |

Procedure code 67229 is restricted to clients who are birth through 1 year of age.

When billed for the same date of service, same eye, any provider, procedure code 67031 will be denied as part of any of the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 67036 | 67108 | 67110 | 67120 | 67121 | 67141 | 67142 | 67208 | 67210 | 67218 |
| 67227 | 67228 | | | | | | | | |

When billed for the same date of service, same eye, any provider, only one of the following procedure codes may be reimbursed: 67220, 67221, 67225, or G0186.

When billed for the same date of service, same eye, by any provider, procedure codes 67025, 67028, 67031, 67036, 67039, 67040, and 67105 will be denied as part of 67108.

Posterior Segment of the Eye, Vitreous–Vitreotomy

Laser surgery to the vitreous may be reimbursed only when billed with one of the following procedure codes: 67031, 67039, 67040, and 67043.

Reimbursement for procedure codes 67031, 67039, 67040, and 67043 is limited to once every 90 days for the same eye.

When billed for the same date of service, same eye, any provider procedure codes 67500 and 69990 are denied as part of 66821.

Procedure code 66821 is denied as part of 66830, 67031, and 67228.

Procedure codes 66820, 66984, 66985, and 67036 will pay according to multiple surgery guidelines when billed with procedure code 66821.

When billed for the same date of service, same eye, different provider procedure codes 66821, 67005, 67010, and 69990 will be denied as part of 67031.

When billed for the same date of service, same eye, any provider procedure code 67031 will be denied as part of any of the following procedure codes: 67036, 67108, 67110, 67120, 67121, 67208, 67218, 67227, and 67228.

9.2.46.3 Eye Surgery by Incision

The following restrictions apply to vitrectomy and cataract surgeries:

- Procedure codes 66500, 66505, 66605, 66625, 66630, and 66635 are denied as part of another procedure when billed with the following cataract surgeries: 65920, 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984, 66985, and 66986. Claims may be appealed with additional documentation to demonstrate the medical necessity.
- Procedure code 66020 is denied as part of another procedure when billed with any related eye surgery procedure code.
- Procedure code 67036 may be reimbursed when billed alone.

- Procedure code 67036 is denied as part of another procedure when billed with procedure codes 67039, 67040, 67041, 67042, 67043, or 67108.
- Procedure codes 67039 and 67040 are combined and reimbursed as procedure code 67108 when billed by the same provider for the same date of service.
- For clients who are 8 years of age and younger, the following cataract extraction and vitrectomy procedure codes, performed on the same eye, will be considered for payment per multiple surgery guidelines:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 66840 | 66850 | 66852 | 66920 | 66930 | 66940 | 66983 | 66984 | 67005 | 67010 |
| 67015 | 67025 | 67027 | 67028 | 67030 | 67031 | 67036 | 67039 | 67040 | 67041 |
| 67042 | 67043 | | | | | | | | |

- For clients who are nine years of age and older, the following procedure codes will be paid when performed on the same eye as a cataract extraction:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 67005 | 67010 | 67015 | 67025 | 67027 | 67028 | 67030 | 67031 | 67036 | 67039 |
| 67040 | 67041 | 67042 | 67043 | | | | | | |

- For clients who are nine years of age and older, the following procedure codes will be denied as part of the codes listed above, when performed on the same eye:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|--|--|
| 66840 | 66850 | 66852 | 66920 | 66930 | 66940 | 66983 | 66984 | | |

Reimbursement for procedure codes 67041, 67042, and 67043 is limited to once every 90 days for the same eye.

9.2.46.4 Intraocular Lens (IOL)

An IOL (V2630, V2631, and V2632) may be reimbursed only to physicians in the office setting (POS 1). Providers must submit a copy of the manufacturer's invoice for procedure code V2631 to TMHP with their claim. Reimbursement for the lens is limited to the actual acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed five percent of the acquisition cost.

Medicaid does not reimburse physicians who supply IOLs to ASCs/HASCs.

Reimbursement for the surgical procedure necessary to implant an IOL remains unchanged.

9.2.46.5 Intravitreal Drug Delivery System

Procedure codes 67027 and 67121 pertain to the procurement, implantation, and removal of an intravitreal drug delivery system (e.g., a ganciclovir implant). They are set to deny when billed concurrently.

9.2.46.6 Other Eye Surgery Limitations

The following procedure codes require modifier LT or RT to identify the eye for which the surgery is being performed:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 65205 | 67311 | 67312 | 67314 | 67316 | 67318 | 67320 | 67331 | 67332 | 67334 |
| 67345 | 67414 | 67800 | 67801 | 67805 | 67808 | V2790 | | | |

In the following table, the procedure codes in Column A may be reimbursed only when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

| Column A Procedure Codes | Column B Procedure Codes |
|----------------------------|---|
| 66990 | 65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, or 67113 |
| 67320, 67331, 67332, 67334 | 67311, 67312, 67314, 67316, or 67318 |
| 67335, 67340 | 67311, 67312, 67314, 67316, 67318, 67320, 67331, 67332, or 67334 |
| V2790 | 65780 |

9.2.47 Organ/Tissue Transplants

Organ/tissue transplants that include bone marrow, peripheral stem cell, heart, intestine, lung, liver, kidney, or pancreas are a benefit of Texas Medicaid.

Solid organ transplants are a benefit of Texas Medicaid when medically necessary based on safety and efficacy, as demonstrated by scientific evidence and by controlled clinical studies, in accordance with the Texas Administrative Code (TAC). Solid organ transplants are limited to clients with a critical medical condition who are expected to have a successful clinical outcome that will result in a return to improved functional independence. Benefits are not available for the following experimental or investigational services:

- Artificial and bioartificial livers
- Xenotransplantation of solid organs
- Thymus transplant

Coverage is limited to one transplant per organ system (or organ systems for combined transplants) per lifetime except for one subsequent transplant because of organ rejection.

Solid organ transplants require prior authorization and may be reimbursed only when performed in a Medicaid-enrolled facility that is a designated children's hospital with a transplant unit or program, or certified for the procedure by the United Network for Organ Sharing (UNOS).

The facility must be in Texas, unless there are no Texas facilities certified by UNOS or designated as a Children's Hospital with a transplant unit or program for the requested procedure.

All requests for out-of-state (OOS) services, whether for pre-transplant evaluation, transportation, or post-transplant monitoring, must be sent to the medical director for prior authorization review. Texas Medicaid will consider authorizing OOS services when the following criteria are met:

- The client does not leave Texas to receive care that can be received in Texas.
- An in-state facility approved for the procedure has declined to accept the client and documentation is submitted to explain why the in-state team cannot perform the procedure.
- There is no physician provider or facility with the level of expertise required to perform the necessary procedure available in Texas, or the client has received an initial transplant at the OOS facility and requires additional transplant services due to complications or graft loss.
- There is reasonable assurance that the client meets the clinical criteria required by Texas Medicaid for transplant approval.
- The service is necessary, reasonable, and federally allowable, and the facility and physicians agree to accept Medicaid reimbursement for these services.

- The OOS facility must be certified by UNOS or designated as a Children's Hospital with a transplant unit or program.

When requesting an OOS prior authorization for a pre-transplant evaluation, the provider must submit a copy of the transplant evaluation performed by a Texas facility to support the need for an OOS solid organ pre-transplant evaluation.

When requesting an OOS prior authorization for transplant of a solid organ, the provider must submit a copy of the transplant evaluation performed by a Texas facility and a copy of the transplant evaluation performed by the OOS facility to support the need for an OOS solid organ transplant.

When requesting an OOS prior authorization for post-transplant monitoring or other post-transplant services, the provider must submit documentation that the client received the initial transplant at the same OOS facility to include complications or graft loss if present, in order to support the need for OOS solid organ post-transplant monitoring or other post-transplant services.

Expenses incurred for the procurement of a living donor's organ are not a benefit of Texas Medicaid.

Referto: Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information about the transplant facility approval criteria.

Subsection 3.2.5.2, "Transplant Benefits and Limitations" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information about organ/tissue transplant program limitations.

9.2.47.1 General Prior Authorization Requirements

Solid organ transplant prior authorization requests must include all of the following:

- A complete history and physical
- A statement of the current medical conditions and status of the transplant recipient
- Documentation of how the client meets the prior authorization criteria specified for the transplant requested
- Documentation of the absence of co-morbidities or contraindications such as the following:
 - Severe pulmonary hypertension
 - End-stage cardiac, renal, hepatic, or other organ dysfunction unrelated to the primary disorder
 - Uncontrolled HIV infection or AIDS defining illness
 - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
 - Ongoing or recurrent active infections that are not effectively treated
 - Psychiatric instability severe enough to jeopardize incentive for adherence to medical regimen
 - Active alcohol or chemical dependency that might interfere with compliance to a medical regimen
- History of compliance with other medical treatments, regimen, and plan of care

Backbench procedures do not require prior authorization but may only be reimbursed when a corresponding transplant procedure has been paid for the same date of service.

Note: Clients who are birth through 20 years of age and who do not meet the criteria for coverage may be considered through the Comprehensive Care Program (CCP).

Additional prior authorization criteria, if applicable, specific to each type of transplant are outlined in the following sections.

If prior authorization is not obtained for a solid organ transplant, services directly related to the transplant within the three-day preoperative and six-week postoperative period are also denied regardless of who provides the services (e.g., laboratory services, status post visits, radiology services). However, coverage for other services needed as a result of complication of the transplant or for services unrelated to the transplant may be considered when medically necessary, reasonable, and federally allowable.

Claims for transplant clients are placed on active review when the transplant was not prior authorized so that the services related to the transplant can be monitored.

9.2.47.2 Heart Transplants

9.2.47.2.1 Prior Authorization for Heart Transplants

A heart transplant to a client for primary heart dysfunction must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

Procedure code 33945 may be considered for prior authorization with medical necessity documentation that indicates a New York Heart Association (NYHA) Class III or IV cardiac disease with one of the following medical conditions:

- Congenital heart disease
- Valvular heart disease
- Viral cardiomyopathy
- Familial and restrictive cardiomyopathy

9.2.47.3 Intestinal Transplants

An intestinal transplant may be considered for clients who are dependent on parental nutrition and have compromised venous access, have had two or more episodes of central line sepsis, or who have begun to manifest progressive parental nutrition associated liver dysfunction. Procedure codes 44135 and 44136 must be prior authorized.

Small bowel transplantation is considered medically necessary in clients with irreversible intestinal failure including, but not limited to:

- Short bowel syndrome
- Pseudo-obstruction
- Microvillus inclusion
- Tumor

The prior authorization request must include documentation of irreversible intestinal failure with failed total parenteral nutrition (TPN) therapy. The client has experienced TPN failure if any one of the following criteria is met:

- Impending or overt liver failure due to TPN-induced liver injury. Clinical indicators include the following:
 - Increased serum bilirubin levels
 - Increased liver enzyme levels
 - Splenomegaly
 - Thrombocytopenia
 - Gastroesophageal varices
 - Coagulopathy
 - Stomal bleeding

- Hepatic fibrosis
- Cirrhosis
- Thrombosis of major central venous channels (subclavian, jugular, or femoral veins). Thrombosis of two or more of these vessels is considered a life-threatening complication and TPN failure.
- Frequent central line-related sepsis. Two or more episodes of central-line-induced systemic sepsis per year that require hospitalization are considered TPN failure. A single episode of central-line-related fungemia, septic shock, or acute respiratory distress syndrome is considered TPN failure.
- Frequent episodes of severe dehydration despite TPN and intravenous fluid supplement. Under certain medical conditions, such as secretory diarrhea and nonconstructable gastrointestinal tract, the loss of combined gastrointestinal and pancreatobiliary secretions exceed the maximum intravenous infusion rates that can be tolerated by the cardiopulmonary system.

Diagnoses that indicate intestinal failure include, but are not limited to, the following:

- Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment
- Small bowel syndrome resulting from postsurgical conditions due to resections
- Intestinal cysts
- Mesenteric cysts
- Small bowel or other tumors involving small bowel
- Crohn's disease
- Mesenteric thrombosis
- Volvulus
- Short-gut syndrome in which there is liver function impairment (usually secondary to TPN)

9.2.47.4 Kidney Transplants

9.2.47.4.1 Prior Authorization for Kidney Transplants

Procedure codes 50360 and 50365 must be prior authorized. Medical necessity documentation of one of the following is required:

- Hemodialysis or continuous ambulatory peritoneal dialysis (CAPD).
- Chronic renal failure with anticipated deterioration to end-stage renal disease.
- End-stage renal disease, evidenced by a creatinine clearance below 20 ml/min or development of symptoms of uremia.
- End-stage renal disease that requires dialysis or is expected to require dialysis within the next 12- to 18-month period.

9.2.47.4.2 Cytogam

Procedure code J0850 is reimbursable by Texas Medicaid. Cytogam is indicated for the attenuation of primary cytomegalovirus disease in seronegative kidney transplant recipients who receive a kidney from a seropositive donor. Payment of cytogam is limited to diagnosis code Z940, Z941, Z942, Z943, Z944, or Z9483. Cytogam is payable only in the office or outpatient setting.

Referto: Subsection 3.2.5, "Organ and Tissue Transplant Services" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for more information about the transplant facility approval criteria.

9.2.47.5 Liver Transplants

9.2.47.5.1 Prior Authorization for Liver Transplants

For a client to be considered for coverage of a liver transplant, the medical records for the client must include documentation showing the client is unresponsive to more conventional and/or standard therapies.

Authorization of procedure codes 47133 and 47135 requires medical necessity documentation of liver disease in one of the following categories:

- Primary cholestatic liver disease
- Other cirrhosis:
 - Alcoholic
 - Hepatitis C, non-A, non-B, and Hepatitis B
- Fulminant hepatic failure
- Metabolic diseases
- Malignant neoplasms
- Benign neoplasms
- Biliary atresia

9.2.47.6 Lung Transplants

9.2.47.6.1 Prior Authorization for Lung Transplants

A lung transplant to a client must be documented as unresponsive to more conventional and/or standard therapies to be considered for coverage.

Prior authorization of procedure codes 32851, 32852, 32853, 32854, and S2060 may be considered with medical necessity documentation of the following:

- Symptoms at rest directly related to chronic pulmonary disease and resultant severe functional limitation
- End-stage pulmonary diseases in one of these categories:
 - Obstructive lung disease
 - Restrictive lung disease
 - Cystic Fibrosis
 - Pulmonary hypertension

9.2.47.7 Pancreas Transplant

9.2.47.7.1 Prior Authorization for Pancreas Transplant

A pancreas/simultaneous kidney-pancreas transplant must be documented as the client being unresponsive to more conventional and/or standard therapies to be considered for coverage.

For prior authorization of procedure codes 48160 and 48554, medical necessity documentation must be submitted that shows the following:

- Recurrent, acute, and severe metabolic and potentially life-threatening complications requiring medical attentions such as:
 - Hypoglycemia
 - Hyperglycemia

- Ketoacidosis
- Failure of exogenous insulin-based management to achieve sufficient glycemic control (HbA1c of greater than 8.0) despite aggressive conventional therapy
- Insensibility to hypoglycemia; or
- Satisfactory kidney function (creatinine clearance greater than 40mL/min), except for kidney-pancreas transplants; and
- Type 1 diabetes with secondary diabetic complications that are progressive despite the best medical management; and
- At least two of the following secondary complications:
 - Diabetic neuropathy
 - Retinopathy
 - Gastroparesis
 - Autonomic neuropathy
 - Extremely labile (brittle) insulin-dependent diabetes mellitus

9.2.47.8 Multi-Organ Transplants

Procedure codes 33935, S2053, and S2054 may be considered for prior authorization if medical necessity documentation meets the requirements for each organ.

Procedure code S2065 may be considered for prior authorization if medical necessity documentation indicates the client meets criteria for a pancreas transplant and has end-stage renal disease that requires dialysis or is expected to require dialysis within the next 12 months.

9.2.47.9 Nonsolid Organ Transplants

Nonsolid organ transplants covered by Texas Medicaid include allogeneic and autologous stem cell transplantation, allogeneic and autologous bone marrow transplantation, autologous islet cell transplantation, and hematopoietic progenitor cell (HPC) boost infusion.

9.2.47.9.1 Allogeneic and Autologous Bone Marrow and Stem Cell Transplantation

Stem cell transplantation is a process in which stem cells are obtained from either a client's or donor's bone marrow, peripheral blood, or umbilical cord blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy and/or radiotherapy used to treat various malignancies, and also can be used to restore function in clients having an inherited or acquired deficiency or defect.

Benefits are not available for any experimental or investigational services, supplies, or procedures.

Coverage of bone marrow and stem cell transplantation is limited to the following procedure codes: 38206, 38230, 38232, 38240, 38241, 38242, and S2142.

Texas Medicaid recognizes the following covered indications for stem cell transplants:

- Allogeneic
 - Hematological malignancy
 - Lymphatic malignancy
 - Bone marrow disorders
 - Hemoglobinopathies
 - Platelet function disorders

- Immunodeficiency disorders
- Inherited metabolic disorders
- Multiple myeloma/plasma cell disorders
- Autologous
 - Hematological malignancy
 - Lymphatic malignancy
 - Germ cell tumors
 - Brain tumors
 - Small round blue cell tumors of childhood
 - Multiple myeloma/plasma cell disorders
- Indications for additional infusions
 - Infusion of stem cells for failure to graft (autologous)
 - Donor leukocyte infusion for persistent or relapsed malignant disease (allogeneic)
- Indications for re-transplantation
 - Relapse of disease
 - Failure to engraft or poor graft function

9.2.47.9.2 Autologous Islet Cell Transplantation

Autologous islet cell transplantation associated with the complete or partial removal of the pancreas (procedure code 48160) is a benefit of Texas Medicaid only for clients with a diagnosis of chronic pancreatitis.

Allogeneic islet cell transplantation is not a benefit.

9.2.47.9.3 HPC Boost Infusion

Prior authorization is required for HPC boost infusion procedure code 38243. The prior authorization request must include documentation of a prior stem cell transplant.

Requests for more than two boost procedures per lifetime requires medical necessity review and approval by the medical director.

9.2.47.9.4 Prior Authorization for Nonsolid Organ Transplants

All nonsolid organ transplants require mandatory prior authorization and must be performed in a Texas facility that is a designated children's hospital or a facility in compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN), the United Network for Organ Sharing (UNOS), or the National Marrow Donor Program (NMDP). Prior authorization is effective for the date span specified on the prior authorization approval letter. If the transplant has not been performed by the end of the authorization period, the physician must apply for an extension.

Documentation supplied with the prior authorization request must include the following:

- A complete history and physical.
- A statement of the client's current medical condition and the expected long-term prognosis for the client from the proposed procedure.

Each subsequent transplant must be prior authorized separately.

Peripheral or umbilical cord blood stem cell transplantation may be authorized in lieu of bone marrow transplantation (BMT), but will not be approved when performed simultaneously.

If a stem cell transplant has been prior authorized for a client who is 21 years of age or older, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay.

Bone marrow harvesting (38230) or peripheral stem cell harvesting (38206) for autologous bone marrow or stem cell transplants are a benefit of Texas Medicaid and require prior authorization.

Autologous harvesting of stem cells (single or multiple sessions) may be reimbursed to the facility when prior authorized by HHSC or its designee and performed in the outpatient setting (POS 5). Harvesting of stem cells performed in the inpatient setting (POS 3) is included in the DRG and will not be reimbursed separately.

Physician services for the storage of stem cells are not a benefit of Texas Medicaid.

Donor expenses are included in the global fee for the transplant recipient and are not reimbursed separately. Therefore, allogeneic bone marrow or stem cell harvesting procedures are not a benefit of Texas Medicaid.

Stem cell transplants for other conditions may be considered on a case by case basis. Documentation for prior authorization must be submitted to determine whether the transplant is medically necessary and appropriate.

9.2.47.10 Organ Procurement

The appropriate DRG reimbursement coverage to the approved institution for a prior authorized solid organ transplant procedure includes procurement of the organ and services associated with the organ procurement as specified by HHSC or its designee. Documentation of organ procurement must be maintained in the hospital medical records.

9.2.48 Orthognathic Surgery

Orthognathic surgery is a benefit of Texas Medicaid only when it is necessary for medical reasons, or when it is necessary as part of an approved plan of care in the Texas Medicaid Dental Program. Orthognathic surgery is administered and may be reimbursed as part of the medical/surgical benefit of Texas Medicaid and not as part of the Texas Medicaid Dental Program.

Treatment of malocclusion is a benefit of the Texas Medicaid Dental Program. Orthognathic surgery is a benefit when it is necessary as part of the approved dental benefit.

Maxillary and/or mandibular facial skeletal deformities are associated with clearly abnormal masticatory malocclusion.

Orthognathic surgery may be considered medically necessary for the following client conditions:

- Producing signs or symptoms of masticatory dysfunction
- Facial skeletal discrepancies associated with documented sleep apnea, airway defects, and soft tissue discrepancies
- Facial skeletal discrepancies associated with documented speech impairments
- Structural abnormalities of the jaws secondary to infection, trauma, neoplasia, or congenital anomalies

Orthognathic surgery may be considered for reimbursement when required for the client to access a dental service. Orthognathic surgery that is done primarily to improve appearance and not for reasons of medical necessity is considered cosmetic and is not a benefit of Texas Medicaid.

9.2.48.1 Prior Authorization for Orthognathic Surgery

The following orthognathic medical surgical services may be considered for reimbursement to oral and maxillofacial surgeons with prior authorization. A narrative explaining medical necessity must be provided with the authorization request.

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 21010 | 21031 | 21032 | 21050 | 21060 | 21073 | 21100 | 21110 | 21120 | 21121 |
| 21122 | 21123 | 21125 | 21127 | 21137 | 21138 | 21139 | 21141 | 21142 | 21143 |
| 21145 | 21146 | 21147 | 21150 | 21151 | 21154 | 21155 | 21159 | 21160 | 21172 |
| 21175 | 21179 | 21180 | 21181 | 21182 | 21183 | 21184 | 21188 | 21193 | 21194 |
| 21195 | 21196 | 21198 | 21199 | 21206 | 21208 | 21209 | 21210 | 21215 | 21230 |
| 21235 | 21240 | 21242 | 21243 | 21244 | 21247 | 21255 | 21256 | 21260 | 21261 |
| 21263 | 21267 | 21268 | 21270 | 21275 | 21295 | 21296 | 21299 | 29800 | 29804 |
| 40840 | 40842 | 40843 | 40844 | 40845 | | | | | |

9.2.49 Osteopathic Manipulative Treatment (OMT)

OMT, when performed by a physician (MD or DO), is a benefit of Texas Medicaid for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury with a neurological component.

OMT is covered when it is performed with the expectation of restoring the patient's level of function, which has been lost or reduced by injury or illness. Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. A model of documentation that supports medical necessity for the treatment plan includes the following:

- Specific modalities/procedures to be used in treatment
- Diagnosis
- Region treated
- Degree of severity
- Impairment characteristics
- Physical examination findings (X-ray or other pertinent findings)
- Specific statements of long- and short-term goals
- Reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment (number of times per week)
- Equipment and techniques used

The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

Reimbursement is contingent on correct documentation of the condition. The acute modifier AT must be submitted with the claim for payment to be made. Paper claims submitted without modifier AT will be denied; electronic claims will be rejected. The AT modifier is described as representing treatment provided for an acute condition or an exacerbation of a chronic condition that persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that

the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

The following procedure codes are payable when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions: 98925, 98926, 98927, 98928, and 98929.

OMT will be denied when billed on the same date of service by the same provider as any of the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 00640 | 51701 | 51702 | 51703 | 64400 | 64405 | 64408 | 64412 | 64415 | 64416 |
| 64417 | 64418 | 64420 | 64421 | 64425 | 64430 | 64435 | 64445 | 64446 | 64447 |
| 64448 | 64449 | 64450 | 64470 | 64472 | 64475 | 64476 | 64479 | 64480 | 64483 |
| 64484 | 64505 | 64510 | 64517 | 64520 | 64530 | 96360 | 96365 | 96372 | 96374 |
| 96375 | 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 |
| 99217 | 99218 | 99219 | 99220 | 99221 | 99222 | 99223 | 99231 | 99232 | 99233 |
| 99234 | 99235 | 99236 | 99238 | 99239 | 99241 | 99242 | 99243 | 99244 | 99245 |
| 99251 | 99252 | 99253 | 99254 | 99255 | 99281 | 99282 | 99283 | 99284 | 99285 |
| 99291 | 99304 | 99305 | 99306 | 99307 | 99308 | 99309 | 99310 | 99315 | 99316 |
| 99318 | 99324 | 99325 | 99326 | 99327 | 99328 | 99334 | 99335 | 99336 | 99337 |
| 99341 | 99342 | 99343 | 99344 | 99345 | 99347 | 99348 | 99349 | 99350 | 99354 |
| 99356 | 99460 | 99461 | 99462 | 99463 | 99464 | 99465 | 99468 | 99469 | 99471 |
| 99472 | 99478 | 99479 | 99480 | | | | | | |

When multiples of procedure codes 98925, 98926, 98927, 98928, and 98929 are billed on the same day by any provider, the most inclusive code is paid and the others are denied.

An E/M or initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day if the client's condition requires a visit for a significant and separately identifiable service above and beyond the usual pre- and post-care associated with the OMT procedure, even if the visit and OMT are related to the same symptom or condition. Modifier 25 must be submitted with the E/M procedure code to identify a separate and distinct service rendered on the same day as OMT.

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Procedure code 97140 will be denied as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

9.2.50 Pain Management

Pain management is a benefit of Texas Medicaid.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as another surgical procedure performed by the same physician are paid according to multiple surgery guidelines.

Procedure codes 62350, 62351, 62355, 62360, 62361, 62362, and 62365 billed on the same day as an anesthesia procedure performed by the same physician are denied as included in the total anesthesia time.

Reimbursement to the physician for the surgical procedure is based on the assigned RVUs or maximum fee. Outpatient facilities are reimbursed at their reimbursement rate. Inpatient facilities are reimbursed under the assigned diagnosis-related group (DRG). No separate payment for the intrathecal pump is made.

Use the following procedure codes when billing for the implantation/revision/replacement of the pump/catheter:

| Procedure Codes | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|
| 62350 | 62351 | 62355 | 62360 | 62361 | 62362 | 62365 |

Procedure codes 62367 and 62368 do not require prior authorization and are payable as a medical service only.

Referto: Subsection 9.2.38, “Implantable Infusion Pumps” in this handbook for more information about implanted pumps.

Acute pain is defined as pain caused by occurrences such as trauma, a surgical procedure, or a medical disorder manifested by increased heart rate, increased blood pressure, increased respiratory rate, shallow respirations, agitation or restlessness, facial grimace, or splinting.

Chronic pain is defined as persistent, often lasting more than six months; symptoms are manifested similarly to that of acute pain.

Postoperative refers to the time frame immediately following a surgical procedure in which a catheter is maintained in the epidural or subarachnoid space for the duration of the infusion of pain medication.

9.2.50.1 Epidural and Subarachnoid Infusion (Not Including Labor and Delivery)

Epidural and subarachnoid infusion for pain management is payable for acute, chronic, and postoperative pain management.

Procedure code 01996 is limited to once per day and is denied when billed on the same day as a surgical/anesthesia procedure. Procedure code 01996 billed longer than 30 days requires medical necessity documentation. Cancer diagnoses are excluded from the 30-day limitation.

Procedure code 01996 is payable to CRNAs and physicians.

9.2.51 Palivizumab Injections

RSV immune globulin, intramuscular palivizumab (*Synagis*) must be obtained through the Texas VDP. Providers must obtain prior authorization through the VDP.

Providers may not bill Texas Medicaid for RSV prophylaxis that was obtained through VDP; however providers may be reimbursed for administering the drug. Providers may refer to the HHSC Texas Medicaid/CHIP Vendor Drug Program website at www.txvendordrug.com/formulary/prior-authorization/synagis for more information about obtaining palivizumab for Texas Medicaid clients.

9.2.52 Panniculectomy and Abdominoplasty

Procedure codes 15830 and 15847 are benefits of Texas Medicaid when prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation establishing medical necessity of the service requested. This documentation must remain in the client's medical record and is subject to retrospective review.

9.2.52.1 Panniculectomy

A panniculectomy (procedure code 15830) may be reimbursed with prior authorization for one of the following conditions when the panniculus hangs to or below the level of the pubis:

- A panniculus has recurrent non-healing ulcers.

- Client is insulin dependent with recurring infection and causing the prolapse of a ventral hernia.
- Panniculus directly causes significant clinical functional impairment.

Panniculectomy is not a benefit when one of following is the primary purpose:

- To remove excess skin and fat from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To minimize the risk of ventral hernia formation of recurrence.
- For the sole purpose of treating neck or back pain.

Panniculectomy may be prior authorized when the client meets one of the following:

- Panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery.
- Panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis.
- Panniculectomy is planned with history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery.

If a panniculectomy is planned and there is no history of significant weight loss or gastric bypass surgery, or a panniculectomy is planned without history of gastric bypass surgery but with significant weight loss and the panniculus hangs to or below the level of the pubis, one of the following must be met:

- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

If a panniculectomy is planned with a history of gastric bypass surgery or abdominoplasty and the client is 12 months post-surgery, the following must be met:

- Documentation that the panniculus hangs to or below the level of the pubis and the client has maintained a significant (100 pounds or more), stable weight loss for at least six months. Documentation must include the weight loss history, prior and current height, prior and current weight, and the history and physical including all previous surgeries.
- Documentation of recurrent episodes of infection or recurrent non-healing ulcers over three months that are non-responsive to treatment or appropriate medical therapy, such as oral or topical prescription. The 12-month post-gastric bypass requirement may be waived.
- The client is insulin-dependent and has a serious infection control problem and the panniculus is causing the prolapse of a ventral hernia. The 12-month post-gastric bypass requirement may be waived.
- Documentation by the treating physician that the panniculus directly causes significant clinical functional impairment. The 12-month post-gastric bypass requirement may be waived. Clinical functional impairment may be indicated by associated musculoskeletal dysfunction or interference with activities of daily living and there is reasonable evidence to support that this surgical intervention will correct the condition.

All medical record documentation pertinent to the client's evaluation and treatment must support medical necessity of the panniculectomy. Documentation may include the following:

- Office records
- Consultation reports
- Operative reports
- Other hospital records (examples: pathology report, history and physical)

Documentation to support the panniculectomy must be submitted with the request for prior authorization. In addition to medical record documentation, the provider may also submit a letter of support or an explanation to substantiate medical necessity.

This service is typically expected to be limited to once per lifetime, by the same provider. Repeat panniculectomies may be considered for prior authorization upon submission of supporting documentation as outlined above.

A panniculectomy provided as a secondary surgery may be considered for prior authorization when the panniculus interferes with a medically necessary intra-abdominal surgery (e.g., abdominal hernia repair or hysterectomy) or to facilitate an improved anatomical field in order to provide radiation treatment to the abdomen. Documentation of medical necessity must include:

- The comorbidity for the diagnosis of the primary surgery or for the nature of the condition undergoing radiation treatment.
- Documentation supporting the need for the panniculectomy as the panniculus hangs below the level of the pubis and will significantly interfere with a planned surgical procedure, or the abdominal structures identified as requiring radiation therapy will not be adequately treated due to the size of the panniculus.

A panniculectomy provided as a secondary surgery may be considered when the primary surgery was performed for an urgent condition defined as a symptom or condition that is not an emergency, but requires further diagnostic workup or treatment within 24 hours to avoid a subsequent emergent situation.

The need for the panniculectomy as a secondary surgery in conjunction with a primary urgent surgery must be supported by retrospective review of submission of all of the following documentation:

- History and physical and the operative report.
- The panniculus hangs below the level of the pubis and would have significantly interfered with the urgent primary surgical procedure.

9.2.52.2 Abdominoplasty

An abdominoplasty (procedure code 15847) is a benefit for clients who are birth through 20 years of age and may be reimbursed with prior authorization for one of the following conditions:

- Prune belly
- Diastasis recti in the presence of a true midline hernia (ventral or umbilical)

Abdominoplasty is not a benefit when one of the following is the primary purpose:

- To remove excess skin and fat and tighten abdominal wall from the middle and lower abdomen in order to contour and alter the appearance of the abdominal area to improve appearance.
- Dissatisfaction with personal body image.
- To repair diastases recti (unless prior authorization criteria has been met).

Abdominoplasty may be prior authorized when the client meets all of the following criteria:

- Documented diagnosis of prune belly (i.e., Eagle Barret syndrome) or repair of diastasis recti in the presence of a true midline hernia (ventral or umbilical).
- Documentation for reconstructive surgery that must include appropriate historical medical record documentation and may include any of the following:
 - Consultation reports
 - Operative reports or other applicable hospital records (examples: pathology report, history and physical)
 - Office records
 - Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)
- For repair of diastasis recti with a true midline hernia, documentation must also include all of the following:
 - The size of the hernia
 - Whether it is reducible, painful, or other symptoms
 - Whether there is a defect rather than just thinning of the abdominal fascia

This service is typically expected to be limited to once per lifetime, by the same provider. Consideration of other abdominal diagnoses may be considered for prior authorization with the submission of additional supporting documentation that may include the following:

- Consultation reports
- Operative reports or other applicable hospital records (examples: pathology report, history and physical)
- Office records
- Letters with pertinent information from provider (when medical records are requested, a letter of support or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination)

9.2.53 Penile and Testicular Prostheses

The following services are a benefit of Texas Medicaid for male clients:

- Removal of a penile prosthesis without replacement (procedure codes 54406 and 54415).
- Insertion of testicular prosthesis for the replacement of congenitally absent testes or testes lost due to disease, injury, or surgery (procedure code 54660)—prior authorization is required.

Procedure code 54660 is a benefit for clients who are birth through 20 years of age. Insertion of a testicular prosthesis may be prior authorized with the following criteria:

- The client has lost a testicle as a result of cancer or trauma or has congenital absence of a testicle.
- The loss of the testicle has resulted in detrimental psycho-social sequelae, as evidenced by a psychiatric evaluation.

Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department using the Special Medical Prior Authorization (SMPA) Request Form. The request must be submitted with documentation that supports medical necessity.

9.2.54 Percutaneous Transluminal Coronary Interventions

Percutaneous transluminal coronary interventions are a therapeutic option for clients who have arteriosclerotic heart disease.

When any of the following procedure codes are performed on the same date of service and on the same vessel as intracoronary vessel stenting, any provider, only the stenting procedure code will be considered for reimbursement: 92973, 92982, 92984, 92995, and 92996.

Angioplasty, atherectomy, or thrombectomy performed on different coronary vessels may be reimbursed separately. When different coronary vessels are not indicated, only the stenting procedure will be paid.

9.2.55 Physical Therapy (PT) Services

Physical therapy (PT) is a payable benefit to physicians.

Referto: Section 4, “Therapy Services Overview” in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (Vol. 2, Provider Handbooks)* for information about physical therapy services provided by a physician.

9.2.56 Physician Evaluation and Management (E/M) Services

E/M is a benefit of Texas Medicaid. Providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS when selecting the level of service provided.

The following E/M services are benefits of Texas Medicaid:

- Domiciliary, rest home, or custodial care services
- Emergency department services
- Group clinical visits
- Home services
- Hospital services including inpatient, observation, critical care, discharge, and concurrent care services (includes consultation and prolonged services)
- Nursing facility services
- Office or other outpatient services for new and established patients (includes consultation and prolonged services)
- Preventive care visits
- Services outside of business hours
- Tobacco use cessation

Claims submitted to TMHP by physicians for services provided during an inpatient hospital stay must be received by TMHP within 95 days of each date of service, not 95 days of the discharge date.

Inpatient claims must indicate the facility’s provider identifier in Block 32 or in the appropriate field of electronic software.

9.2.56.1 Office or Other Outpatient Hospital Services

9.2.56.1.1 New and Established Patient Services

A new patient is one who has not received any professional services from a physician or from another physician of the same specialty who belongs to the same group practice, within the past three years. Providers must use procedure codes 99202, 99203, 99204, and 99205 when billing for new patient services provided in the office or an outpatient or other ambulatory facility. New patient visits are limited to one every three years, per client, per provider.

An established patient is one who has received professional services from a physician or from another physician of the same specialty within the same group practice, within the last three years. Providers must use procedure codes 99211, 99212, 99213, 99214, and 99215 when billing for established patient services provided in the office or an outpatient or other ambulatory facility.

Established office or outpatient care visits are limited to once per day, same provider. When a new patient checkup is billed for the same date of service as a new patient acute care visit, both new patient services may be reimbursed when billed by the same provider or provider group if no other acute care visits or preventive care medical checkups have been billed in the past three years.

Modifier 25 must be submitted when the services rendered are performed for a significant separately identifiable service by the same physician or physician group on the same date of service. Modifier 25 is required when the provider submits a claim with the following:

- A second office or outpatient visit on the same day as another office or outpatient visit
- An office or outpatient visit beyond the usual preoperative care associated with the procedure that was performed

Note: *Office or outpatient visits provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.*

Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request. The documentation must clearly indicate what the significant problem/abnormality was, including the important, distinct correlation with signs and symptoms to demonstrate a distinctly different problem that required additional work and must support that the requirements for the level of service billed were met or exceeded.

The date and time of both services performed must be outlined in the medical record and the time of the second service must be different than the time of the first service, although a different diagnosis is not required.

Examples of additional visits to which Modifier 25 must be appended include, but are not limited to:

- A second E/M service for the same date of service as a group visit with the required E/M visit.
- An established patient E/M service for the same date of service as a THSteps medical checkup.
- An E/M service for the same date of service as a scheduled procedure.

Office visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) provided on the same date of service as a planned procedure (minor or extensive) are included in the cost of the procedure and are not separately reimbursed.

Office visit procedure code 99211, 99212, 99213, 99214, or 99215 must be billed by the same provider with the same date of service as a group clinical visit.

9.2.56.2 Group Clinical Visits

Texas Medicaid may reimburse physicians for group clinical visits (procedure code 99078) providing clinical services and educational counseling to a group of clients with the same condition.

To be considered for reimbursement, procedure code 99078 must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215.

Group clinical visits may be reimbursed for established patients only. The client's plan of care must be determined and documented in the medical record by the physician before attending group clinical visits.

Participation of established patients in a group clinical visit is optional. Informed consent must be obtained from the client and maintained in the medical record before rendering group clinical visit services.

The physician leading the group clinical visit is responsible for the effectiveness and content of the information provided during the group clinical visit.

Nationally approved curriculum on asthma and diabetes, such as that available through the American Association of Diabetic Educators and Asthma Education and Prevention Programs approved by the CDC must be incorporated into the educational portion of group clinical visits.

Group clinical visits must last at least 1 hour, but no longer than 2 hours, with a minimum of 2 clients and a maximum of 20.

To promote self-management of the chronic disease, the group visit must include a presentation that instructs and informs the client about clinical issues, including how to prevent disease exacerbation or complications, properly use medications and other therapeutic techniques, or live with chronic illness topics. Group visit presentations must include:

- Diabetic education consisting of the following:
 - What diabetes is
 - Nutrition
 - Exercise and physical activity
 - Prevention of acute complications
 - Prevention of chronic complications
 - Monitoring
 - Medication
- Asthma education consisting of the following:
 - What is asthma?
 - What are symptoms of asthma?
 - What happens during an episode of asthma?
 - What exacerbates asthma?
 - How is asthma controlled?
 - What physical activities can people with asthma do?
 - A question and answer period
 - A short (approximately 5 to 15 minutes per client) one-on-one private direct (face-to-face) encounter with the physician consisting of:
 - A physical exam
 - The gathering, monitoring, and reviewing of laboratory and diagnostic tests
 - Medical decision making that includes an individual treatment plan

Documentation in the client's medical record must support level of E/M service as per the CMS and CPT manual approved guidelines.

The documentation of the individual treatment plan retained in the client's medical record must include data collected (physical exam and lab findings), educational services provided, patient participation, and the beginning and ending time of the visit.

Group visits for conditions of diabetes or asthma are limited to a maximum of four per year for any provider.

9.2.56.2.1 Group Clinical Visits for Diabetes

Group clinical visits are benefits of Texas Medicaid for the management of the condition of diabetes when submitted with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| E0800 | E0801 | E0810 | E0811 | E0821 | E0822 | E0829 | E08311 |
| E08319 | E083211 | E083212 | E083213 | E083219 | E083291 | E083292 | E083293 |
| E083299 | E083311 | E083312 | E083313 | E083319 | E083391 | E083392 | E083393 |
| E083399 | E083411 | E083412 | E083413 | E083419 | E083491 | E083492 | E083493 |
| E083499 | E083511 | E083512 | E083513 | E083519 | E083521 | E083522 | E083523 |
| E083529 | E083531 | E083532 | E083533 | E083539 | E083541 | E083542 | E083543 |
| E083549 | E083551 | E083552 | E083553 | E083559 | E083591 | E083592 | E083593 |
| E083599 | E0836 | E0837X1 | E0837X2 | E0837X3 | E0837X9 | E0839 | E0840 |
| E0841 | E0842 | E0843 | E0844 | E0849 | E0851 | E0852 | E0859 |
| E08610 | E08618 | E08620 | E08621 | E08622 | E08628 | E08630 | E08638 |
| E08641 | E08649 | E0865 | E0869 | E088 | E089 | E0900 | E0901 |
| E0910 | E0911 | E0921 | E0922 | E0929 | E09311 | E09319 | E093211 |
| E093212 | E093213 | E093219 | E093291 | E093292 | E093293 | E093299 | E093311 |
| E093312 | E093313 | E093319 | E093391 | E093392 | E093393 | E093399 | E093411 |
| E093412 | E093413 | E093419 | E093491 | E093492 | E093493 | E093499 | E093511 |
| E093512 | E093513 | E093519 | E093521 | E093522 | E093523 | E093529 | E093531 |
| E093532 | E093533 | E093539 | E093541 | E093542 | E093543 | E093549 | E093551 |
| E093552 | E093553 | E093559 | E0936 | E093591 | E093592 | E093593 | E093599 |
| E0937X1 | E0937X2 | E0937X3 | E0937X9 | E0939 | E0940 | E0941 | E0942 |
| E0943 | E0944 | E0949 | E0951 | E0952 | E0959 | E09610 | E09618 |
| E09620 | E09621 | E09622 | E09628 | E09630 | E09638 | E09641 | E09649 |
| E0965 | E0969 | E098 | E099 | E1010 | E1011 | E1021 | E1022 |
| E1029 | E10311 | E10319 | E103211 | E103212 | E103213 | E103219 | E103291 |
| E103292 | E103293 | E103299 | E103311 | E103312 | E103313 | E103319 | E103391 |
| E103392 | E103393 | E103399 | E103411 | E103412 | E103413 | E103419 | E103491 |
| E103492 | E103493 | E103499 | E103511 | E103512 | E103513 | E103519 | E103521 |
| E103522 | E103523 | E103529 | E103531 | E103532 | E103533 | E103539 | E103541 |
| E103542 | E103543 | E103549 | E103551 | E103552 | E103553 | E103559 | E103591 |
| E103592 | E103593 | E103599 | E1036 | E1037X1 | E1037X2 | E1037X3 | E1037X9 |
| E1039 | E1040 | E1041 | E1042 | E1043 | E1044 | E1049 | E1051 |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| E1052 | E1059 | E10610 | E10618 | E10620 | E10621 | E10622 | E10628 |
| E10630 | E10638 | E10641 | E10649 | E1065 | E1069 | E108 | E109 |
| E1100 | E1101 | E1110 | E1111 | E1121 | E1122 | E1129 | E11311 |
| E11319 | E113211 | E113212 | E113213 | E113219 | E113291 | E113292 | E113293 |
| E113299 | E113311 | E113312 | E113313 | E113319 | E113391 | E113392 | E113393 |
| E113399 | E113411 | E113412 | E113413 | E113419 | E113491 | E113492 | E113493 |
| E113499 | E113511 | E113512 | E113513 | E113519 | E113521 | E113522 | E113523 |
| E113529 | E113531 | E113532 | E113533 | E113539 | E113541 | E113542 | E113543 |
| E113549 | E113551 | E113552 | E113553 | E113559 | E113591 | E113592 | E113593 |
| E113599 | E1136 | E1137X1 | E1137X2 | E1137X3 | E1137X9 | E1139 | E1140 |
| E1141 | E1142 | E1143 | E1144 | E1149 | E1151 | E1152 | E1159 |
| E11610 | E11618 | E11620 | E11621 | E11622 | E11628 | E11630 | E11638 |
| E11641 | E11649 | E1165 | E1169 | E118 | E119 | E1300 | E1301 |
| E1310 | E1311 | E1321 | E1322 | E1329 | E13311 | E13319 | E133211 |
| E133212 | E133213 | E133219 | E133291 | E133292 | E133293 | E133299 | E133311 |
| E133312 | E133313 | E133319 | E133391 | E133392 | E133393 | E133399 | E133411 |
| E133412 | E133413 | E133419 | E133491 | E133492 | E133493 | E133499 | E133511 |
| E133512 | E133513 | E133519 | E133521 | E133522 | E133523 | E133529 | E133531 |
| E133532 | E133533 | E133539 | E133541 | E133542 | E133543 | E133549 | E133551 |
| E133552 | E133553 | E133559 | E133591 | E133592 | E133593 | E133599 | E1336 |
| E1337X1 | E1337X2 | E1337X3 | E1337X9 | E1339 | E1340 | E1341 | E1342 |
| E1343 | E1344 | E1349 | E1351 | E1352 | E1359 | E13610 | E13618 |
| E13620 | E13621 | E13622 | E13628 | E13630 | E13638 | E13641 | E13649 |
| E1365 | E1369 | E138 | E139 | | | | |

9.2.56.3 Group Clinical Visits for Asthma

Group clinical visits are benefits of Texas Medicaid for the management of the condition of asthma when submitted with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|-------|-------|--------|
| J440 | J441 | J449 | J4520 | J4521 | J4522 | J4530 | J4531 |
| J4532 | J4540 | J4541 | J4542 | J4550 | J4551 | J4552 | J45901 |
| J45902 | J45909 | J45990 | J45991 | J45998 | | | |

9.2.56.3.1 Group Clinical Visits for Pregnancy

Group clinical visits are benefits of Texas Medicaid for the management of the condition of pregnancy when submitted with procedure code 99078 and modifier TH, along with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| O0900 | O0901 | O0902 | O0903 | O0910 | O0911 | O0912 | O0913 |
| O09211 | O09212 | O09213 | O09219 | O09291 | O09292 | O09293 | O09299 |

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| O0930 | O0931 | O0932 | O0933 | O0940 | O0941 | O0942 | O0943 |
| O09511 | O09512 | O09513 | O09519 | O09521 | O09522 | O09523 | O09529 |
| O09611 | O09612 | O09613 | O09619 | O09621 | O09622 | O09623 | O09629 |
| O0970 | O0971 | O0972 | O0973 | O09811 | O09812 | O09813 | O09819 |
| O09821 | O09822 | O09823 | O09829 | O09891 | O09892 | O09893 | O09899 |
| O0990 | O0991 | O0992 | O0993 | O09A0 | O09A1 | O09A2 | O09A3 |
| Z331 | Z3400 | Z3401 | Z3402 | Z3403 | Z3480 | Z3481 | Z3482 |
| Z3483 | Z3490 | Z3491 | Z3492 | Z3493 | | | |

Providers are encouraged to provide a comprehensive curriculum or use materials from the Centering Pregnancy Program that will be incorporated into the educational portion of the group clinical visit.

Comprehensive curriculums will allow clinical issues to be identified to promote a healthy pregnancy. The education material may include screenings and preparations, health maintenance, counseling, and birth plans:

- Screenings and preparations may consist of the following:
 - Expected course of the pregnancy
 - Anticipated outline of the scheduled visits
 - Signs and symptoms, which should be reported to the physician as soon as possible
 - Laboratory services
 - Appropriate use of medications
 - Proper weight monitoring
 - Immunizations (e.g., hepatitis, varicella, or RhoGAM)
 - Complications of pregnancy that may occur (e.g., preeclampsia, diabetes, or edema)
- Health maintenance may consist of the following:
 - Hygiene (e.g., hot tubs or baths)
 - Sexual activity
 - Exercise
 - Nutrition and dietary needs
- Counseling may consist of the following:
 - Use of seat belts
 - Job activity
 - Air travel
 - Dental care appointments
 - Domestic abuse or violence
 - Tobacco or drug use
- Birth planning may consist of the following:
 - What to expect during labor and delivery

- Pain control during labor
- Complications during delivery that may occur (e.g., Cesarean section or episiotomy)
- Breast feeding
- Newborn care
- Postpartum adjustments

Group clinical visits for the management of pregnancy are restricted to female clients who are 10 through 55 years of age and are limited to a maximum of 10 visits per 270 days for any provider.

To be considered for reimbursement, procedure code 99078 with modifier TH must be billed for the same date of service by the same provider as E/M procedure code 99211, 99212, 99213, 99214, or 99215 with modifier TH.

9.2.56.3.2 Preventive Care Visits

Adult preventive services must be provided in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations with grades A or B. USPSTF recommendations, with specific age and frequency guidelines, are listed on the USPSTF website. The following are recommended screens in addition to USPSTF and are covered separately:

- Tuberculosis screening
- Prostate cancer screening; prostate specific antigen (PSA) for men who are 50 through 64 years of age

Preventive care services are comprehensive visits that may include counseling, anticipatory guidance, and risk-factor-reduction interventions. Documentation must indicate the anticipatory guidance rendered.

Preventive health visits for clients who are birth through 20 years of age are available through THSteps medical checkups.

Referto: Section 4, “THSteps Medical” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

Subsection 4.3.11.2.3, “Hearing Screening” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)* for additional information about hearing screenings.

Adult preventive services (procedure codes 99385, 99386, 99387, 99395, 99396, and 99397) are a benefit of Texas Medicaid for clients who are 21 years of age and older. Adult preventive services are limited to one service per rolling year, any provider, and must be billed with diagnosis code Z0000, Z0001, Z01411, or Z01419.

The following USPSTF recommendations are not reimbursed separately but must be provided, when applicable, as part of the routine preventive exam:

- Counseling to prevent tobacco use and tobacco-caused disease
- Behavioral counseling in primary care to promote a healthy diet
- Behavioral interventions to promote breast feeding
- Screening for obesity in adults (with intensive counseling and interventions)
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
- Screening for depression

The USPSTF recommendation of chemoprevention of breast cancer is not a benefit of Texas Medicaid.

Laboratory, immunization, and diagnostic procedures recommended by USPSTF are covered benefits and may be billed separately, as clinically indicated, using the most appropriate diagnosis code that represents the client's condition. Diagnosis code Z0000 or Z0001 may each be used once per rolling year for each screen if no other diagnosis is appropriate for the service rendered, but no more frequently than recommended by the USPSTF.

Services that exceed USPSTF recommendations are not considered part of a screening and require medical documentation to justify medical necessity of the services performed.

For clients who are 21 years of age and older, breast exams and Pap smears are available through programs related to women's health, including Texas Medicaid family planning services and the Healthy Texas Women (HTW) program.

Referto: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

Section 2, "Healthy Texas Women (HTW) Program Overview" in the *Healthy Texas Women Program Handbook (Vol. 2, Provider Handbooks)*.

9.2.56.3.3 Tobacco Use Cessation

Tobacco use cessation counseling is a benefit for male and female clients who are 10 years of age and older and must be submitted with procedure codes 99406 and 99407. Tobacco use cessation services delivered in a group setting will be limited to a maximum of 8 participants per group and must be submitted with modifier HQ.

| Modifier | Description |
|----------|------------------|
| HQ | Group Counseling |

Procedure codes 99406 and 99407 may be reimbursed when submitted with the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| F17200 | F17201 | F17203 | F17208 | F17209 | F17210 | F17211 | F17213 |
| F17218 | F17219 | F17220 | F17221 | F17223 | F17228 | F17229 | F17290 |
| F17291 | F17293 | F17298 | F17299 | | | | |

Procedure codes 99406 and 99407 may be billed in any combination by the same or a different provider, whether individual or group counseling, and are limited to eight services per rolling year.

Additional services require documentation of medical necessity to exceed the established limit.

Procedure codes 99406 and 99407 are limited to once per day, same or different procedure code, any provider.

Referto: Subsection 4.1.17, "Tobacco Use Cessation" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)* for additional information related to the tobacco use cessation counseling and additional covered diagnoses related to pregnancy.

9.2.56.3.4 Office and Outpatient Consultation Services

A consultation is an E/M service provided at the request of another provider for the evaluation of a specific condition or illness. The consultation must meet the following requirement:

- There must be a request from the referring provider for the evaluation of a particular condition or illness.

- There must be correspondence from the consulting provider back to the referring provider indicating the consulting provider's medical findings.

During a consultation, the consulting provider may initiate diagnostic and therapeutic services if necessary.

The visit is not considered a consultation if any of the following applies:

- If diagnostic or therapeutic treatment is initiated during a consultation and the patient returns for follow-up care, the follow-up visit is considered an established patient visit, and must be billed as an established patient visit.
- If the purpose of the referral is to transfer care.

The medical records maintained by both the referring and consulting providers must identify the other provider and the reason for consultation.

Providers must use procedure code 99241, 99242, 99243, 99244, or 99245 when billing new or established patient consultations in the office, or in an outpatient or other ambulatory facility.

Office or outpatient consultations are limited to one consultation every six months by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this six-month period will be denied.

9.2.56.3.5 Physician Services Provided in the Emergency Department

Providers must use procedure codes 99281, 99282, 99283, 99284, and 99285 when billing emergency department services. If an emergency department visit is billed by the same provider with the same date of service as an office visit, outpatient consultation, inpatient consultation, or subsequent nursing facility service, the emergency department visit may be reimbursed and the other services will be denied.

If an emergency department visit is billed by the same provider with the same date of service as an initial nursing facility service, the initial nursing facility service may be reimbursed and the emergency department visit will be denied.

Emergency department visits are denied when billed with the same date of service as an observation service (procedure code 99217) by the same provider.

Multiple emergency department visits provided by the same provider for the same client on the same day must have the times for each visit documented on the claim form. Also, more than one visit billed with the same date of service can be indicated by adding the appropriate modifier to the claim form. Medical documentation is required to support this service.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for nonemergent and nonurgent physicians' services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The emergency department procedure code that is submitted on the claim is used to determine the appropriate reimbursement for these services. The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered by the physician in the hospital's emergency department. The reimbursement for each service is determined by multiplying the base allowable fee by 60 percent.

Referto: Section 4, "Outpatient Hospital (Medical and Surgical Acute Care Outpatient Facility)" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for information on emergency department services by facilities (room and ancillary).

Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information.

9.2.56.3.6 After-Hours Services

Texas Medicaid limits reimbursement for after-hours charges to office-based providers rendering services after routine office hours.

An office-based provider must bill an after-hours charge in addition to a visit charge for providing services after routine office hours. This after-hours charge must be billed when a provider judges it medically necessary to provide after-hours care for a patient with an emergent condition. A provider's routine office hours are the hours posted at the physician's office as the usual office hours. Medicaid reimburses office-based physicians an inconvenience or after-hours charge when any of the following situations exist:

- The physician leaves the office or home to see a client in the emergency room.
- The physician leaves the home and returns to the office to see a client after the physician's routine office hours.
- The physician is interrupted from routine office hours to attend to another client's emergency outside of the office.

Charges for inconvenience or after-hours services by emergency department-based physicians or emergency department-based groups are not allowed.

After-hours procedure codes are limited to one per day, same provider.

Providers must use one of the following procedure codes to report after-hours services:

| After-Hours Procedure Codes | | |
|-----------------------------|-------|-------|
| 99050 | 99056 | 99060 |

9.2.56.3.7 Observation Services

Hospital observation (procedure codes 99217, 99218, 99219, and 99220) are professional services provided for a period of more than 6 hours but fewer than 24 hours regardless of the hour of the initial contact, even if the client remains under physician care past midnight.

Hospital observation services must be submitted using the procedure code 99234, 99235, or 99236.

Observation care discharge day management procedure code 99217 must be billed to report services provided to a client upon discharge from observation status if the discharge is on a date other than the initial date of admission. If an observation care discharge day management visit is billed by the same provider with the same date of service as an established office or outpatient visit, the observation care discharge visit may be reimbursed and the other services will be denied. The following procedure codes are denied if submitted with the same date of service as procedure code 99217:

| Procedure Codes | | |
|-----------------|-------|-------|
| 99218 | 99219 | 99220 |

If a physician observation visit and a prolonged service are billed by the same provider for the same date of service, only one procedure code may be reimbursed.

If dialysis treatment and a physician observation visit are billed by the same provider (and same specialty other than an internist or nephrologist) with the same date of service, the dialysis treatment may be reimbursed and the physician observation visit will be denied. Subsequent observation care, per day (procedure codes 99224, 99225, and 99226), is also a benefit of Texas Medicaid.

Observation may take place in any patient care area of the hospital or outpatient setting.

9.2.56.4 Other Inpatient and Outpatient Hospital Services

A hospital care visit submitted by the same provider for the same client within three days of a new patient office, home, nursing facility, or skilled nursing facility (SNF) visit, for the same or for a similar diagnosis must be submitted as a subsequent care visit.

Referto: Subsection 9.2.69.6, “Global Fees” in this handbook for more information about global services.

9.2.56.5 Prolonged Physician Services

Prolonged services involve face-to-face patient contact and may be provided in the office, outpatient hospital, or inpatient hospital settings. The face-to-face patient contact must exceed the time threshold of the following E/M procedure codes submitted for the date of service and be beyond the usual service.

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 | 99221 |
| 99222 | 99223 | 99231 | 99232 | 99233 | 99241 | 99242 | 99243 | 99244 | 99245 |
| 99251 | 99252 | 99253 | 99254 | 99255 | 99341 | 99342 | 99343 | 99344 | 99345 |
| 99347 | 99348 | 99349 | 99350 | | | | | | |

The following procedure codes must be used for prolonged physician services:

| Procedure Codes | Limitation |
|--|---|
| 99354 and 99356 | Used in conjunction with the E/M procedure code to report the first hour of prolonged service and are limited to one per day. |
| 99355 and 99357 | Used to report each additional 30 minutes and are limited to a quantity of 3 units or 1.5 hours per day. |
| Note: Prolonged services that are less than 30 minutes in duration cannot not be reported separately. | |

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

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

Prolonged services in the inpatient setting involving face-to-face client contact that is beyond the usual service may be reimbursed when provided on the same day as an initial hospital visit (procedure codes 99221, 99222, 99223, 99251, 99252, 99253, 99254, and 99255) or a subsequent hospital visit (99231, 99232, 99233).

Prolonged physician services are denied when billed with critical care or emergency room visits billed with the same date of service, same provider.

Prolonged physician services without a face-to-face contact (procedure codes 99358 and 99359) are not a benefit of Texas Medicaid.

Note: For non-face-to-face prolonged physician services, and for use of the unlisted evaluation and management procedure code for clients who are birth through 20 years of age, refer to subsection 2.5.1.1.6, “Non-Face-to-Face Prolonged Services” in the *Children’s Services Handbook (Vol. 2, Provider Handbooks)*.

Referto: Subsection 4.2.2, “Psychotherapy” in the *Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks)* for more information about prolonged psychotherapy services.

Physician standby services are not a benefit of Texas Medicaid.

9.2.56.5.1 Hospital Admissions, Initial Visits, and Subsequent Visits

Inpatient hospital visits must be submitted using procedure codes 99221, 99222, 99223, 99231, 99232, and 99233.

If a subsequent hospital visit (procedure code 99231, 99232, or 99233) following admission is billed by the same provider with the same date of service as any of the following emergency department visits, office visits, or outpatient consultations, the subsequent hospital visit may be reimbursed and the other visits will be denied:

| Procedure Code | | | | | | | | | |
|----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99281 | 99282 | 99283 | 99284 | 99285 | 99202 | 99203 | 99204 | 99205 | 99211 |
| 99212 | 99213 | 99214 | 99215 | 99241 | 99242 | 99243 | 99244 | 99245 | |

Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period for the same diagnosis. Additional initial hospital visits with the same diagnosis within a 30-day period will be denied.

A subsequent hospital visit (procedure code 99231, 99232, or 99233) will be denied when billed on the same day to the same provider as critical care services (procedure codes 99291 and 99292).

E/M services provided in a hospital setting following a major procedure and provided by the same provider or in direct follow-up for postsurgical care are included in the surgeon's global surgical fee and are denied as included in another procedure.

Referto: Subsection 9.2.44, "Newborn Services" in this handbook for information about newborn services.

9.2.56.5.2 Concurrent Care

Concurrent care exists when services are provided to a patient by more than one physician on the same day during a period of hospitalization in the inpatient hospital setting. Concurrent care is appropriate when the level of care and the documented clinical circumstances require the skills of different specialties to successfully manage the patient in accordance with accepted standards of good medical practice. Concurrent care may be reimbursed to providers of different specialties when the services are for unrelated diagnoses involving different organ systems.

Concurrent care will be denied when billed for providers of the same specialty for the same or related diagnoses. Denied concurrent care may be appealed when accompanied by documentation of medical necessity.

Each appeal submitted for concurrent care must contain the following information:

- Documentation of the medical necessity for the physician's services (care and treatment)
- Diagnosis and indication of the severity of the client's condition (acute or critical)
- Role of the physician in the care of the client, including the name of the admitting physician
- Specialty and subspecialty of each physician and any limitations of practice

Claims appealed without clear documentation of medical necessity as described above will be denied.

Important: *If the attending physician requests only a consultation, the request must be clearly stated in the orders.*

All concurrent care is subject to retrospective review. Documentation of medical necessity for concurrent care must be retained by the physician as required by federal law and must include, but is not limited to, documentation of:

- The orders for concurrent care or valid reasons for the request by the attending physician.

- The name of the requesting physician by the physician rendering concurrent care.

9.2.56.5.3 Consultations

Consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting must be billed using procedure codes 99251, 99252, 99253, 99254, and 99255.

One initial inpatient consultation (procedure code 99251, 99252, 99253, 99254, or 99255) is allowed for each hospitalization within a 30-day period. Subsequent consultations billed as initial consultations during this time period will be denied.

Referto: Subsection 9.2.56.3.4, “Office and Outpatient Consultation Services” in this handbook for additional criteria information.

9.2.56.5.4 Critical Care

Critical care includes the care of critically ill clients that require the constant attention of the physician. The physician must either be at bedside or immediately available to the client. The physician’s full attention must be devoted to the client so that the physician cannot render E/M to any other client during the same period of time. Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, neonatal intensive care unit, or the emergency department care facility. The following procedure codes are used to bill critical care services:

| Procedure Code | Limitations |
|--|--|
| 99291 | A per day charge for the first 30 to 74 minutes of critical care (time spent by the physician does not have to be continuous on that day). |
| 99292 | A per day charge for each additional 30 minutes beyond the first 74 minutes of critical care for up to 6 units or 3 hours per day.* |
| 99471 | A per day charge for initial inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age. |
| 99472 | A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 29 days through 24 months of age. |
| 99475 | A per day charge for initial inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age. |
| 99476 | A per day charge for subsequent inpatient pediatric critical care of the critically ill client who is 2 years through 5 years of age. |
| * If the number of units is not stated on the claim, a quantity of one is allowed. | |

Services for a client who is not critically ill and unstable but who was treated in a critical care unit must be reported using subsequent hospital visit codes or hospital consultation codes.

If the same provider who performed a major surgery must also perform critical care on the same day for the same client, the provider must bill the critical care with documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure.

Critical care (procedure codes 99291, 99292, 99471, 99472, 99475, and 99476) may be reimbursed only to the provider rendering the critical care service at the time of crisis. Critical care involves high-complexity decision-making to access, manipulate, and support vital system functions. While providers from various specialties may be consulted to render an opinion and assist in the management of a particular portion of the care, only the provider managing the care of the critically ill patient during a life threatening crisis may bill the critical care procedure codes.

Critical care procedure codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous.

Actual time spent with the individual client must be recorded in the client's record and reflect the time billed on the claim. The time that can be reported as critical care is the time spent engaged in work directly related to the individual client's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.

Time spent under the following circumstances may not be reported as critical care:

- Activities that occur outside of the unit or off the floor
- Activities that do not directly contribute to the treatment of the client
- While performing separately reportable procedures or services

Critical care of less than 30 minutes total duration per day must be reported with the appropriate E/M procedure code.

If critical care that meets the initial 30-minute time requirement is provided to the same client by different physicians, the initial provider's claim may be reimbursed. The second provider's claim will be denied but may be appealed. The time spent by each physician cannot overlap; two physicians cannot bill critical care for care delivered at the same time. Supporting medical record documentation that includes the time in which the critical care was rendered must be provided by the second physician. In addition, a statement must be submitted indicating the physician was the only provider managing the care of the critically ill patient during the life threatening crisis.

If the provider's time exceeds the 74-minute threshold for procedure code 99291, procedure code 99292 may be billed for each additional 30 minutes. Procedure code 99292 must be billed by the same performing provider or by a member of the same performing provider's group practice and is limited to 6 units per day for any provider.

Inpatient critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care procedure codes 99471 and 99472. The pediatric critical care procedure codes are reported as long as the infant or young child qualifies for critical care services during the hospital stay through 24 months of age.

Pediatric critical care (procedure codes 99471, 99472, 99475, and 99476) is a per-day charge. Only one physician can bill pediatric critical care per day. If an inpatient or outpatient E/M service is billed by the same provider with the same date of service as pediatric critical care, the E/M service is denied.

Critical care provided to a neonatal, pediatric, or adult client in an outpatient setting (e.g., emergency room), which does not result in admission must be billed using procedure codes 99291 and 99292.

Critical care provided to a neonatal or pediatric client in both the outpatient and inpatient settings on the same day must be billed using the appropriate neonatal or pediatric critical care procedure code.

If critical care (procedure code 99291 or 99292) is provided to a patient at a distinctly separate time from another outpatient E/M service by the same provider, both services may be reimbursed with supporting medical record documentation.

Prolonged physician services (procedure codes 99354, 99355, 99356, and 99357) will be denied when billed by the same provider with the same date of service as critical care (procedure code 99291, 99292, 99471, 99472, 99475, or 99476).

Claims may be subject to retrospective review to ensure documentation supports the medical necessity of the service when billing the claim.

Critical care procedure codes 99291 and 99292 will be denied when submitted with the same date of service by the same provider as neonatal intensive care procedure code 99468, 99469, 99478, 99479, or 99480.

9.2.56.5.5 Hospital Discharge

Hospital discharge must be submitted using procedure code 99238 or 99239.

Hospital discharge management billed by the same provider with the same date of service as the admission will be denied.

Discharge management billed by the same provider with the same date of service as an emergency room visit will be considered for reimbursement and the emergency visit will be denied.

Subsequent hospital visits billed by the same provider with the same date of service as discharge management will be denied.

9.2.56.5.6 Nursing Facility Services

Providers must use the following when billing initial nursing facility assessments, subsequent nursing facility care, and annual nursing facility assessments in a nursing facility:

| Procedure Codes | | | | | | | | | |
|--|--------|--------|-------|-------|-------|-------|-------|-------|-------|
| 99304* | 99305* | 99306* | 99307 | 99308 | 99309 | 99310 | 99315 | 99316 | 99318 |
| * Initial nursing facility assessments include all services related to an admission to the nursing facility. | | | | | | | | | |

Comprehensive initial nursing facility assessments performed by the same provider for the same diagnosis are limited to one every six months. The second initial nursing facility assessment within the six-month period will be denied.

Prolonged services in the nursing facility involving direct (face-to-face) patient contact that is beyond the usual service may be reimbursed on the same day as a nursing facility visit (procedure code 99304, 99305, 99306, 99307, 99308, 99309, or 99310).

All E/M services, regardless of setting, are considered part of the initial nursing facility care when performed by the same provider on the same day as the admission.

Subsequent nursing facility care E/M procedure codes 99307, 99308, 99309, and 99310 are limited to one per day regardless of diagnosis.

9.2.56.5.7 Observation

When a patient is admitted to the hospital as an inpatient and is discharged in less than 48 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This is an acceptable billing practice under Texas Medicaid when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement.

Referto: Subsection 9.2.56.3.7, “Observation Services” in this handbook for more information about hospital observation.

9.2.56.6 Domiciliary, Rest Home, or Custodial Care Services

The following procedure codes are used to report E/M in a facility that provides room, board, and other personal assistance services:

| New Patient Procedure Codes | | | | |
|-------------------------------------|-------|-------|-------|-------|
| 99324 | 99325 | 99326 | 99327 | 99328 |
| Established Patient Procedure Codes | | | | |
| 99334 | 99335 | 99336 | 99337 | |

Established patient visits billed on the same date of service as a new patient visit, by the same provider, will be denied as part of another procedure. Established patient visits are limited to one per day regardless of diagnosis.

Established patient visits billed on the same day as a consultation visit, by the same provider, are denied.

9.2.56.7 Home Services

Home services are provided in a private residence. New patient visits will be limited to once every three years. Providers must utilize procedure codes 99341, 99342, 99343, 99344, and 99345 when billing for new patient services provided in the home setting. New patient visits are limited to one every three years.

Providers must use procedure codes 99347, 99348, 99349, and 99350 when billing established patient services provided in the home setting.

A subsequent home visit (procedure codes 99347, 99348, 99349, and 99350) billed with the same date of service as a new patient home visit (procedure codes 99344 and 99345) by the same provider will be denied as part of another procedure, regardless of the diagnosis.

Subsequent home E/M codes are limited to one per day, regardless of diagnosis.

9.2.56.8 Referrals

A *referral* is defined as the transfer of the total or specific care of a patient from one physician to another; a referral does not constitute a consultation. These services must be billed using the appropriate E/M visit code.

When a Texas Medicaid provider refers a Texas Medicaid client to another provider for additional treatment or services, the referring provider must forward notification of the client's eligibility and his provider identifier. The client must be made aware that the provider he/she is referred to does or does not participate in Texas Medicaid. Some clients not eligible for Medicaid are eligible for family planning through the HHSC Family Planning Program. These clients should be referred to contracted agency providers for family planning services.

9.2.56.8.1 Referral Requirements for Children with Disabilities

All health-care professionals are required by state and federal legislation to refer children who are 35 months of age or younger with developmental delays to early childhood intervention services provided under the authority of the Texas Health and Human Services Commission (HHSC).

Referto: Subsection 2.8, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (Vol. 2, *Provider Handbooks*).

9.2.57 Physician Services in a Long Term Care (LTC) Nursing Facility

HHSC requires initial certification and recertification of Medicaid clients in nursing facilities by physicians in accordance with guidelines set forth in federal regulations. Physician visits for certification and recertification are considered medically necessary, and are reimbursable by Medicaid whether performed in the physician's office or the nursing facility.

Additional information is available on the HHSC website at <https://hhs.texas.gov>.

9.2.58 Podiatry and Related Services

Podiatry and related services are a benefit of Texas Medicaid.

9.2.58.1 Clubfoot Casting

Procedure code 29450 is limited to clients who are birth through 3 years of age and is payable to a physician in the management of clubfoot when a previous surgery has been performed. The physician may bill the appropriate E/M code with a casting code and be reimbursed for both. Procedure code 29750 is limited to clients who are birth through 3 years of age and is payable to a physician in addition to the initial casting or strapping procedure.

Use modifiers LT (left) and RT (right) with all procedures, as appropriate.

Casting and wedging are benefits if the client has one of the following conditions:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|-------|
| M21541 | M21542 | M21549 | 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 | | | | | | | |

9.2.58.2 Flat Foot Treatment

Reimbursement for treatment of deformities of the foot and lower extremity that includes flat foot as a component of the deformity may be considered when the client presents with significant pain in the foot, leg, or knee, resulting in a loss of or decrease in function, along with a secondary condition such as valgus deformity or plantar fasciitis.

Treatment of flat foot (flexible pes planus) that is solely cosmetic in nature is not a benefit of Texas Medicaid.

9.2.58.3 Routine Foot Care

Routine foot care must be medically necessary and billed with the following procedure codes. No specific diagnosis restrictions exist. The following procedures are limited to one service every six months per client, regardless of provider specialty: 11055, 11056, 11057, 11719, and G0127.

9.2.59 Prostate Procedures for Benign Prostatic Hyperplasia (BPH)

Prostate procedures are a benefit of Texas Medicaid and include surgical, minimally invasive, and laser procedures. Prostate procedures treat lower urinary tract symptoms (LUTS) attributed to benign prostatic hyperplasia (BPH).

BPH is an overgrowth of cells in the prostate gland and is increasingly common as men age. BPH does not require treatment and is not the target of interventions; however, BPH can lead to an enlargement of the prostate (benign prostatic enlargement [BPE]).

BPE can result in lower urinary tract symptoms (LUTS) which includes urinary frequency, urinary retention, inability to completely empty the bladder, blood in the urine, and kidney disease. Symptoms can be mild, moderate or severe.

LUTS attributable to BPH may significantly worsen the quality of life of male patients.

Treatment of LUTS attributable to BPH include a continuum of interventions ranging from lifestyle modifications, pharmacological management, minimally invasive therapy (MIST), laser therapy, to surgery.

Various prostate procedure services may be provided in the inpatient hospital, outpatient hospital, ambulatory surgical center or office settings.

In some cases, surgical or minimally invasive therapies might be appropriate as a first line of therapy without a trial of pharmacological management for reasons of patient preference or for reasons including inability to empty the bladder, urinary reflux, kidney disease, repeated urinary infections, kidney stones, or hematuria resulting from BPH.

Pharmacological management may be the first line treatment of BPH. Medication therapy may not be tolerated due to adverse effects including low blood pressure, dizziness, fatigue, and impaired sexual function.

Surgical therapies may have longer durability, but often require an inpatient setting using general anesthesia and result in a longer recovery time.

TURP (Transurethral Resection of the Prostate) has been a preferred surgical treatment of BPH for many years and is the standard by which other treatments are compared. TURP may have a high rate of durability which may be contrasted with an increased rate of complications.

Minimally invasive therapies (MISTs) have developed as an alternative to the surgical approach of TURP, however they may have less durability than TURP.

MIST may be performed in an office setting, ambulatory surgical center or outpatient hospital under local anesthesia.

MIST may offer a short recovery time and patients are able to return to normal activity faster. MIST often preserves sexual functioning. After lifestyle modifications and medication, the next line of treatment may include minimally invasive therapy.

9.2.59.1 Minimally Invasive Therapies (MIST) for BPH

Minimally invasive therapy is an option for patients who wish a less invasive technique that may be performed in a lower acuity setting, as well as higher surgical risk patients.

9.2.59.1.1 Types of Minimally Invasive Therapy

Prostatic Urethral Lift (PUL) involves placement of one or more implants in the lateral lobes of the prostate using a transurethral delivery device, with minimal side effects. Procedure codes 52441, 52442, C9739, and C9740, are a covered benefit when the following restrictions are met:

- Client is 45 years of age and older
- Prostate gland volume is ≤ 80 gm and verified absence of an obstructive middle lobe
- International Prostate Symptom Score (IPSS) ≥ 12
- Pharmacological management has been unsuccessful or side effects intolerable
- No current urinary tract infection
- No allergy to nickel
- Surgical intervention is required

Transurethral water vapor therapy, also known as water vapor energy ablation (procedure code 53854) causes transurethral destruction of prostate tissue by radiofrequency and is indicated in prostate volumes <80 gm.

Transurethral Microwave Thermotherapy (TUMT) (procedure code 53850) is indicated for BPH when patients have a prostate length of 30-55 mm and have failed pharmacological management. The procedure is contraindicated for patients with:

- Prostate cancer
- Penile or metallic implants
- Lack of bladder control due to nerve problems
- Nerve problems caused by diabetes
- Narrowing of the urethra due to scarring
- Prior prostate surgery or pelvic radiation therapy

Transurethral Needle Ablation (TUNA) (procedure code 53852) destroys prostate tissue by radiofrequency thermotherapy and is suitable for prostates ≤ 60 gm with predominantly lateral lobes. The procedure is an option when invasive surgery is not possible due to comorbidities.

Laser Therapy as an option for treating BPH, is indicated when there is an increased bleeding risk.

9.2.59.1.2 Types of Laser Procedures

Interstitial Laser Coagulation (ILC) laser coagulation of prostate, procedure code 52647, is a minimally invasive laser procedure producing coagulation lesions in the prostate for small to medium prostates (30-40 g).

Photoselective Vaporization of the Prostate (PVP), procedure code 52648, is a laser vaporization of prostate suitable for all patients, including those taking anticoagulation or antiplatelet medication.

Contact Laser ablation of the Prostate (CLAP) (procedure code 52648) may be reimbursed when the following is present:

- High risk of bleeding
- Prostates >100 gm
- Urinary retention

Holmium Laser Procedures of the Prostate (HoLAP), Holmium Laser Enucleation of the Prostate (HoLEP), and Holmium Laser Resection of the Prostate (HoLRP), (procedure code 52649) may be used for all patients, but particularly if anticoagulant or antiplatelet therapy is used.

Surgical Therapy is a first-line treatment if the patient is unable to completely empty the bladder, has urinary reflux possibly resulting in backflow of urine into the kidney causing swelling of the kidney, or kidney disease caused by BPH, frequent urinary infections, kidney stones, or continuing blood in the urine caused by BPH. Surgical therapy may be necessary after failing medications or other treatments.

9.2.59.1.3 Types of Surgical Therapy

Transurethral resection of the prostate (TURP) (procedure codes 52601, 52630, and 52640) are the gold standard for treating moderate to severe BPH after failing medication and when minimally invasive procedures are contraindicated.

Transurethral incision of the prostate (TUIP) (procedure code 52450) is utilized when minimally invasive procedures are contraindicated, and patient is not a good candidate for TURP. Usually used to treat small prostates ≤ 30 grams and it has a lower risk of blood transfusion than TURP. Services are limited to once per day.

Prostatectomy Perineal (procedure code 55801), Suprapubic (procedure code 55821), and Retropubic, (procedure code 55831) are suitable treatments for larger prostates > 50 grams and for men who are also good surgical candidates.

Urethral Stent Temporary (procedure code 53855) is designed for short term use (6 months to 3 years) and is suitable for high-risk patients especially those with urinary retention.

Urethral Stent Permanent (procedure code 52282) is utilized in men ≥ 60 years or < 60 years who are poor surgical candidates' w/ prostate ≥ 2.5 cm long. The procedure is considered for high-risk patients especially with urinary retention.

9.2.59.2 Prior Authorization and Documentation Requirements

Prior authorization is required for:

- Prostatic Urethral Lift (PUL) add on procedure code 52442 utilizing more than 6 implants.
- Assistant surgeons for holmium laser procedures of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate (HoLRP).

Note: All other services addressed in this section do not require prior authorization.

Requests for prior authorization must be received and approvals must be obtained before services are rendered. Requests received after the service date will be denied.

The SMPA form must be submitted, signed, and dated within 60 days before the date of service. Services will not be authorized prior to the ordering provider's signature date.

To facilitate determination of medical necessity and avoid unnecessary denials, the provider must maintain correct and complete information, including documentation for medical necessity for the test requested. The provider must maintain documentation of medical necessity in the client's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies, and to confirm eligibility criteria are met for the benefit.

Prior authorization requests must be submitted on a SMPA Request Form and must include the following documentation: the client's diagnosis, medical necessity for choosing the procedure, the expected total number of implants required for the procedure, and a brief statement addressing the medical necessity for the number of implants requested.

Medical necessity must be documented for assistant surgeons for holmium laser procedures of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate, (HoLRP).

In addition to documentation requirements outlined in this section, if any, of the following requirements apply: all services outlined in this section are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.

Documentation in the medical record should include a diagnosis of BPH and LUTS that in the opinion of the provider requires a procedure as an intervention for treatment.

Reimbursement is restricted for holmium laser procedure of the prostate, procedure code 52649, including holmium laser ablation of the prostate (HoLAP), holmium laser enucleation of the prostate (HoLEP), and holmium laser resection of the prostate (HOLRP), unless there is an approved prior authorization for an assistant surgeon obtained before the procedure.

Referto: "Section 5: Fee-for-Service Prior Authorizations" (Vol. 1, General Information) for detailed information about prior authorization requirements.

9.2.59.3 Reimbursement Billing Guidelines

The following procedure codes may be reimbursed for prostate procedures:

| BPH Procedures Reimbursement Information | | |
|--|----------------------------|---|
| Service Category | Procedure Codes | Additional Information |
| Minimally Invasive Therapy (MIST) Prostatic Urethral Lift (PUL) | 52441, 52442, C9739, C9740 | Only Prostatic Urethral Lift (PUL) procedure code 52442 requires prior authorization if more than 6 total implants. Procedure codes 52441, C9739, and C9740 may only be billed once per lifetime. |
| Minimally Invasive Therapy (MIST)-Other | 53850, 53852, 53854 | Procedure codes 53850, 53852, and 53854 utilize heat or energy transfer techniques to reduce prostate size by tissue necrosis. |
| Laser Therapy | 52647, 52648, 52649 | Procedure codes 52647, 52648, and 52649 are not covered in an office setting. |

| BPH Procedures Reimbursement Information | | |
|--|----------------------------|--|
| Service Category | Procedure Codes | Additional Information |
| Surgical Therapy | 52601, 52630, 52640, 52450 | Procedure code 52601 may be billed for the first TURP and may be billed again if the first TURP is staged with modifier 58. Procedure codes 52630 and 52640 may not be billed on the same day of service. Procedure codes 52601, 52630, 52640, and 52450, are all limited to once per day. |
| Prostatectomy | 55801, 55821, 55831 | Suitable for larger prostates and requires hospital admission and services are limited to one service per day. |
| Urethral Stent | 52282, 53855 | May be temporary or permanent procedure code 52282, and is limited to men who are 60 years of age or older. |

| Modifier | Use For |
|----------|--|
| 58 | Procedure code 52601 if billed a second time in a staged procedure |

The Prostatic Urethral Lift (PUL) procedure in an office setting or a hospital outpatient department is billed as procedure code 52441 for the first implant and each subsequent implant is billed separately as procedure code 52442.

If the PUL procedure is billed with procedure code 52442, then procedure code 52441 must also be billed for the same date of service.

The PUL procedure in an ambulatory surgical center setting is billed as procedure code C9739 for the first through third implants and four or more subsequent implants are billed separately as procedure code C9740.

The PUL procedure is limited to one procedure per lifetime. The PUL procedure is billed with only one set of codes, either procedure codes 52441 and 52442 in an office setting or outpatient hospital setting OR procedure codes C9739 and C9740 in an ambulatory surgical center setting. More than 7 implants will require prior authorization. Procedure code 52442 (2 or more implants) will require prior authorization if procedure code 52442 is billed for more than 6 implants.

A TURP may be billed with procedure code 52601, 52630, or 52640 and may be reimbursed to the physician performed in a hospital, an outpatient hospital setting, and an ambulatory surgical center with only one service per day.

If a provider submits separate charges for any of the TURP procedure codes listed above and procedure code 52351 or 52354, the charges for procedure codes 52351 and 52354 will be denied as part of the TURP procedure billed as procedure code 52601.

If the first TURP is performed as a staged procedure, the first procedure may be billed as procedure code 52601. The next part of the staged TURP procedure may also be billed as procedure code 52601 but must also include Modifier 58.

A subsequent TURP (not including the staged TURP for procedure code 52601 with modifier 58) may be billed as either procedure code 52630 or procedure code 52640.

A TUMT, procedure code 53850, may be performed in an office as well as hospital setting, and reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center and may be performed only once per day.

A TUNA, procedure code 53852, reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center setting or an office setting and may be performed only once per day.

Transurethral water vapor therapy, procedure, code 53854, may be performed in an office, and reimbursed to the physician in the outpatient hospital setting as well in an ambulatory surgical center.

A TUIP, procedure code 52450, is reimbursed to the physician in the inpatient hospital setting as well in an ambulatory surgical center and may be performed only once per day.

An ILC, procedure code 52647, may be reimbursed to the physician in the inpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

A PVP, procedure code 52648, may be reimbursed to the physician in the inpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

Holmium Laser Procedures of the Prostate (HoLAP), Holmium Laser Enucleation of the Prostate (HoLEP), and Holmium Laser Resection of the Prostate (HoLRP), procedure code 52649, may be reimbursed to the physician in the inpatient and outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day and may allow for an assistant surgeon.

A permanent urethral stent, procedure code 52282, may be performed in an office and may be reimbursed to the physician in the inpatient or outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

A temporary urethral stent, procedure code 53855, may be performed in an office and may be reimbursed to the physician in the inpatient or outpatient hospital setting as well as in an ambulatory surgical center; and may be performed only once per day.

9.2.60 Radiation Therapy

Radiation treatment management may be reimbursed by Texas Medicaid as defined in the *Current Procedure Terminology* (CPT) manual under the “Radiation Treatment Management” section.

The following radiation therapy services are limited to once per day unless documentation submitted with an appeal supports the need for the service to be provided more frequently:

- Therapeutic radiation treatment planning
- Therapeutic radiology simulation-aided field setting
- Teletherapy
- Brachytherapy isodose calculation
- Treatment devices
- Proton beam delivery/treatment
- Intracavitary radiation source application
- Interstitial radiation source application
- Remote afterloading high intensity brachytherapy
- Radiation treatment delivery
- Localization
- Radioisotope therapy

Laboratory and diagnostic radiological services provided in the office setting may be reimbursed to physicians as a total component. Radiation treatment centers may also be reimbursed for the total component for these services in the outpatient hospital setting. Injectable medications given during the course of therapy in any setting may be reimbursed separately.

Routine follow-up care by the same physician on the day of any therapeutic radiology service will be denied. Medical services within program limitations may be reimbursed on appeal when documentation supports the medical necessity of the visit due to services unrelated to the radiation treatment or radiation treatment complication.

The professional component and the technical component will be denied when billed with the total component. The total component includes the professional and the technical components.

The professional component may be reimbursed for services rendered in the inpatient hospital setting, radiation treatment center setting, or outpatient hospital setting. Physicians billing client services rendered in the office setting or in a facility recognized by Medicaid as a radiation treatment center may be reimbursed for total components.

9.2.60.1 Brachytherapy

9.2.60.1.1 Prior Authorization for Brachytherapy

Prior authorization is not required for brachytherapy.

9.2.60.1.2 Other Limitations on Brachytherapy

Clinical brachytherapy services include admission to the hospital and daily care. Initial and subsequent hospital care will be denied as part of another service when billed with the same date of service as clinical brachytherapy services.

An office visit will be denied as part of another service when billed with the same date of service by the same provider as clinical treatment planning and clinical brachytherapy.

Normal follow-up care by the same physician will be denied as part of another service when billed with the same dates of service as any therapeutic radiology service. Any other E/M office visit will be denied as part of another service when billed with the same date of service by the same provider as the radiation treatment or radiation treatment complication.

Providers may use modifier 25 to indicate that the additional visit was for a separate, distinct service unrelated to the radiation treatment or radiation treatment complication. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available upon request.

Each service provided using procedure codes 77321 and 77470 are limited to once per two calendar months.

Documentation that supports the provision of special procedures must be maintained in the client's medical record and made available upon request.

9.2.60.2 Stereotactic Radiosurgery

9.2.60.2.1 Prior Authorization for Stereotactic Radiosurgery

The following procedure codes are a benefit of Texas Medicaid with prior authorization and documentation of medical necessity:

| | | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 32701 | 61781 | 61782 | 61783 | 61796 | 61797 | 61798 | 61799 | 61800 | 63620 |
| 63621 | 76145 | 77336 | 77370 | 77371 | 77372 | 77373 | 77399 | 77423 | 77520 |
| 77522 | 77523 | 77525 | G0339 | G0340 | G6002 | S8030 | | | |

Prior authorization requests received after the requested start date of service will be denied for dates of service prior to the date the request was received.

Prior authorization requirements for stereotactic radiosurgery and stereotactic body radiation therapy may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Benign and malignant tumors of the central nervous system
- Vascular malformations
- Soft tissue tumors in chest, abdomen, or pelvis
- Trigeminal neuralgia refractory to medical management

Stereotactic radiosurgery and stereotactic body radiation therapy are considered investigational and not a benefit of Texas Medicaid for all other indications including, but not limited to, epilepsy, chronic pain, and pancreatic adenocarcinoma.

Prior authorization requirements for proton beam (procedure codes 77520, 77522, 77523, 77525, and S8030) and helium ion radiosurgery (procedure code 77423) may include, but are not limited to, diagnoses indicating one of the following medical conditions:

- Melanoma of the uveal tract (iris, choroid, ciliary body)
- Postoperative treatment for chordomas or low-grade chondrosarcomas of the skull or cervical spine
- Prostate cancer
- Pituitary neoplasms
- Other central nervous system tumors located near vital structures

Prior authorization for neutron beam radiosurgery may be considered for malignant neoplasms of the salivary gland.

Prior authorization requirements for procedure code 77399 include, but are not limited to, diagnosis, documentation of medical necessity, a specific description of the procedure to be performed, and an indication that the procedure would not be covered by a more specific procedure code.

Stereotactic radiosurgery and stereotactic body radiation therapy will not be prior authorized for clients with metastatic disease and a projected life span of less than six months or for clients with widespread cerebral or extracranial metastasis that is not responsive to systemic therapy.

9.2.60.2.2 Other Limitations on Stereotactic Radiosurgery

In the following table, the procedure codes in Column A may be reimbursed when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

| Column A Procedure Code | Column B Procedure Code |
|-------------------------|-------------------------|
| 61797 | 61796, 61798 |
| 61799 | 61798 |
| 61800 | 61796, 61798 |
| 63621 | 63620 |

Procedure codes 61796 and 63620 must not be billed more than once per course of treatment.

Procedure codes 61797 and 61799 must not be billed more than once per lesion, and may only be billed up to four times for the entire course of treatment, regardless of the number of lesions treated.

Procedure code 63621 may only be billed up to two times for the entire course of treatment, regardless of the number of lesions treated.

Procedure codes 77336 and 77370 may be reimbursed to the ordering physician if consultation is performed with a qualified medical physicist for stereotactic radiosurgery, brachytherapy, or any other method of radiation therapy for which medical necessity is determined.

Procedure code 77336 will be limited to once per week of treatment.

Procedure code 77370 will be limited to once per course of treatment. A special medical physics consultation may be reimbursed when the input and complex analysis of a qualified medical physicist are beyond that of a continuing medical physics consultation and are necessary to address a patient-specific reason or scenario.

9.2.61 Radiology Services

In compliance with HHS regulations, physicians (MDs and DOs), group practices, and clinics may not bill for radiology services provided outside their offices. These services must be billed directly by the facility/provider that performs the service.

This restriction does not affect radiology services performed by physicians or under their supervision in their offices. The radiology equipment must be owned by physicians and be located in their office to allow for billing of TOS 4 (complete procedure) or TOS T with modifier TC to Texas Medicaid. If physicians are members of a clinic that owns and operates radiology facilities, they may bill for these services. However, if physicians practice independently and share space in a medical complex where radiology facilities are located, they may not bill for these services even if they own or share ownership of the facility, unless they supervise and are responsible for the operation of the facilities on a daily basis.

Providers billing for three or more of the same radiology procedures on the same day must indicate the time the procedure was performed to indicate that it is not a duplicate service. The use of modifiers 76 and 77 does not remove the requirement of indicating the times services were rendered. The original claim will be denied but can be appealed with the documentation of procedure times.

When billing for services in an inpatient or outpatient hospital setting, the radiologist may only bill the professional interpretation of procedures (modifier 26). This also applies when providing services to a client who is in an inpatient status even if the client is brought to the radiologist's office for the service. The hospital is responsible for all facility services (the technical component) even if the service is supplied by another facility/provider.

A separate charge for an X-ray interpretation billed by the attending or consulting physician is not allowed concurrently with that of the radiologist. Interpretations are considered part of the attending or consulting physician's overall work-up and treatment of the patient.

Providers other than radiologists are sometimes under agreement with facilities to provide interpretations in specific instances. Those specialties may be paid if a radiologist does not bill for the professional component of X-ray procedures.

If duplicate billings are found between radiologists and the other specialties, the radiologist may be paid, and the other provider is denied.

Oral preparations for X-rays are included in the charge for the X-ray procedure when billed by a physician. Separate charges for the oral preparation are denied as part of another procedure on the same day.

Separate charges for injectable radiopharmaceuticals used in the performance of specialized X-ray procedures may be paid. If a procedure code is not indicated, an unlisted code must have a drug name, route of administration, and dosage written on the claim.

9.2.61.1 Diagnosis Requirements

Physicians enrolled and practicing as radiologists are not routinely required to send a diagnosis with their request for payment except when providing the following services:

- Arteriograms

- Venography
- Chest X-rays
- Cardiac blood pool imaging
- Echography

Radiologists are required to identify the referring provider by full name and credentials in Block 17 of the CMS-1500 claim form. Radiology procedures submitted by all other physician specialties must reference a diagnosis with every procedure billed. As with all procedures billed to Texas Medicaid, baseline screening and/or comparison studies are not a benefit.

9.2.61.2 Cardiac Blood Pool Imaging

Cardiac blood pool imaging may be reimbursed with procedure codes 78472, 78473, 78481, 78483, 78494, and 78496. Prior authorization is required for outpatient diagnostic services.

Referto: Subsection 9.2.25.9, “Myocardial Perfusion Imaging” in this handbook for more information about myocardial perfusion imaging.

Section 3, “Radiological and physiological laboratory services” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for additional information and authorization requirements.

9.2.61.3 Chest X-Rays

All providers including radiologists billing for chest X-rays must supply a diagnosis code.

Screening, baseline, or rule-out studies do not qualify for reimbursement.

9.2.61.4 Magnetic Resonance Angiography (MRA)

MRA is an effective diagnostic tool used to detect, diagnose, and aid the treatment of heart disorders, stroke, and blood vessel diseases.

Referto: Section 3, “Radiological and physiological laboratory services” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for additional information and authorization requirements.

9.2.61.5 Magnetic Resonance Imaging (MRI)

MRIs may be an effective diagnostic tool for detecting defects, diseases, and trauma.

Referto: Section 3, “Radiological and physiological laboratory services” in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)* for additional information and authorization requirements.

9.2.61.6 Technetium TC 99M

Procedure codes A9500 (Sestamibi) and A9502 (Tetrofosmin) are limited to three per day when billed by the same provider.

9.2.62 Magnetoencephalography (MEG)

Magnetoencephalography is a benefit of Texas Medicaid when medically necessary for the presurgical evaluation of clients with intractable epilepsy (i.e., refractory or drug-resistant epilepsy), brain tumors, vascular malformations of the brain, or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information.

MEG is a noninvasive method of measuring magnetic fields in the brain and is used to precisely localize both the essential functional cortex (i.e., eloquent cortex) and abnormal epileptogenic brain activity as part of a presurgical evaluation. The origin of abnormal MEG brain activity can be precisely localized (source localization) and displayed as a map or image.

The term magnetic source imaging (MSI) refers to an imaging technique that combines a MEG scan with an anatomic magnetic resonance imaging (MRI) image of the brain to map or visualize brain activity.

MEG may assist in guiding the placement of intracranial Electroencephalography (EEG) and, in some patients, avoid an unnecessary intracranial EEG. In the case of pre-surgical mapping of patients with operable lesions, MEG provides non-invasive localization of eloquent cortices (e.g., motor, sensory, language, auditory, or visual).

Physicians must provide MEG services in a comprehensive level IV epilepsy center or a physiological laboratory. A neurologist, epileptologist, or neurosurgeon must order the MEG test.

MEG is not a stand-alone test. Pre-surgical evaluation with MEG testing must include a comprehensive evaluation by the medical team.

Procedure codes 95965, 95966, and 95967 may be reimbursed for MEG services. Procedure code 95967 is an add-on code and must be submitted with procedure code 95966.

Physicians may be reimbursed for the professional component of MEG services.

9.2.62.1 Prior Authorization for MEG

Prior authorization is required for MEG. Prior authorization requests must be submitted using the [Special Medical Prior Authorization \(SMPA\) Request Form](#). The ordering physician must sign and date the form and submit it to the SMPA department. Requests must include documentation supporting the medical necessity of the study. The ordering physician must maintain all documentation.

Providers must include information about the MEG test facility. This information must be documented on the SMPA form.

Prior authorization requests must include a completed SMPA request form and all of the following documentation:

- Documentation of one of the following conditions: intractable epilepsy, brain tumors, or vascular malformations of the brain
- The statement of medical necessity from the ordering physician, which must support the need for MEG with identified medical conditions as applicable, including:
 - History of treatment methods used
 - Length of treatment and treatment outcomes
 - Date of onset of supporting diagnoses
 - Types of previous diagnostic testing used or considered and documentation that indicates how these tests have failed to provide the necessary information to address the client's medical needs or when one or more conventional measures of localizing the seizure focus have failed to provide sufficient information

Documentation from the ordering physician outlining how the MEG test will assist in identifying the area to be resected in instances when an MEG test is needed due to a tumor and surgery is the first option.

Documentation that includes the name and number of medications, tried and failed, to control the client's seizure activity when the MEG request is related to intractable epilepsy.

The date of prior MEG, the results of the previous MEG tests, and supporting medical documentation outlining the medical reasons for the repeat MEG requested if the request is for a repeat MEG.

Providers may submit prior authorization requests electronically, through the provider website, fax, or by standard mail.

The provider may complete and submit the required prior authorization documentation through any approved electronic method. The provider must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, in order to complete the prior authorization process electronically.

The provider may complete and submit the required prior authorization documentation through fax or standard mail and must maintain a copy of the prior authorization request as well as all submitted documentation in the client's medical record at the performing provider's place of business, to complete the prior authorization process by paper.

Providers must include correct and complete information, such as documentation of medical necessity for the service(s) requested, in order to avoid unnecessary denials. Providers must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request.

Requests for prior authorization with documentation supporting the medical necessity for the number of studies requested must be received on, or before, the requested date(s) of service.

Note: *Requests received after the services are performed will be denied for dates of service that occurred before the date the request was received.*

9.2.62.2 Documentation Requirements

In addition to documentation requirements outlined in the "Prior Authorization for MEG" section, the following requirements apply:

- All MEG services are subject to retrospective review to ensure that the documentation in the client's medical record supports the medical necessity of the service(s) provided.
- Magnetic Source Imaging procedure code S8035 is not a benefit of Texas Medicaid, but it may be used for informational purposes.

9.2.62.3 Noncovered Services

The following MEG services are not benefits of Texas Medicaid:

- MEG when used as a stand-alone test for epilepsy
- MEG used as a first-line diagnostic screening
- MEG when used for evaluation of:
 - Alzheimer's disease
 - Autism
 - Cognitive and mental disorders
 - Developmental dyslexia
 - Learning disorders
 - Migraines
 - Multiple sclerosis
 - Parkinson's disease
 - Schizophrenia
 - Stroke rehabilitation
 - Traumatic brain injury

Note: *This list is not all inclusive.*

9.2.63 Reduction Mammoplasties

9.2.63.1 Prior Authorization for Reduction Mammoplasty

Procedure code 19318 is the removal of breast tissue and is a benefit of Texas Medicaid when prior authorized.

For prior authorization of reduction mammoplasty, a completed “Medicaid Certificate of Medical Necessity for Reduction Mammoplasty” form signed and dated by the physician, must be submitted and include at least one of the following criteria:

- Evidence of severe neck and/or back pain with incapacitation from the pain.
- Evidence of ulnar pain or paresthesia from thoracic nerve root compression.
- Submammary dermatological conditions such as intertrigo and acne that are refractory to conventional medication.
- Shoulder grooving with ulceration due to breast size.

In addition to the above criteria, documentation must indicate:

- The minimum weight of tissue expected to be removed from each breast with consideration to height and weight is as follows:

| Height and Weight Chart | | |
|-------------------------|---------------|----------------------|
| Under 5' | <140 lb | 300 grams per breast |
| 5'-5'.4" | up to 180 lb | 350 grams per breast |
| 5'.4"-5'.7" | up to 220 lb | 400 grams per breast |
| 5'.7"- and up | 211 lb and up | 500 grams per breast |

- The client, if 40 years of age or older, has had a mammogram within the past year that was negative for cancer.

The following services are *not* a benefit of Texas Medicaid:

- Reduction mammoplasty for cosmetic purposes (such as the equalization of breast size)
- Augmentation mammoplasty to increase breast size

The physician is required to maintain the following documentation in the client's clinical records:

- A complete history and physical
- Pulmonary function studies results
- Past treatments, therapies, and outcomes for pain control and weight reduction

The physician is required to maintain preoperative photographs (frontal and lateral views) in the client's clinical records and must be made available to Texas Medicaid upon request.

For reimbursement purposes on a bilateral procedure, the full allowed amount will be paid to the surgeon and assistant surgeon for the first breast reduction and one half the allowed amount will be paid for the second reduction. Facilities are paid for one surgical procedure.

When submitting for prior authorization, requests *must* be sent to TMHP Special Medical Prior Authorization. Sending requests directly to the TMHP Medical Director delays the processing of the request. Providers are to mail prior authorization requests for reduction mammoplasty to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax 1-512-514-4213

9.2.64 Renal Disease

9.2.64.1 Dialysis Patients

Physician reimbursement for supervision of patients on dialysis is based on a monthly capitation payment (MCP) calculated by Medicare. The MCP is a comprehensive payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all POSs except inpatient hospital. The original onset date must be the same date entered on the 2728 form sent to the Social Security office.

9.2.64.1.1 Physician Supervision of Dialysis Patients

Physician supervision of outpatient ESRD services includes services provided in the course of office visits where any of the following occur:

- The routine monitoring of dialysis.
- The treatment or follow-up of complications of dialysis, including:
 - The evaluation of related diagnostic tests and procedures.
 - Services involved in prescribing therapy for illnesses unrelated to renal disease, if the treatment occurs without increasing the number of physician-client contacts.

Use the following procedure codes when billing for physician supervision of outpatient ESRD dialysis services:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 90951 | 90952 | 90953 | 90954 | 90955 | 90956 | 90957 | 90958 | 90959 | 90960 |
| 90961 | 90962 | 90963 | 90964 | 90965 | 90966 | 90967 | 90968 | 90969 | 90970 |

The procedure codes must be billed as described below:

- In the circumstances where the client is not on home dialysis and has had a complete assessment visit during the calendar month and ESRD-related services are provided for a full month, procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be used, determined by the number of face-to-face visits the physician has had with the client during the month, and the client's age.
- When a full calendar month of ESRD-related services are reported for clients on home dialysis, procedure codes 90963, 90964, 90965, or 90966 must be used, determined by the client's age.
- Report procedure codes 90967, 90968, 90969, and 90970 when ESRD related services are provided for less than a full month, per day, under the following conditions:
 - The client is seen for a partial month and is not on home dialysis and received one or more face-to-face visits but did not receive a complete assessment.
 - The client is on home dialysis and received less than a full month of services.

- The client is a transient client.
- The client was hospitalized during a month of services before a complete assessment could be performed.
- Dialysis was stopped due to recovery or death of client.
- The client received a kidney transplant.
- Procedure codes 90967, 90968, 90969, and 90970 are limited to one per day by any provider. When billing procedure code 90967, 90968, 90969, or 90970, the date of service must indicate each day that supervision was provided.
- Procedure codes 90967, 90968, 90969, and 90970 will be denied when billed within the same calendar month by any provider as procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966.
- Procedure codes 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, or 90966 are limited to once per calendar month by any provider, and only one service may be reimbursed per calendar month by any provider.

The following services may be provided in conjunction with physician supervision of ESRD dialysis but are considered non-routine and may be billed separately:

- Dec clotting of shunts when performed by the physician.
- Physician services to inpatient clients. If a client is hospitalized during a calendar month of ESRD related services before a complete assessment is performed, or the client receives one or more face-to-face assessments, but the timing of inpatient admission prevents the client from receiving a complete assessment, the physician must bill procedure code 90967, 90968, 90969, or 90970 for each date of outpatient supervision and bill the appropriate hospital evaluation and management code for individual services provided on the hospitalized days. If a client has a complete assessment during a month in which the client is hospitalized, procedure code 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, or 90962 must be reported for the month of supervision, determined by the number of face-to-face physician visits with the client during the month, and the client's age. The appropriate inpatient evaluation and management codes must be reported for procedures provided during the hospitalization.
- Dialysis at an outpatient facility other than the usual dialysis setting for a patient of a physician who bills the MCP. The physician must bill procedure code 90967, 90968, 90969, or 90970 for each date supervision is provided. The physician may not bill for days that the client dialyzed elsewhere.
- Physician services beyond those that are related to the treatment of the patient's renal condition that cause the number of physician-patient contacts to increase. Physicians may bill on a fee-for-service basis if they supply documentation on the claim that the illness is not related to the renal condition and that additional visits are required.

Use procedure codes 90935, 90937, 90945, and 90947 for inpatient dialysis services for ESRD or non-ESRD clients when the physician is present during dialysis treatment. The physician must be physically present and involved during the course of the dialysis. These codes are not payable for a cursory visit by the physician; hospital visit codes must be used for a cursory visit.

The hospital procedure codes 90935, 90937, 90945, and 90947 are for complete care of the patient; hospital visits cannot be billed on the same day as these codes. However, if the physician only sees the patient when they are not dialyzing, the physician must bill the appropriate hospital visit code. The inpatient dialysis code must not be submitted for payment.

Only one of procedure code 90935, 90937, 90945, or 90947 may be reimbursed per day, any provider.

Procedure codes 90935, 90937, 90945, and 90947 may also be used for outpatient dialysis services for non-ESRD clients.

Inpatient services provided to hospitalized clients for whom the physician has agreed to bill monthly, may be reimbursed in one of the following three ways:

- The physician may elect to continue monthly billing, in which case she or he may not bill for individual services provided to the hospitalized clients.
- The physician may reduce the monthly bill by 1/30th for each day of hospitalization and charge fees for individual services provided on the hospitalized days.
- The physician may bill for inpatient dialysis services using the inpatient dialysis procedure codes. The physician must be present and involved with the clients during the course of the dialysis.

Clients may receive dialysis at an outpatient facility other than his or her usual dialysis setting, even if their physician bills for monthly dialysis coordination. The physician must reduce the monthly billed amount by 1/30th for each day the client is dialyzed elsewhere.

Physician services beyond those related to the treatment of the client's renal condition may be reimbursed on a fee-for-service basis. The physician should provide documentation stating the illness is not related to the renal condition and added visits are required.

Payment is made for physician training services in addition to the monthly capitation payment for physician supervision rendered to maintenance facility clients.

9.2.64.2 Laboratory Services for Dialysis Patients

Texas Medicaid may reimburse for laboratory services performed for dialysis patients.

Charges for routine laboratory services performed according to established frequencies are included in the facility's composite rate billed to Texas Medicaid regardless of where the tests were performed. Routine laboratory testing processed by an outside laboratory are billed to the facility and billed by a renal dialysis facility, unless they are inclusive tests.

Nonroutine laboratory services for people dialyzing in a facility and all laboratory work for people on CAPD may be billed separately from the dialysis charge.

Referto: Subsection 6.2.9, "Laboratory and Radiology Services" in the *Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks)* for more information on laboratory services.

9.2.64.3 Self-Dialysis Patients

Physician reimbursement for supervision of patients on self-dialysis is made after completion of the patient's training. If the training is not completed, payment is proportionate to the amount of time spent in training. Payment for training may be made in addition to payment under the MCP for physician supervision of an in-facility maintenance dialysis patient. Use procedure codes 90989 and 90993 for dialysis training regardless of the type of training performed. These procedure codes must be billed as specified:

- When complete dialysis training is provided, bill procedure code 90989. Providers are to use modifier AT when using this procedure code. The date of service indicates the date training was completed, and the quantity is 1.
- When dialysis training is not completed, bill procedure code 90993. The date of service must list each day that a session of training was provided and the quantity must indicate the number of training sessions provided.

The amount of reimbursement of subsequent training is determined by prorating the physician's payment for initial training sessions. The amount of payment for each additional training session does not exceed \$20.

9.2.64.3.1 Physician Supervision

All physician services required to create the capacity for self-dialysis must include:

- Direction of and participation in training of dialysis patients.
- Review of family and home status and environment, and counseling and training of family members.
- Review of training progress.

9.2.64.3.2 Initial Training

The following services are included in the physician charge for supervision of a client on self-dialysis:

- Physician services rendered during a dialysis session including those backup dialyses that occur in outpatient facility settings.
- Office visits for the routine evaluation of patient progress, including the interpretation of diagnostic tests and procedures.
- Physician services rendered by the attending physician in the course of an office visit, the primary purpose of which is routine monitoring or the follow-up of complications of dialysis, including services involved in prescribing therapy for illnesses unrelated to renal disease, which may be appropriately treated without increasing the number of contacts beyond those occurring at regular monitoring sessions or visits for treatment of renal complications.
- General support services (for example, arranging for supplies).

9.2.64.3.3 Subsequent Training

No additional payment is made after the initial self-dialysis training course unless subsequent training is required for one of the following reasons:

- A change from the client's treatment machine to one the client had not been trained to use in the initial training course
- A change in setting
- A change in dialysis partner

The physician must document the reason for additional training sessions on the CMS-1500 paper claim form.

Dialysis equipment and supplies used by the client who dialyzes in the home are not benefits of Texas Medicaid, including the lease or purchase of dialysis machines and disposable supply kits.

9.2.65 Sign Language Interpreting Services

Sign language interpreting services are benefits of Texas Medicaid. Providers must use procedure code T1013 with modifier U1 for the first hour of service, and T1013 with modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, same provider, and procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day, same provider.

Sign language interpreting services are available to Medicaid clients who are deaf or hard of hearing or to a parent or guardian of a Medicaid client if the parent or guardian is deaf or hard of hearing.

Physicians in private or group practices with fewer than 15 employees may be reimbursed for this service. The physician will be responsible for arranging and paying for the sign language interpreting services to facilitate the medical services being provided. The physician will then seek reimbursement from Texas Medicaid for providing this service.

Sign language interpreting services must be provided by an interpreter who possesses one of the following certification levels (i.e., levels A through H) issued by either the Office of Deaf and Hard of Hearing Services, Board for Evaluation of Interpreters (BEI) or the National Registry of Interpreters for the Deaf (RID).

Certification Levels:

- BEI Level I/Ii and BEI OC: B (Oral Certificate: Basic)
- BEI Basic and RID NIC (National Interpreter Certificate) Certified
- BEI Level II/IIi, RID CI (Certificate of Interpretation), RID CT (Certificate of Transliteration), RID IC (Interpretation Certificate), and RID TC (Transliteration Certificate)
- BEI Level III/IIIi, BEI OC: C (Oral Certificate: Comprehensive), BEI OC: V (Oral Certificate: Visible), RID CSC (Comprehensive Skills Certificate), RID IC/TC, RID CI/CT, RID RSC (Reverse Skills Certificate), and RID CDI (Certified Deaf Interpreter)
- BEI Advanced and RID NIC Advanced
- BEI IV/IVi, RID MCSC (Master Comprehensive Skills Certificate), and RID SC: L (Specialist Certificate: Legal)
- BEI V/VI
- BEI Master; and RID NIC Master

Interpreting services include the provision of voice-to-sign, sign-to-voice, gestural-to-sign, sign-to-gestural, voice-to-visual, visual-to-voice, sign-to-visual, or visual-to-sign services for communication access provided by a certified interpreter.

The physician requesting interpreting services must maintain documentation verifying the provision of interpreting services. Documentation of the service must be included in the client's medical record and must include the name of the sign language interpreter and the interpreter's certification level. Documentation must be made available if requested by HHSC or its designee.

9.2.66 * Skin Therapy

Skin therapy is a benefit of Texas Medicaid and may be reimbursed with the following procedure codes:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 15782 | 15783 | 15792 | 15793 | 17000 | 17003 | 17004 | 17106 | 17107 | 17108 |
| 17110 | 17111 | 17250 | 17260 | 17261 | 17262 | 17263 | 17264 | 17266 | 17270 |
| 17271 | 17272 | 17273 | 17274 | 17276 | 17280 | 17281 | 17282 | 17283 | 17284 |
| 17286 | 17311 | 17312 | 17313 | 17314 | 17315 | 17340 | 17999 | 11900 | 11901 |
| 96900 | 96910 | 96912 | 96913 | 96920 | 96921 | 96922 | 96999 | | |

Claims for incision and drainage of acne when the diagnosis states there is infection or pustules may be paid.

Procedure codes 96900, 96910, 96912, 96913, 96920, 96921, and 96922 are covered benefits for the following diagnosis codes:

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|--------|--------|--------|-------|-------|-------|-------|
| A672 | B070 | B081 | B550 | B551 | B552 | B559 | C8401 |
| C8402 | C8403 | C8404 | C8405 | C8406 | C8407 | C8408 | C8409 |
| H02731 | H02732 | H02734 | H02735 | L100 | L101 | L102 | L103 |
| L104 | L105 | L1081 | L1089 | L120 | L121 | L122 | L128 |

| [Revised] Diagnosis Codes | | | | | | | |
|----------------------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| L130 | L131 | L138 | L139 | L200 | L2081 | L2082 | L2083 |
| L2084 | L2089 | L210 | L211 | L218 | L219 | L22 | L230 |
| L231 | L232 | L233 | L235 | L236 | L237 | L2381 | L240 |
| L241 | L242 | L243 | L244 | L245 | L246 | L247 | L2481 |
| L24A0 | L24A1 | L24A2 | L24A9 | L24B0 | L24B1 | L24B2 | L24B3 |
| L270 | L271 | L272 | L278 | L279 | L300 | L301 | L302 |
| L303 | L304 | L305 | L400 | L401 | L402 | L403 | L404 |
| L4050 | L4051 | L4052 | L4053 | L4054 | L4059 | L408 | L410 |
| L411 | L412 | L413 | L414 | L415 | L418 | L42 | L440 |
| L560 | L561 | L562 | L563 | L564 | L565 | L570 | L571 |
| L572 | L573 | L574 | L575 | L580 | L581 | L700 | L701 |
| L702 | L703 | L704 | L705 | L708 | L710 | L711 | L718 |
| L730 | L80 | | | | | | |

Intralesional injection(s) may be considered for reimbursement in addition to an office visit.

Procedure codes 11900 and 11901 are covered benefits for intralesional injections for the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|------------------------|---------|---------|---------|---------|---------|---------|---------|
| B070 | B081 | B550 | B551 | B552 | B559 | D863 | L400 |
| L401 | L402 | L403 | L404 | L4050 | L4051 | L4052 | L4053 |
| L4054 | L4059 | L408 | L410 | L411 | L412 | L413 | L414 |
| L415 | L418 | L42 | L440 | L700 | L701 | L702 | L703 |
| L704 | L705 | L708 | L710 | L711 | L718 | L730 | L732 |
| L910 | L928 | T2000XA | T2000XD | T2000XS | T20011A | T20011D | T20011S |
| T20012A | T20012D | T20012S | T2002XA | T2002XD | T2002XS | T2003XA | T2003XD |
| T2003XS | T2004XA | T2004XD | T2004XS | T2005XA | T2005XD | T2005XS | T2006XA |
| T2006XD | T2006XS | T2007XA | T2007XD | T2007XS | T2009XA | T2009XD | T2009XS |
| T2010XA | T2010XD | T2010XS | T20111A | T20111D | T20111S | T20112A | T20112D |
| T20112S | T2012XA | T2012XD | T2012XS | T2013XA | T2013XD | T2013XS | T2014XA |
| T2014XD | T2014XS | T2015XA | T2015XD | T2015XS | T2016XA | T2016XD | T2016XS |
| T2017XA | T2017XD | T2017XS | T2019XA | T2019XD | T2019XS | T2020XA | T2020XD |
| T2020XS | T20211A | T20211D | T20211S | T20212A | T20212D | T20212S | T2022XA |
| T2022XD | T2022XS | T2023XA | T2023XD | T2023XS | T2024XA | T2024XD | T2024XS |
| T2025XA | T2025XD | T2025XS | T2026XA | T2026XD | T2026XS | T2027XA | T2027XD |
| T2027XS | T2029XA | T2029XD | T2029XS | T2030XA | T2030XD | T2030XS | T20311A |
| T20311D | T20311S | T20312A | T20312D | T20312S | T2032XA | T2032XD | T2032XS |
| T2033XA | T2033XD | T2033XS | T2034XA | T2034XD | T2034XS | T2035XA | T2035XD |
| T2035XS | T2036XA | T2036XD | T2036XS | T2037XA | T2037XD | T2037XS | T2039XA |
| T2039XD | T2039XS | T2040XA | T2040XD | T2040XS | T20411A | T20411D | T20411S |
| T20412A | T20412D | T20412S | T2042XA | T2042XD | T2042XS | T2043XA | T2043XD |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T2043XS | T2044XA | T2044XD | T2044XS | T2045XA | T2045XD | T2045XS | T2046XA |
| T2046XD | T2046XS | T2047XA | T2047XD | T2047XS | T2049XA | T2049XD | T2049XS |
| T2050XA | T2050XD | T2050XS | T20511A | T20511D | T20511S | T20512A | T20512D |
| T20512S | T2052XA | T2052XD | T2052XS | T2053XA | T2053XD | T2053XS | T2054XA |
| T2054XD | T2054XS | T2055XA | T2055XD | T2055XS | T2056XA | T2056XD | T2056XS |
| T2057XA | T2057XD | T2057XS | T2059XA | T2059XD | T2059XS | T2060XA | T2060XD |
| T2060XS | T20611A | T20611D | T20611S | T20612A | T20612D | T20612S | T2062XA |
| T2062XD | T2062XS | T2063XA | T2063XD | T2063XS | T2064XA | T2064XD | T2064XS |
| T2065XA | T2065XD | T2065XS | T2066XA | T2066XD | T2066XS | T2067XA | T2067XD |
| T2067XS | T2069XA | T2069XD | T2069XS | T2070XA | T2070XD | T2070XS | T20711A |
| T20711D | T20711S | T20712A | T20712D | T20712S | T2072XA | T2072XD | T2072XS |
| T2073XA | T2073XD | T2073XS | T2074XA | T2074XD | T2074XS | T2075XA | T2075XD |
| T2075XS | T2076XA | T2076XD | T2076XS | T2077XA | T2077XD | T2077XS | T2079XA |
| T2079XD | T2079XS | T2100XA | T2100XD | T2100XS | T2101XA | T2101XD | T2101XS |
| T2102XA | T2102XD | T2102XS | T2103XA | T2103XD | T2103XS | T2104XA | T2104XD |
| T2104XS | T2106XA | T2106XD | T2106XS | T2107XA | T2107XD | T2107XS | T2110XA |
| T2110XD | T2110XS | T2111XA | T2111XD | T2111XS | T2112XA | T2112XD | T2112XS |
| T2113XA | T2113XD | T2113XS | T2114XA | T2114XD | T2114XS | T2116XA | T2116XD |
| T2116XS | T2117XA | T2117XD | T2117XS | T2119XA | T2119XD | T2119XS | T2120XA |
| T2120XD | T2120XS | T2121XA | T2121XD | T2121XS | T2122XA | T2122XD | T2122XS |
| T2123XA | T2123XD | T2123XS | T2124XA | T2124XD | T2124XS | T2126XA | T2126XD |
| T2126XS | T2127XA | T2127XD | T2127XS | T2130XA | T2130XD | T2130XS | T2131XA |
| T2131XD | T2131XS | T2132XA | T2132XD | T2132XS | T2133XA | T2133XD | T2133XS |
| T2134XA | T2134XD | T2134XS | T2136XA | T2136XD | T2136XS | T2137XA | T2137XD |
| T2137XS | T2140XA | T2140XD | T2140XS | T2141XA | T2141XD | T2141XS | T2142XA |
| T2142XD | T2142XS | T2143XA | T2143XD | T2143XS | T2144XA | T2144XD | T2144XS |
| T2146XA | T2146XD | T2146XS | T2147XA | T2147XD | T2147XS | T2150XA | T2150XD |
| T2150XS | T2151XA | T2151XD | T2151XS | T2152XA | T2152XD | T2152XS | T2153XA |
| T2153XD | T2153XS | T2154XA | T2154XD | T2154XS | T2156XA | T2156XD | T2156XS |
| T2157XA | T2157XD | T2157XS | T2159XA | T2159XD | T2159XS | T2160XA | T2160XD |
| T2160XS | T2161XA | T2161XD | T2161XS | T2162XA | T2162XD | T2162XS | T2163XA |
| T2163XD | T2163XS | T2164XA | T2164XD | T2164XS | T2166XA | T2166XD | T2166XS |
| T2167XA | T2167XD | T2167XS | T2170XA | T2170XD | T2170XS | T2171XA | T2171XD |
| T2171XS | T2172XA | T2172XD | T2172XS | T2173XA | T2173XD | T2173XS | T2174XA |
| T2174XD | T2174XS | T2176XA | T2176XD | T2176XS | T2177XA | T2177XD | T2177XS |
| T2200XA | T2200XD | T2200XS | T22011A | T22011D | T22011S | T22012A | T22012D |
| T22012S | T22021A | T22021D | T22021S | T22022A | T22022D | T22022S | T22031A |
| T22031D | T22031S | T22032A | T22032D | T22032S | T22041A | T22041D | T22041S |
| T22042A | T22042D | T22042S | T22049A | T22049D | T22049S | T22051A | T22051D |
| T22051S | T22052A | T22052D | T22052S | T22061A | T22061D | T22061S | T22062A |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T22062D | T22062S | T22091A | T22091D | T22091S | T22092A | T22092D | T22092S |
| T2210XA | T2210XD | T2210XS | T22111A | T22111D | T22111S | T22112A | T22112D |
| T22112S | T22121A | T22121D | T22121S | T22122A | T22122D | T22122S | T22131A |
| T22131D | T22131S | T22132A | T22132D | T22132S | T22141A | T22141D | T22141S |
| T22142A | T22142D | T22142S | T22151A | T22151D | T22151S | T22152A | T22152D |
| T22152S | T22161A | T22161D | T22161S | T22162A | T22162D | T22162S | T22191A |
| T22191D | T22191S | T22192A | T22192D | T22192S | T2220XA | T2220XD | T2220XS |
| T22211A | T22211D | T22211S | T22212A | T22212D | T22212S | T22221A | T22221D |
| T22221S | T22222A | T22222D | T22222S | T22231A | T22231D | T22231S | T22232A |
| T22232D | T22232S | T22239A | T22239D | T22239S | T22241A | T22241D | T22241S |
| T22242A | T22242D | T22242S | T22249A | T22249D | T22249S | T22251A | T22251D |
| T22251S | T22252A | T22252D | T22252S | T22261A | T22261D | T22261S | T22262A |
| T22262D | T22262S | T22291A | T22291D | T22291S | T22292A | T22292D | T22292S |
| T2230XA | T2230XD | T2230XS | T22311A | T22311D | T22311S | T22312A | T22312D |
| T22312S | T22321A | T22321D | T22321S | T22322A | T22322D | T22322S | T22331A |
| T22331D | T22331S | T22332A | T22332D | T22332S | T22341A | T22341D | T22341S |
| T22342A | T22342D | T22342S | T22351A | T22351D | T22351S | T22352A | T22352D |
| T22352S | T22361A | T22361D | T22361S | T22362A | T22362D | T22362S | T22369A |
| T22369D | T22369S | T22391A | T22391D | T22391S | T22392A | T22392D | T22392S |
| T2240XA | T2240XD | T2240XS | T22411A | T22411D | T22411S | T22412A | T22412D |
| T22412S | T22421A | T22421D | T22421S | T22422A | T22422D | T22422S | T22431A |
| T22431D | T22431S | T22432A | T22432D | T22432S | T22441A | T22441D | T22441S |
| T22442A | T22442D | T22442S | T22451A | T22451D | T22451S | T22452A | T22452D |
| T22452S | T22461A | T22461D | T22461S | T22462A | T22462D | T22462S | T22491A |
| T22491D | T22491S | T22492A | T22492D | T22492S | T2250XA | T2250XD | T2250XS |
| T22511A | T22511D | T22511S | T22512A | T22512D | T22512S | T22521A | T22521D |
| T22521S | T22522A | T22522D | T22522S | T22531A | T22531D | T22531S | T22532A |
| T22532D | T22532S | T22541A | T22541D | T22541S | T22542A | T22542D | T22542S |
| T22551A | T22551D | T22551S | T22552A | T22552D | T22552S | T22561A | T22561D |
| T22561S | T22562A | T22562D | T22562S | T22591A | T22591D | T22591S | T22592A |
| T22592D | T22592S | T2260XA | T2260XD | T2260XS | T22611A | T22611D | T22611S |
| T22612A | T22612D | T22612S | T22621A | T22621D | T22621S | T22622A | T22622D |
| T22622S | T22631A | T22631D | T22631S | T22632A | T22632D | T22632S | T22641A |
| T22641D | T22641S | T22642A | T22642D | T22642S | T22649A | T22649D | T22649S |
| T22651A | T22651D | T22651S | T22652A | T22652D | T22652S | T22661A | T22661D |
| T22661S | T22662A | T22662D | T22662S | T22691A | T22691D | T22691S | T22692A |
| T22692D | T22692S | T2270XA | T2270XD | T2270XS | T22711A | T22711D | T22711S |
| T22712A | T22712D | T22712S | T22721A | T22721D | T22721S | T22722A | T22722D |
| T22722S | T22731A | T22731D | T22731S | T22732A | T22732D | T22732S | T22741A |
| T22741D | T22741S | T22742A | T22742D | T22742S | T22751A | T22751D | T22751S |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T22752A | T22752D | T22752S | T22761A | T22761D | T22761S | T22762A | T22762D |
| T22762S | T22791A | T22791D | T22791S | T22792A | T22792D | T22792S | T23001A |
| T23001D | T23001S | T23002A | T23002D | T23002S | T23011A | T23011D | T23011S |
| T23012A | T23012D | T23012S | T23021A | T23021D | T23021S | T23022A | T23022D |
| T23022S | T23031A | T23031D | T23031S | T23032A | T23032D | T23032S | T23041A |
| T23041D | T23041S | T23042A | T23042D | T23042S | T23051A | T23051D | T23051S |
| T23052A | T23052D | T23052S | T23061A | T23061D | T23061S | T23062A | T23062D |
| T23062S | T23071A | T23071D | T23071S | T23072A | T23072D | T23072S | T23091A |
| T23091D | T23091S | T23092A | T23092D | T23092S | T23101A | T23101D | T23101S |
| T23102A | T23102D | T23102S | T23111A | T23111D | T23111S | T23112A | T23112D |
| T23112S | T23121A | T23121D | T23121S | T23122A | T23122D | T23122S | T23131A |
| T23131D | T23131S | T23132A | T23132D | T23132S | T23141A | T23141D | T23141S |
| T23142A | T23142D | T23142S | T23151A | T23151D | T23151S | T23152A | T23152D |
| T23152S | T23161A | T23161D | T23161S | T23162A | T23162D | T23162S | T23171A |
| T23171D | T23171S | T23172A | T23172D | T23172S | T23191A | T23191D | T23191S |
| T23192A | T23192D | T23192S | T23201A | T23201D | T23201S | T23202A | T23202D |
| T23202S | T23211A | T23211D | T23211S | T23212A | T23212D | T23212S | T23221A |
| T23221D | T23221S | T23222A | T23222D | T23222S | T23231A | T23231D | T23231S |
| T23232A | T23232D | T23232S | T23241A | T23241D | T23241S | T23242A | T23242D |
| T23242S | T23251A | T23251D | T23251S | T23252A | T23252D | T23252S | T23261A |
| T23261D | T23261S | T23262A | T23262D | T23262S | T23271A | T23271D | T23271S |
| T23272A | T23272D | T23272S | T23291A | T23291D | T23291S | T23292A | T23292D |
| T23292S | T23301A | T23301D | T23301S | T23302A | T23302D | T23302S | T23311A |
| T23311D | T23311S | T23312A | T23312D | T23312S | T23321A | T23321D | T23321S |
| T23322A | T23322D | T23322S | T23331A | T23331D | T23331S | T23332A | T23332D |
| T23332S | T23341A | T23341D | T23341S | T23342A | T23342D | T23342S | T23351A |
| T23351D | T23351S | T23352A | T23352D | T23352S | T23361A | T23361D | T23361S |
| T23362A | T23362D | T23362S | T23371A | T23371D | T23371S | T23372A | T23372D |
| T23372S | T23391A | T23391D | T23391S | T23392A | T23392D | T23392S | T23401A |
| T23401D | T23401S | T23402A | T23402D | T23402S | T23411A | T23411D | T23411S |
| T23412A | T23412D | T23412S | T23421A | T23421D | T23421S | T23422A | T23422D |
| T23422S | T23431A | T23431D | T23431S | T23432A | T23432D | T23432S | T23441A |
| T23441D | T23441S | T23442A | T23442D | T23442S | T23451A | T23451D | T23451S |
| T23452A | T23452D | T23452S | T23461A | T23461D | T23461S | T23462A | T23462D |
| T23462S | T23471A | T23471D | T23471S | T23472A | T23472D | T23472S | T23491A |
| T23491D | T23491S | T23492A | T23492D | T23492S | T23501A | T23501D | T23501S |
| T23502A | T23502D | T23502S | T23511A | T23511D | T23511S | T23512A | T23512D |
| T23512S | T23521A | T23521D | T23521S | T23522A | T23522D | T23522S | T23531A |
| T23531D | T23531S | T23532A | T23532D | T23532S | T23541A | T23541D | T23541S |
| T23542A | T23542D | T23542S | T23551A | T23551D | T23551S | T23552A | T23552D |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T23552S | T23561A | T23561D | T23561S | T23562A | T23562D | T23562S | T23571A |
| T23571D | T23571S | T23572A | T23572D | T23572S | T23591A | T23591D | T23591S |
| T23592A | T23592D | T23592S | T23601A | T23601D | T23601S | T23602A | T23602D |
| T23602S | T23611A | T23611D | T23611S | T23612A | T23612D | T23612S | T23621A |
| T23621D | T23621S | T23622A | T23622D | T23622S | T23631A | T23631D | T23631S |
| T23632A | T23632D | T23632S | T23641A | T23641D | T23641S | T23642A | T23642D |
| T23642S | T23651A | T23651D | T23651S | T23652A | T23652D | T23652S | T23661A |
| T23661D | T23661S | T23662A | T23662D | T23662S | T23671A | T23671D | T23671S |
| T23672A | T23672D | T23672S | T23691A | T23691D | T23691S | T23692A | T23692D |
| T23692S | T23701A | T23701D | T23701S | T23702A | T23702D | T23702S | T23711A |
| T23711D | T23711S | T23712A | T23712D | T23712S | T23721A | T23721D | T23721S |
| T23722A | T23722D | T23722S | T23731A | T23731D | T23731S | T23732A | T23732D |
| T23732S | T23741A | T23741D | T23741S | T23742A | T23742D | T23742S | T23751A |
| T23751D | T23751S | T23752A | T23752D | T23752S | T23761A | T23761D | T23761S |
| T23762A | T23762D | T23762S | T23771A | T23771D | T23771S | T23772A | T23772D |
| T23772S | T23791A | T23791D | T23791S | T23792A | T23792D | T23792S | T24001A |
| T24001D | T24001S | T24002A | T24002D | T24002S | T24011A | T24011D | T24011S |
| T24012A | T24012D | T24012S | T24021A | T24021D | T24021S | T24022A | T24022D |
| T24022S | T24031A | T24031D | T24031S | T24032A | T24032D | T24032S | T24091A |
| T24091D | T24091S | T24092A | T24092D | T24092S | T24101A | T24101D | T24101S |
| T24102A | T24102D | T24102S | T24111A | T24111D | T24111S | T24112A | T24112D |
| T24112S | T24121A | T24121D | T24121S | T24122A | T24122D | T24122S | T24131A |
| T24131D | T24131S | T24132A | T24132D | T24132S | T24191A | T24191D | T24191S |
| T24192A | T24192D | T24192S | T24201A | T24201D | T24201S | T24202A | T24202D |
| T24202S | T24211A | T24211D | T24211S | T24212A | T24212D | T24212S | T24221A |
| T24221D | T24221S | T24222A | T24222D | T24222S | T24229A | T24229D | T24229S |
| T24231A | T24231D | T24231S | T24232A | T24232D | T24232S | T24291A | T24291D |
| T24291S | T24292A | T24292D | T24292S | T24301A | T24301D | T24301S | T24302A |
| T24302D | T24302S | T24311A | T24311D | T24311S | T24312A | T24312D | T24312S |
| T24321A | T24321D | T24321S | T24322A | T24322D | T24322S | T24331A | T24331D |
| T24331S | T24332A | T24332D | T24332S | T24391A | T24391D | T24391S | T24392A |
| T24392D | T24392S | T24401A | T24401D | T24401S | T24402A | T24402D | T24402S |
| T24411A | T24411D | T24411S | T24412A | T24412D | T24412S | T24421A | T24421D |
| T24421S | T24422A | T24422D | T24422S | T24431A | T24431D | T24431S | T24432A |
| T24432D | T24432S | T24491A | T24491D | T24491S | T24492A | T24492D | T24492S |
| T24501A | T24501D | T24501S | T24502A | T24502D | T24502S | T24511A | T24511D |
| T24511S | T24512A | T24512D | T24512S | T24521A | T24521D | T24521S | T24522A |
| T24522D | T24522S | T24531A | T24531D | T24531S | T24532A | T24532D | T24532S |
| T24591A | T24591D | T24591S | T24592A | T24592D | T24592S | T24601A | T24601D |
| T24601S | T24602A | T24602D | T24602S | T24611A | T24611D | T24611S | T24612A |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T24612D | T24612S | T24621A | T24621D | T24621S | T24622A | T24622D | T24622S |
| T24631A | T24631D | T24631S | T24632A | T24632D | T24632S | T24691A | T24691D |
| T24691S | T24692A | T24692D | T24692S | T24701A | T24701D | T24701S | T24702A |
| T24702D | T24702S | T24711A | T24711D | T24711S | T24712A | T24712D | T24712S |
| T24721A | T24721D | T24721S | T24722A | T24722D | T24722S | T24731A | T24731D |
| T24731S | T24732A | T24732D | T24732S | T24791A | T24791D | T24791S | T24792A |
| T24792D | T24792S | T25011A | T25011D | T25011S | T25012A | T25012D | T25012S |
| T25021A | T25021D | T25021S | T25022A | T25022D | T25022S | T25031A | T25031D |
| T25031S | T25032A | T25032D | T25032S | T25091A | T25091D | T25091S | T25092A |
| T25092D | T25092S | T25111A | T25111D | T25111S | T25112A | T25112D | T25112S |
| T25121A | T25121D | T25121S | T25122A | T25122D | T25122S | T25131A | T25131D |
| T25131S | T25132A | T25132D | T25132S | T25191A | T25191D | T25191S | T25192A |
| T25192D | T25192S | T25211A | T25211D | T25211S | T25212A | T25212D | T25212S |
| T25221A | T25221D | T25221S | T25222A | T25222D | T25222S | T25231A | T25231D |
| T25231S | T25232A | T25232D | T25232S | T25291A | T25291D | T25291S | T25292A |
| T25292D | T25292S | T25311A | T25311D | T25311S | T25312A | T25312D | T25312S |
| T25321A | T25321D | T25321S | T25322A | T25322D | T25322S | T25331A | T25331D |
| T25331S | T25332A | T25332D | T25332S | T25391A | T25391D | T25391S | T25392A |
| T25392D | T25392S | T25411A | T25411D | T25411S | T25412A | T25412D | T25412S |
| T25421A | T25421D | T25421S | T25422A | T25422D | T25422S | T25431A | T25431D |
| T25431S | T25432A | T25432D | T25432S | T25491A | T25491D | T25491S | T25492A |
| T25492D | T25492S | T25511A | T25511D | T25511S | T25512A | T25512D | T25512S |
| T25521A | T25521D | T25521S | T25522A | T25522D | T25522S | T25531A | T25531D |
| T25531S | T25532A | T25532D | T25532S | T25591A | T25591D | T25591S | T25592A |
| T25592D | T25592S | T25611A | T25611D | T25611S | T25612A | T25612D | T25612S |
| T25621A | T25621D | T25621S | T25622A | T25622D | T25622S | T25631A | T25631D |
| T25631S | T25632A | T25632D | T25632S | T25711A | T25711D | T25711S | T25712A |
| T25712D | T25712S | T25721A | T25721D | T25721S | T25722A | T25722D | T25722S |
| T25731A | T25731D | T25731S | T25732A | T25732D | T25732S | T25791A | T25791D |
| T25791S | T25792A | T25792D | T25792S | T2601XA | T2601XD | T2601XS | T2602XA |
| T2602XD | T2602XS | T2611XA | T2611XD | T2611XS | T2612XA | T2612XD | T2612XS |
| T2621XA | T2621XD | T2621XS | T2622XA | T2622XD | T2622XS | T2631XA | T2631XD |
| T2631XS | T2632XA | T2632XD | T2632XS | T2641XA | T2641XD | T2641XS | T2642XA |
| T2642XD | T2642XS | T2651XA | T2651XD | T2651XS | T2652XA | T2652XD | T2652XS |
| T2661XA | T2661XD | T2661XS | T2662XA | T2662XD | T2662XS | T2671XA | T2671XD |
| T2671XS | T2672XA | T2672XD | T2672XS | T2681XA | T2681XD | T2681XS | T2682XA |
| T2682XD | T2682XS | T2691XA | T2691XD | T2691XS | T2692XA | T2692XD | T2692XS |
| T271XXA | T271XXD | T271XXS | T275XXA | T275XXD | T275XXS | T280XXA | T280XXD |
| T280XXS | T281XXA | T281XXD | T281XXS | T282XXA | T282XXD | T282XXS | T283XXA |
| T283XXD | T283XXS | T2840XA | T2840XD | T2840XS | T28411A | T28411D | T28411S |

| Diagnosis Codes | | | | | | | |
|-----------------|---------|---------|---------|---------|---------|---------|---------|
| T28412A | T28412D | T28412S | T2849XA | T2849XD | T2849XS | T285XXA | T285XXD |
| T285XXS | T286XXA | T286XXD | T286XXS | T287XXA | T287XXD | T287XXS | T288XXA |
| T288XXD | T288XXS | T2890XA | T2890XD | T2890XS | T28911A | T28911D | T28911S |
| T28912A | T28912D | T28912S | T2899XA | T2899XD | T2899XS | T300 | T304 |
| T310 | T3110 | T3111 | T3120 | T3121 | T3122 | T3130 | T3131 |
| T3132 | T3133 | T3140 | T3141 | T3142 | T3143 | T3144 | T3150 |
| T3151 | T3152 | T3153 | T3154 | T3155 | T3160 | T3161 | T3162 |
| T3163 | T3164 | T3165 | T3166 | T3170 | T3171 | T3172 | T3173 |
| T3174 | T3175 | T3176 | T3177 | T3180 | T3181 | T3182 | T3183 |
| T3184 | T3185 | T3186 | T3187 | T3188 | T3190 | T3191 | T3192 |
| T3193 | T3194 | T3195 | T3196 | T3197 | T3198 | T3199 | T320 |
| T3210 | T3211 | T3220 | T3221 | T3222 | T3230 | T3231 | T3232 |
| T3233 | T3240 | T3241 | T3242 | T3243 | T3244 | T3250 | T3251 |
| T3252 | T3253 | T3254 | T3255 | T3260 | T3261 | T3262 | T3263 |
| T3264 | T3265 | T3266 | T3270 | T3271 | T3272 | T3273 | T3274 |
| T3275 | T3276 | T3277 | T3280 | T3281 | T3282 | T3283 | T3284 |
| T3285 | T3286 | T3287 | T3288 | T3290 | T3291 | T3292 | T3293 |
| T3294 | T3295 | T3296 | T3297 | T3298 | T3299 | | |

Procedure codes 15782, 15783, 15792, 15793, and 17999 require prior authorization. Requests for prior authorization must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation supporting the medical necessity of the anticipated procedure. This documentation must remain in the client's medical record and is subject to retrospective review. To avoid unnecessary denials, the physician must provide correct and complete information.

Dermabrasion procedures (procedure codes 15782 and 15783) and chemical peel procedures (procedure codes 15792 and 15793) may be prior authorized with documentation that the client meets all of the following criteria:

- A diagnosis of actinic keratosis with more than three lesions.
- Failed conservative treatment or documentation that conservative treatment is contraindicated.

Prior authorization requests for procedure code 17999 must include the following documentation:

- A clear, concise description of the procedure to be performed.
- Reason for recommending the particular procedure.
- Documentation that a specific procedure code is not available for the procedure requested.
- The client's diagnosis.
- Medical records indicating prior treatment for the diagnosis and the medical necessity of the requested procedure.
- Place of service the procedure is to be performed.
- Documentation that the procedure is not investigational or experimental.
- The physician's intended fee for the procedure including a comparable procedure code.

9.2.67 Sleep Studies

Sleep study procedure code 95806 is not a benefit of Texas Medicaid.

9.2.67.1 Actigraphy

Actigraphy (procedure code 95803) may be reimbursed in the office or outpatient hospital setting with a limit of one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Actigraphy can be performed as a stand-alone procedure or as an adjunct to polysomnography or multiple sleep latency test (MSLT).

Actigraphy (procedure code 95803) must be billed with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| F5104 | F5105 | F5113 | G2581 | G4700 | G4701 | G4709 | G4710 |
| G4711 | G4712 | G4713 | G4714 | G4719 | G4720 | G4721 | G4722 |
| G4723 | G4724 | G4725 | G4726 | G4727 | G4729 | G4761 | |

If the primary care physician performs the actigraphy, the technical component must be billed (procedure code 95803 with modifier TC).

Documentation of actigraphy must include a hard-copy printout or electronic file. Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording and integration of the information gathered from other professionals' analysis and observations. Documentation of the interpretation must be maintained by the interpreting physician.

Under the following conditions, actigraphy may be a useful adjunct to a detailed history, examination, and subjective sleep diary for the diagnosis and treatment of insomnia, circadian-rhythm disorders, and excessive sleepiness:

- When demonstration of multiday rest-activity patterns is necessary to diagnose, document severity, and guide the proper treatment.
- When more objective information regarding the day-to-day timing or the amount or patterns of a client's sleep is necessary for optimal clinical decision-making.
- When the severity of a sleep disturbance reported by the client or caretaker seems inconsistent with clinical impressions or laboratory findings.
- To clarify the effects of, and under some instances, compliance with pharmacologic, behavioral, phototherapeutic, or chronotherapeutic treatment.
- In symptomatic clients for whom an accurate history cannot be obtained and at least one of the following is true:
 - A polysomnographic study has already been conducted.
 - A polysomnographic study is considered unlikely to be of much diagnostic benefit.
 - A polysomnographic study is not yet clearly indicated (because of the absence of accurate historical data).
 - A polysomnographic study is not immediately available.

Actigraphy may be useful in the assessment of specific aspects of the following disorders:

- Insomnia. Assessment of sleep variability, measurement of treatment effects, and detection of sleep phase alterations in insomnia secondary to circadian rhythm disturbance.

- Restless legs syndrome or periodic limb movement disorder. Assessment of treatment effects.

9.2.67.2 Pneumocardiograms

Pneumocardiograms (procedure code 95807) are limited to clients who are birth through 12 months of age.

Pneumocardiograms are limited to one per day, and two per rolling year by any provider. Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Procedure code 95807 must be billed with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|------|
| G4731 | G4733 | G4734 | G4735 | G4736 | G4737 | P282 | P283 |
| P284 | P285 | P2911 | P2912 | R063 | R0681 | R0902 | R230 |
| R6813 | | | | | | | |

Documentation of the complete readings associated with the pneumocardiogram and the physician's interpretation must be maintained in the client's medical record in a hard-copy printout or electronic file at the facility where the procedure is performed.

The physician's interpretation and report must include inspection and integration of the information gathered from all physiological systems and other professionals' analysis and observations.

9.2.67.3 Polysomnography

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is a benefit of Texas Medicaid.

Polysomnography is distinguished from sleep studies by the inclusion of sleep staging that includes a 1-to 4- lead electroencephalogram (EEG), electro-oculogram (EOG), and a limb or submental electromyogram (EMG).

Additional parameters of sleep that are evaluated in polysomnography include, but are not limited to, the following:

- ECG
- Airflow (by thermistor or intra-nasal pressure monitoring)
- Respiratory effort
- Adequacy of oxygenation by oximetry or transcutaneous monitoring
- Extremity movement or motor activity
- EEG monitoring for sleep staging
- Nocturnal penile tumescence
- Esophageal pH or intraluminal pressure monitoring
- Continuous blood pressure monitoring
- Snoring
- Body positions
- Adequacy of ventilation by end-tidal or transcutaneous CO₂ monitoring

For a sleep study to be reported as a polysomnography, sleep must be recorded and staged. Use the following procedure codes to bill for polysomnography studies: 95782, 95783, 95808, 95810, and 95811.

Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is limited to one per day and two per rolling year by any provider and is allowed for the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|--------|--------|--------|--------|
| E6601 | E662 | F10182 | F10282 | F10982 | F11182 | F11282 | F11982 |
| F13182 | F13282 | F13982 | F14182 | F14282 | F14982 | F15182 | F15282 |
| F15982 | F19182 | F19282 | F19982 | F5101 | F5102 | F5103 | F5104 |
| F5105 | F5109 | F5111 | F5112 | F5113 | F5119 | F513 | F514 |
| F515 | F518 | F519 | G120 | G121 | G1221 | G128 | G2581 |
| G373 | G4700 | G4701 | G4710 | G4711 | G4712 | G4713 | G4719 |
| G4720 | G4721 | G4722 | G4723 | G4724 | G4725 | G4726 | G4727 |
| G4729 | G4730 | G4731 | G4732 | G4733 | G4734 | G4735 | G4736 |
| G4737 | G4739 | G47411 | G47419 | G47421 | G47429 | G4750 | G4751 |
| G4752 | G4753 | G4754 | G4759 | G4761 | G4762 | G4763 | G4769 |
| G478 | G479 | G7100 | G7101 | G7102 | G7109 | G7120 | G7121 |
| G71220 | G71228 | G7129 | G809 | G8250 | G901 | G931 | J353 |
| J9610 | J9611 | J9612 | N5201 | N5202 | N5203 | N521 | N5235 |
| N5236 | N5237 | Q040 | Q041 | Q042 | Q078 | Q308 | Q311 |
| Q312 | Q313 | Q315 | Q318 | Q320 | Q321 | Q322 | Q323 |
| Q324 | Q672 | Q673 | Q674 | Q750 | Q751 | Q752 | Q753 |
| Q754 | Q755 | Q758 | Q759 | Q770 | Q771 | Q773 | Q774 |
| Q775 | Q777 | Q778 | Q779 | Q781 | Q789 | Q870 | R0681 |
| R0902 | | | | | | | |

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of the polysomnography testing must be maintained in the client's medical record at the sleep facility and include approximately 1,000 pages or the electronically-stored equivalent of data during a single nighttime recording. Each record must be for sleep-wake states and stages, cardiac arrhythmias, respiratory events, motor activity, oxygen desaturations, and behavioral observations.

Documentation must also include the technologist's analysis and report, the patient's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's professional interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

9.2.67.4 Multiple Sleep Latency Test (MSLT)

Multiple sleep latency test (procedure code 95805) is limited to one per day and two per rolling year by any provider, and is restricted to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|--------|--------|--------|-------|-------|-------|-------|
| E662 | F5104 | F5105 | G2581 | G4700 | G4701 | G4709 | G4730 |
| G47411 | G47419 | G47421 | G47429 | G4753 | G4761 | | |

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG
- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95782, 95783, 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.67.5 Home Sleep Study Test

Home sleep study tests are unattended studies that are performed in the client's home using a portable monitoring device. The portable monitoring device must meet American Academy of Sleep Medicine (AASM) practice parameters and clinical guidelines.

Home sleep study testing is a benefit of Texas Medicaid only when performed in conjunction with a comprehensive sleep evaluation that has been performed by a physician who is board-certified or board-eligible, as outlined in the AASM guidelines. Documentation of the comprehensive sleep evaluation must be kept in the client's medical record. The evaluation must indicate probability of moderate to severe obstructive sleep apnea to support medical necessity for home sleep study testing.

Procedure codes G0398, G0399, and G0400 are a benefit for Texas Medicaid clients who are 18 years of age and older with suspected or proven simple, uncomplicated obstructive sleep apnea. Procedure codes G0398, G0399, and G0400 are restricted to diagnosis code G4733.

Home sleep study tests are payable to physicians in the office setting. Procedure codes G0398, G0399, and G0400 are limited to one per day and a combined total of two tests per rolling year, with any provider. If a client needs more than two tests in a rolling year, subsequent tests must be performed in a sleep facility.

9.2.67.6 Sleep Facility Restrictions for Polysomnography and Multiple Sleep Latency Testing

Sleep facilities that perform services for Medicaid clients must be accredited with the AASM or the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Sleep facilities must maintain documentation with proof that the facility is accredited. Documentation is subject to retrospective review. Sleep facilities that perform services for Texas Medicaid clients must also follow current AASM practice parameters and clinical guidelines.

Physicians who provide supervision in sleep facilities must be board-certified or board-eligible, as outlined in the AASM guidelines.

Sleep facility technicians, technologists, and trainees must demonstrate that they have the skills, competencies, education, and experience that are set forth by their certifying agencies and AASM as necessary for advancement in the profession.

Polysomnographic technologists, technicians, and trainees must meet the following supervision requirements:

- A polysomnographic trainee provides basic polysomnographic testing and associated interventions under the direct supervision of a polysomnographic technician, polysomnographic technologist, or a physician.

Note: *Direct supervision means that the supervising licensed/certified professional must be present in the office suite or building and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the supervising professional must be present in the room while the service is provided.*

- A polysomnographic technologist provides comprehensive evaluation and treatment of sleep disorders under the general supervision of the clinical director (MD or DO).
- A polysomnographic technician provides comprehensive polysomnographic testing and analysis and associated interventions under the general supervision of a polysomnographic technologist or clinical director (MD or DO).
- The supervising physician must be readily available to the performing technologist throughout the duration of the study, but is not required to be in the building.

The sleep facility must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of the nonphysician staff who use the equipment.

Services provided without the required level of supervision are not considered medically appropriate and will be recouped upon retrospective record review.

Claims denied for more than two times per year may be appealed with documentation of medical necessity.

Documentation of MSLT must be maintained in the client's medical record at the sleep facility and include a hard copy or electronic copy of four to five, 20-minute recordings of sleep-wake states and stages spaced at two-hour intervals throughout the day, taking approximately seven to nine hours to complete. In addition, documentation must include the physiological recordings typically made during daytime testing. These typically include:

- EEG
- Electro-oculogram (EOG)
- EMG
- EKG

- Audio and video recordings made during the monitored portion of the day

Documentation must also include the technologist's analysis and report, the client's subjective report, and the influence of intervention applied during the night.

Interpretation and treatment recommendations must be completed by a sleep specialist. The physician's interpretation and report must include inspection of the entire recording, examination of the technologist's analysis and observations, and integration of the information gathered from all physiological systems. Documentation of the interpretation must be maintained in the sleep facility and by the interpreting physician.

MSLT procedure code 95805 must be performed in conjunction with polysomnography procedure code 95808, 95810, or 95811. Polysomnography must be performed on the date before MSLT. MSLT that is not performed in conjunction with polysomnography will be denied, but may be considered on appeal with documentation that explains why the polysomnography did not occur.

9.2.68 Speech Therapy (ST) Services

Speech therapy (ST) is a payable benefit to physicians.

Referto: Section 4, "Therapy Services Overview" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook (Vol. 2, Provider Handbooks)* for information about speech therapy services provided by a physician.

9.2.69 Surgery Billing Guidelines

9.2.69.1 Primary Surgeon

A primary surgeon may be reimbursed for services provided in the inpatient hospital, outpatient hospital setting, and ASC/HASC Center.

A surgeon billing for a surgery and an assistant surgery fee on the same day may be reimbursed if two separate procedures are performed.

Referto: Subsection 9.2.69.7, "Multiple Surgeries" in this handbook.

9.2.69.2 Anesthesia Administered by Surgeon

If the physician bills for a surgical procedure and anesthesia for the same procedure, the surgery is paid and the anesthesia is denied as part of the surgical procedure. The exception to this policy is an epidural during labor and delivery.

Referto: Subsection 9.2.7, "Anesthesia" in this handbook.

9.2.69.3 Assistant Surgeon

Assistant surgeons may be reimbursed 16 percent of the TMRM fee for the surgical procedures performed.

Medicaid follows the TEFRA regulations for assistant surgeons in teaching hospitals. TEFRA states that an assistant surgeon will not be paid in a hospital classified by Medicare as a teaching facility with an approved graduate training program in the performing physician's specialty. Medicaid may consider reimbursement for an assistant surgeon at a teaching hospital classified by Medicare as a teaching facility with approved graduate training program if one of the following situations is present and documented on the claim:

- No qualified resident was available. (Modifier 82 may be used to document this exception.)
- There were exceptional medical circumstances such as an emergency or life-threatening situation requiring immediate attention (modifiers 80 and KX).
- The primary surgeon has a policy of never, without exception, involving a resident in the preoperative, operative, or postoperative care of a patient (modifiers 80 and KX).

- The surgical procedure was complex and required a team of physicians (modifiers 80 and KX).

Use of these modifiers is not required but expedites claims processing. Therefore, it is *recommended* that these modifiers be used in conjunction with the procedure code rather than a narrative statement when these specific circumstances exist.

All claims for assistant surgeon services must include in Block 32 of the CMS-1500 paper claim form the name, address, and provider identifier of the hospital in which the surgery was performed. If the physician seeks an exception to this TEFRA regulation based on unavailability of a qualified resident, the following certification statement must appear on or attached to the claim form:

“I understand that section 1842(b)(6)(D) of the Social Security Act generally prohibits reasonable charge payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary, and that no qualified residents were available to perform the services. I further understand that these services are subject to postpayment review by TMHP.”

Surgical procedures that do not ordinarily require the services of an assistant, as identified by Medicare, are denied when billed as an assistant surgery. One assistant surgeon is reimbursed for surgical procedures when appropriate.

Use modifier AS when the physician assistant is not enrolled as an individual provider and provides assistance at surgery. The claim must include the PA's name and license number. Only procedures currently allowed for assistant surgeons are payable.

PAs actively enrolled as a Medicaid provider with an assigned provider identifier may bill assistant surgery services on a separate claim form using the PA's individual provider identifier and modifiers U7 and 80.

9.2.69.4 Bilateral Procedures

When a bilateral procedure is performed and an appropriate bilateral code is not available, a unilateral code must be used. The unilateral code must be billed twice with a quantity of 1 for each code. For all procedures, use modifiers LT (left) and RT (right) as appropriate. For example, bilateral application of short leg cast is billed as follows:

| Procedure Code | Modifier |
|----------------|----------|
| 29405 | LT |
| 29405 | RT |

9.2.69.5 Cosurgery

Cosurgery (two surgeons) may be reimbursed when the skills of two surgeons (usually with different skills) are required in the management of a specific surgical procedure. Cosurgery is for a surgery where the two surgeons' separate contributions to the successful outcome of the procedure are considered to be of equal importance.

Note: *No additional reimbursement will be made for an assistant surgeon.*

Cosurgeons may be reimbursed for surgical procedure codes that are billed with modifier 62 if the CMS fee schedule indicates that the procedure allows for cosurgeons. Claims will not suspend for manual review of the documentation of medical necessity. Reimbursement will be calculated at 62.5 percent of the amount allowed for the intraoperative portion of the surgical procedure's fee.

No cosurgery payment is made for claims submitted without modifier 62. In instances where the surgeons do not use modifier 62, the first claim received at TMHP for the service is considered that of the primary surgeon, and the subsequent claim is denied as a previously paid service.

9.2.69.6 Global Fees

Texas Medicaid uses global surgical periods to determine reimbursement for services that are related to surgical procedures. The following services are included in the global surgical period:

- Preoperative care, including history and physical
- Hospital admission work-up
- Anesthesia (when administered and monitored by the primary surgeon)
- Surgical procedure (intraoperative)
- Postoperative follow-up and related services
- Complications following the surgical procedure that do not require return trips to the operating room

Texas Medicaid adheres to a global fee concept for minor and major surgeries and invasive diagnostic procedures. Global surgical periods are defined as follows:

- 0-day Global Period-Reimbursement includes the surgical procedure and all associated services that are provided on the same day.
- 10-day Global Period-Reimbursement includes the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 10 days following the date of the surgical procedure.
- 90-day Global Period-Reimbursement includes the surgical procedure, preoperative services that are provided on the day before the surgical procedure, any associated services that are provided on the same day of the surgery, and any associated services that are provided for up to 90 days following the date of the surgical procedure.

Procedure codes that are designated as “Carrier Discretion” will have their global periods determined by HHSC.

Note: All unlisted surgical procedure codes have a 42 day global period assigned by Texas Medicaid.

The global surgical fee period applies to both emergency and nonemergency surgical procedures. Physicians who are in the same group practice and specialty must bill, and are reimbursed, as if they were a single provider.

Modifiers

For services that are rendered in the preoperative, intraoperative, or postoperative period to be correctly reimbursed, providers must use the appropriate modifiers from the following table. Failure to use the appropriate modifier may result in recoupment.

| Modifiers Related to Surgical Fees | | | | | |
|------------------------------------|----|----|----|----|----|
| 24 | 25 | 54 | 55 | 56 | 57 |
| 58 | 62 | 76 | 77 | 78 | 79 |

For services that are billed with modifier 54, 55, or 56, medical record documentation must be maintained by both the surgeon and the physician who provides preoperative or postoperative care. Reimbursement for claims associated with modifier 54, 55, or 56 is limited to the same total amount as would have been paid if only one physician provided all of the care, regardless of the number of physicians who actually provide the care.

If a physician provided all of the preoperative, intraoperative, and postoperative care, claims may be considered for reimbursement when they are submitted without a modifier.

Documentation Requirements

For services that are billed with any of the listed modifiers to be considered for reimbursement, providers must maintain documentation in the client's medical record that supports the medical necessity of the services. Acceptable documentation includes, but is not limited to, progress notes, operative reports, laboratory reports, and hospital records.

On a case-by-case basis, providers may be required to submit additional documentation that supports the medical necessity of services before the claim will be reimbursed.

Note: *Retrospective review may be performed to ensure that the submitted documentation supports the medical necessity of the surgical procedure and any modifier used to bill the claim.*

Preoperative Services

Preoperative physician E/M services (such as office or hospital visits) that are directly related to the planned surgical procedure and provided during the preoperative limitation period will be denied if they are billed by the surgeon or anesthesiologist who was involved in the surgical procedure.

Reimbursement will be considered when the E/M services are performed for distinct reasons that are unrelated to the procedure. E/M services that meet the definition of a significant, separately identifiable service may be billed with modifier 25 if they are provided on the same day by the same provider as the surgical procedure.

Modifier 25 is not used to report an E/M service that results in a decision to perform a surgical procedure. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request. If the decision to perform a minor procedure is made during an E/M visit immediately before the surgical procedure, the E/M visit is considered a routine preoperative service and is not separately billable.

Physicians who provide only preoperative services for surgical procedures with a 10- or 90-day global period may submit claims using the surgical procedure code with the identifying modifier 56. Reimbursement will be limited to a percentage of the fee for the surgical procedure.

E/M services that are provided during the preoperative period (one day before or the same day) of a major surgical procedure (90-day global period) and result in the initial decision to perform the surgical procedure may be considered for reimbursement when billed with modifier 57. The client's medical record must clearly indicate when the initial decision to perform the procedure was made.

Intraoperative Services

Physicians who perform a surgical procedure with a 10- or 90-day global period but do not render postoperative services must bill the surgical procedure code with modifier 54. Modifier 54 indicates that the surgeon provided the surgical care only. Documentation in the medical record must support the transfer of care and must indicate that an agreement has been made with another physician to provide the postoperative management.

Postoperative services

Postoperative services that are directly related to the surgical procedure are included in the global surgical fee and are not reimbursed separately. Postoperative services include, but are not limited to, all of the following:

- Postoperative follow-up visits (any place of service)
- Postoperative pain management
- Miscellaneous services, including:
 - Dressing changes
 - Local incision care

- Platelet gel
- Removal of operative packs
- Removal of cutaneous sutures, staples, lines, wires, drains, casts, or splints
- Replacement of vascular access lines
- Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes
- Changes or removal of tracheostomy tubes

Note: *Removal of postoperative dressings or anesthetic devices is not eligible for separate reimbursement as the removal is considered part of the allowance for the primary surgical procedure.*

If the surgeon provides the surgery and only the postoperative care for a procedure that has a 10- or 90-day global period, the surgeon must include the following details on the claim form:

- The surgical procedure, date of the surgery, and modifier 54, which indicates that he or she was the surgeon.
- The surgical procedure, date of service, and modifier 55 to denote the postoperative care.

Note: *Providers must not submit a claim for the postoperative care until after the client has been seen during a face-to-face follow-up visit.*

When a transfer of care occurs for postoperative care for procedures that have a 10- or 90-day global period, the following conditions apply:

- When transfer of care occurs immediately after surgery, the surgeon or other provider assuming in-hospital postoperative care must bill subsequent care procedure code 99231, 99232, or 99233.
- When the transfer of care occurs after hospital discharge, the surgeon or other provider who provides postdischarge care must bill the appropriate surgical code with modifier 55. Reimbursement will be limited to a percentage of the allowable fee for the surgical procedure.
- Documentation in the medical record must include all of the following:
 - A copy of the written transfer agreement.
 - The dates the care was assumed and relinquished.
- The claim must indicate in the comments field of the claim form the dates on which care was assumed and relinquished, and the units field must reflect the total number of postoperative care days provided. Claims that are submitted on the CMS-1500 paper claim form must include the date of surgery in Block 14 and the dates on which care was assumed and relinquished in Block 19.

Staged or related surgical procedures or services that are performed during the postoperative period may be reimbursed when they are billed with modifier 58. A postoperative period will be assigned to the subsequent procedure. Documentation must indicate that the subsequent procedure or service was not the result of a complication and any of the following:

- It was planned at the time of the initial surgical procedure.
- It is more extensive than the initial surgical procedure.
- It is for therapy following an invasive diagnostic surgical procedure.

Note: *Modifier 58 does not apply to procedure codes that are already defined as staged or sessioned services in the Current Procedural Terminology (CPT) Manual (e.g., 65855 or 66821).*

Hospital visits by the surgeon during the same hospitalization as the surgery are considered to be related to the surgery and, as a result, not separately billable; however, separate payment for such visits can be allowed if any of the following conditions apply:

- Immunotherapy management is provided by the transplant surgeon. Immunosuppressant therapy following transplant surgery is covered separately from other postoperative services, so postoperative immunosuppressant therapy is not part of the global fee allowance for the transplant surgery. This coverage applies regardless of the setting.
- Critical care is provided by the surgeon for a burn or trauma patient.
- The hospital visit is for a diagnosis that is unrelated to the original surgery.

E/M services that are provided by the same provider for reasons that are unrelated to the operative surgical procedure may be considered for reimbursement if they are billed with modifier 24. The submitted documentation must substantiate the reasons for providing E/M services.

- Modifier 24 may be billed with modifier 25 if a significant, separately identifiable E/M service that was performed on the day of a procedure falls within the postoperative period of another unrelated procedure.
- Modifier 24 may be billed with modifier 57 if an E/M service that was performed within the postoperative period of another unrelated procedure results in the decision to perform major surgery.

Return Trips to the Operating Room

Return trips to the operating room for a repeat surgical procedure on the same part of the body may be considered for reimbursement when billed with modifiers 76 and 77. Billing with modifier 76 or 77 initiates the beginning of a new global period. Medical record documentation must support the need for a repeat procedure.

All surgical procedure codes with a predefined limitation (e.g., once per lifetime, one every 5 years) must not be submitted with modifier 76 or 77.

For modifiers 76 and 77, the repeated procedure must be the same as the initial surgical procedure. The repeat procedure must be billed with the appropriate modifier. The reason for the repeat surgical procedure should be entered in the narrative field on the claim form.

Return trips to the operating room for surgical procedures that are related to the initial surgery (i.e., complications) may be considered for reimbursement when they are billed with modifier 78 by the same provider.

- When a surgical procedure has a 0-day global period, the full value of the surgical procedure will be reimbursed; when the procedure has a 10- or 90-day global period only the intraoperative portion will be reimbursed.
- When an unlisted procedure is billed because no code exists to describe the treatment for the complications, reimbursement is a maximum of 50 percent of the value of the intraoperative services that were originally performed.

Reimbursement for the postoperative period of the first surgical procedure includes follow-up services from both surgical procedures, and no additional postoperative reimbursement is allotted. The global period will be based on the first surgical procedure.

Billing with modifier 78 does not begin a new global period.

Surgical procedures that are performed by the same provider during the postoperative period may be considered for reimbursement when they are billed with modifier 79 for any of the following:

- When the same procedure is performed with a different diagnosis.

- When the same procedure is performed on the left and right side of the body in different operative sessions and that procedure is billed with the RT or LT modifier.
- When a different procedure is performed with the same diagnosis.
- When a different procedure is performed with a different diagnosis.

Billing with modifier 79 initiates a new global surgical period.

9.2.69.7 Multiple Surgeries

Medicaid payment for multiple surgeries is based on the following guidelines:

- When two surgical procedures are performed on the same day at the same operative session, the primary procedure (such as the higher paying procedure) is paid at the full TMRM allowance. Secondary procedures performed on the same day are paid at half of the TMRM allowance when medically justified.
- Surgical procedures performed at different operative sessions on the same day are paid at the full TMRM allowance for each primary procedure at each session.
- Vaginal deliveries followed by tubal ligations are considered different operative sessions and are paid at full allowance for each primary procedure at a different session (i.e., both vaginal delivery and tubal ligation are paid at full allowance).
- Procedure code 58611 performed in conjunction with a Cesarean section is reimbursed at full allowance in cases where the allowance already represents half of the primary procedure.
- When a surgical procedure and a biopsy on the same organ or structure is done on the same day, the charges will be reviewed and reimbursement will be made only for the service with the higher of the allowed amounts.

9.2.69.8 Office Procedures

CMS has identified certain surgical procedures that are more appropriately performed in the office setting rather than as outpatient hospital, ASC/HASC procedures. The following list of surgical procedure codes should be billed in POS 1 (physician's office). The medical necessity and/or special circumstances that dictate that these surgical procedures be performed in a POS other than the office must be documented on the claim. These surgical procedures are evaluated on a retrospective basis that may cause recoupment and/or adjustment of the original claim payment. This list is not all inclusive.

| Procedure Codes | | |
|-------------------------|----------------------------|-------------------------|
| Excision benign lesions | Excision malignant lesions | Manipulation (urethral) |
| 11400 | 11600 | 53600 |
| 11401 | 11601 | 53601 |
| 11402 | 11602 | 53620 |
| 11403 | 11603 | 53621 |
| 11404 | 11604 | 53660 |
| 11420 | 11620 | 53661 |
| 11421 | 11621 | |
| 11422 | 11622 | |
| 11423 | 11623 | |
| 11440 | 11624 | |
| 11441 | 11640 | |
| 11442 | 11641 | |

| Procedure Codes | | |
|------------------|------------------|-----------------|
| 11443 | 11642 | |
| 11444 | 11643 | |
| | 11644 | |
| Simple repairs | Endoscopy | Biopsy (tongue) |
| 28010 | 31505 | 41100 |
| 28011 | | |
| Lesions (penile) | Lesions (eyelid) | |
| 54060 | 67801 | |

9.2.69.9 Orthopedic Hardware

Reimbursement for the orthopedic hardware (e.g., buried wire, pin, screw, metal band, nail, rod, or plate) is part of the surgeon's global fee or the facility's payment group. The hardware is not reimbursed separately to either the surgeon or the facility.

The removal of orthopedic hardware is not payable to the same provider who inserted it, if removed within the global operative care period of the original insertion.

Services for removal of orthopedic hardware may be reimbursed separately after the global post operative care period.

9.2.69.10 Second Opinions

Texas Medicaid benefits include payment to physicians when eligible clients request second opinions about specific problems. The claim must be coded with the appropriate office or hospital visit codes, and the notation "Client Initiated Second Opinion" should be identified in Block 24D of the CMS-1500 paper claim form.

Referto: Subsection 9.2.56.3.4, "Office and Outpatient Consultation Services" in this handbook.

9.2.69.11 Supplies, Trays, and Drugs

Payment to physicians for supplies is not allowed under Texas Medicaid. All supplies, including anesthetizing agents, inhalants, surgical trays, or dressings are included in the surgical payment on the day of surgery when the surgery is performed in the office or home setting.

Reimbursement for office visits includes overhead for supplies. If any of these items are submitted separately, they are denied as included in the surgical fee. If the supplies are submitted with a place of service (POS) other than the office, these supplies are denied as services that must be billed by the hospital, or as services that are included in nursing facility charges.

Silver nitrate applicators, used to treat granulated tissue around gastrostomy tubes and tracheostomies, are considered part of the office/hospital visit. Silver nitrate applicators are not a benefit for home use.

9.2.70 Telemedicine Services

Telemedicine services are a benefit of Texas Medicaid.

Referto: The *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)* for information about telemedicine services.

9.2.71 * Therapeutic Apheresis

The following conditions must be met for therapeutic apheresis:

- To perform the medical services, including all nonphysician services, and to respond to medical emergencies at all times during client care, direct supervision by a physician is required.

- Each client must be under the care of a physician.

Procedure codes 36511, 36512, 36513, 36514, and 36516 are limited to the following diagnosis codes:

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|
| C880 | C882 | C883 | C888 | C9000 | C9002 | C9010 | C9011 |
| C9012 | C9020 | C9021 | C9022 | C9030 | C9031 | C9032 | C9100 |
| C9101 | C9102 | C9110 | C9111 | C9112 | C9130 | C9131 | C9132 |
| C9140 | C9141 | C9142 | C9150 | C9151 | C9152 | C9160 | C9161 |
| C9162 | C9190 | C9191 | C9192 | C91A0 | C91A1 | C91A2 | 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 |
| C9332 | C9391 | C9392 | C93Z0 | C93Z1 | C93Z2 | C9400 | C9401 |
| C9402 | C9420 | C9421 | C9422 | C9430 | C9431 | C9432 | C9440 |
| C9441 | C9442 | C9480 | C9481 | C9482 | C9500 | C9501 | C9502 |
| C9510 | C9511 | C9512 | C9590 | C9591 | C9592 | D45 | D472 |
| D473 | D474 | D47Z2 | D5700 | D5701 | D5702 | D5703 | D5709 |
| D571 | D5720 | D57211 | D57212 | D57213 | D57218 | D57219 | D57412 |
| D57413 | D57418 | D5742 | D57431 | D57432 | D57433 | D57438 | D57439 |
| D5744 | D57451 | D57452 | D57453 | D57458 | D57459 | D5780 | D57811 |
| D57812 | D57813 | D57818 | D57819 | D588 | D589 | D590 | D5910 |
| D5911 | D5912 | D5913 | D5919 | D592 | D593 | D594 | D599 |
| D6182 | D65 | D682 | D68311 | D6851 | D6852 | D6859 | D6861 |
| D6862 | D6869 | D688 | D690 | D691 | D692 | D693 | D6941 |
| D6942 | D6949 | D696 | D698 | D699 | D72828 | D732 | D740 |
| D748 | D749 | D750 | D751 | D7589 | D759 | D761 | D762 |
| D763 | D77 | D890 | D892 | D8940 | D8941 | D8942 | D8943 |
| D8949 | E0842 | E0942 | E1042 | E1142 | E7800 | E7801 | E7841 |
| E7849 | G603 | G610 | G6181 | G6182 | G6189 | G620 | G621 |
| G622 | G6281 | G6282 | G63 | G64 | G650 | G7000 | G7001 |
| G731 | I00 | I010 | I012 | I018 | I019 | I773 | I776 |
| I7789 | K716 | K7200 | K7201 | K7581 | K759 | K760 | K762 |
| K767 | K7689 | K77 | K8041 | K8043 | K8045 | K8047 | K8061 |
| K8063 | K8065 | K8081 | L100 | L101 | L102 | L103 | L104 |
| L105 | L1081 | L1089 | L109 | L900 | L940 | L941 | L943 |
| M05011 | M05012 | M05021 | M05022 | M05031 | M05032 | M05041 | M05042 |
| M05051 | M05052 | M05061 | M05062 | M05071 | M05072 | M0509 | M05411 |
| M05412 | M05421 | M05422 | M05431 | M05432 | M05441 | M05442 | M05451 |
| M05452 | M05461 | M05462 | M05471 | M05472 | M0549 | M05611 | M05612 |
| M05621 | M05622 | M05631 | M05632 | M05641 | M05642 | M05651 | M05652 |

| [Revised] Diagnosis Codes | | | | | | | |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|
| M05661 | M05662 | M05671 | M05672 | M0569 | M069 | M08011 | M08012 |
| M08021 | M08022 | M08031 | M08032 | M08041 | M08042 | M08051 | M08052 |
| M08061 | M08062 | M08071 | M08072 | M0809 | M080A | M083 | M08411 |
| M08412 | M08421 | M08422 | M08431 | M08432 | M08441 | M08442 | M08451 |
| M08452 | M08461 | M08462 | M08471 | M08472 | M0848 | M084A | M08832 |
| M08841 | M08842 | M08851 | M08852 | M08861 | M08931 | M08932 | M08941 |
| M08942 | M08951 | M08952 | M08961 | M08962 | M089A | M310 | M3110 |
| M3111 | M3119 | M320 | M3210 | M3219 | M328 | M3300 | M3301 |
| M3302 | M3309 | M3310 | M3311 | M3312 | M3319 | M3320 | M3321 |
| M3322 | M3329 | M3390 | M3391 | M3392 | M3399 | M340 | M341 |
| M342 | M3481 | M3482 | M3483 | M3489 | N000 | N001 | N002 |
| N003 | N004 | N005 | N006 | N007 | N008 | N00A | N010 |
| N011 | N012 | N013 | N014 | N015 | N016 | N017 | N018 |
| N01A | N032 | N034 | N035 | N037 | N03A | N040 | N042 |
| N044 | N045 | N047 | N048 | N049 | N04A | N052 | N054 |
| N055 | N058 | N059 | N05A | N08 | N171 | N172 | T8690 |
| T8693 | T8699 | | | | | | |

Procedure code 36516 may be considered for reimbursement when billed for the low density lipoprotein (LDL) apheresis (such as Liposorber LA 15) or the protein A immunoabsorption (such as Prosorba) columns.

The protein A immunoabsorption column is indicated for use in either of the following cases:

- Clients who have a platelet count of less than 100,000 mm³.
- Adult clients who have signs and symptoms of moderate to severe rheumatoid arthritis with long-standing disease who have failed, or are intolerant to, DMARDs.

The LDL apheresis column is indicated for use in clients who have severe familial hypercholesterolemia whose cholesterol levels remain elevated despite a strict diet and ineffective or intolerated maximum drug therapy. Coverage is considered for the following high-risk population, for whom diet has been ineffective and maximum drug therapy has either been ineffective or not tolerated:

- Functional hypercholesterolemia homozygotes with LDL-C > 500 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 300 mg/dL.
- Functional hypercholesterolemia heterozygotes with LDL-C > 200 mg/dL and documented coronary heart disease.

Baseline LDL-C levels are to be obtained after the client has had, at a minimum, a six-month trial on an American Heart Association (AHA) Step II diet or equivalent and maximum tolerated combination drug therapy designed to reduce LDL-C. Baseline lipid levels are to be obtained during a two- to four-week period and should be within 10 percent of each other, indicating a stable condition.

Therapeutic apheresis using the LDL apheresis column may be reimbursed for diagnosis code E780.

Apheresis is denied for all other diagnosis codes. Other diagnosis codes can be reviewed by the TMHP Medical Director or designee on appeal with documentation of medical necessity.

Laboratory work before and during the apheresis procedure is covered when apheresis is performed in the outpatient setting (POS 5). Laboratory work billed in conjunction with apheresis performed in the inpatient setting (POS 3) is included in the DRG reimbursement and is not paid separately.

9.2.72 Therapeutic Phlebotomy

Therapeutic phlebotomy is a treatment whereby a prescribed amount of blood is withdrawn for medical reasons. Conditions that cause an elevation of the red blood cell volume or disorders that cause the body to accumulate too much iron may be treated by therapeutic phlebotomy.

Therapeutic phlebotomy is a benefit of Texas Medicaid and may be billed using procedure code 99195. This procedure code should be used only for the therapeutic form of phlebotomy and not for diagnostic reasons.

Reimbursement of therapeutic phlebotomy is limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|--------|--------|-------|------|-------|-------|
| D45 | D649 | D750 | D751 | E800 | E801 | E8020 | E8021 |
| E8029 | E8310 | E83110 | E83118 | E8319 | P611 | | |

Therapeutic phlebotomy will be automatically denied for all other diagnosis codes.

9.2.73 Therapeutic Radiopharmaceuticals

Therapeutic radiopharmaceuticals, when used for therapeutic treatment, are a benefit of Texas Medicaid.

The following procedure codes may be submitted for therapeutic radiopharmaceuticals:

| Procedure Codes | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|
| 79403 | A9513 | A9542 | A9543 | A9563 | A9564 | A9590 | A9600 | A9699 |

9.2.73.1 Prior Authorization for Therapeutic Radiopharmaceuticals

Prior authorization is required for ibritumomab tiuxetan procedure codes A9542 and A9543.

Only one ibritumomab tiuxetan (procedure codes A9542 and A9543) may be prior authorized and reimbursed once per lifetime, any provider with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| C8259 | C8399 | C8499 | C84A9 | C84Z9 | C8519 | C8529 | C8589 |
| C8599 | | | | | | | |

Ibritumomab tiuxetan may be prior authorized when all of the following criteria are met:

- Client has a diagnosis of either a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma.
- Client has failed, relapsed, or become refractory to conventional chemotherapy and the following is documented:
 - Marrow involvement is less than 26 percent.
 - Platelet count is 100,000 cell/mm³ or greater.
 - Neutrophil count is 1,500 cell/mm³ or greater.
- Client has failed a trial of rituximab.

Prior authorization must be submitted through Special Medical Prior Authorization department.

Prior authorization is required for lutetium lu 177 dotatate (Lutathera) procedure code A9513.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 will be considered with documentation that meets all of the following criteria:

- The client has a diagnosis of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (one of the following diagnosis codes must be submitted on the prior authorization request: C7A00, C7A010, C7A011, C7A012, C7A019, C7A020, C7A021, C7A022, C7A023, C7A024, C7A025, C7A026, C7A029, C7A092, C7A094, C7A095, C7A096).
- The client is 18 years of age or older.
- The client is not pregnant or breastfeeding.
- The official pathology report documents a GEP-NET with Ki67 index less than 20 percent.
- The disease is metastatic, or locally advanced and unresectable as indicated by one of the following:
 - Positive somatostatin receptor scintigraphy with correlative magnetic resonance imaging (MRI)
 - Computed tomography (CT) imaging of metastatic measurable disease
 - 68-Ga-Dotate positron emission tomography (PET) scan positive for metastatic disease
- The client experienced disease progression while on a long-acting somatostatin analog (e.g. octreotide, lanreotide).
- The client has not had prior treatment with Peptide Receptor Radionuclide Therapy (PRRT), and has not had prior external radiation therapy to more than 25 percent of the bone marrow.
- The documentation includes an oncologist's or nuclear medicine specialist's complete written order and prescription for Lutetium lu 177 dotatate intravenous infusion.
- A treatment plan that includes all of the following documentation:
 - Lutetium lu 177 dotatate 7.4 GBq (200 mCi) every 60 days for a total of 4 doses that is administered in a facility under the control of a physician who is licensed and authorized to administer radiopharmaceuticals
 - The recommended use of premedication and concomitant medications of somatostatin analogs, antiemetics, and specialized amino acid solution
 - The restrictions and usage of long- and short-acting octreotide agents before, during, and after lutetium lu 177 dotatate intravenous infusions
 - Details of withholding the treatments for contraindicated circumstances including, but not limited to:
 - Thrombocytopenia
 - Anemia neutropenia
 - Renal toxicity
 - Hepatotoxicity
 - Other non-hematologic toxicities

Prior authorization requests must be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Referto: Subsection 5.5.1.2, “Document Requirements and Retention” in “Section 5: Fee-for-Service Prior Authorizations” (*Vol. 1, General Information*) for additional information about electronic signatures.

An SMPA Request Form must be completed, signed, and dated by the prescribing provider. The SMPA form will not be accepted after 90 days from the date of the prescribing provider’s signature.

The completed SMPA Request Form must be maintained by the prescribing provider in the client’s medical record and is subject to retrospective review.

Section C of the SMPA Request Form under Statement of Medical Necessity must contain the following:

- Documentation of the client’s dosage
- The administration schedule
- The number of injections to be administered during the prior authorization period
- The requested units/millicuries per injection
- The dosage calculation

To facilitate the determination of medical necessity and avoid unnecessary denials, the prescribing provider must submit correct and complete information, including documentation of medical necessity for the equipment or supplies requested, the procedure codes, and the numerical quantities for services requested. The provider must maintain documentation of medical necessity in the client’s medical record.

Prior authorization must be requested through the Special Medical Prior Authorization (SMPA) department with appropriate documentation.

Requests can be mailed or faxed to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace parkway
Austin, TX 78727
Fax: 1-512-514-4213

Requests for prior authorization can also be submitted online through the TMHP website at www.tmhp.com.

9.2.73.1.1 Reimbursement Limitations for Ibritumomab tiuxetan and Lutetium lu 177 dotatate

Ibritumomab tiuxetan is indicated for the treatment of clients that have failed rituximab and have CD20 antigen-expressing relapsed or refractory, low grade, follicular, or transformed non-Hodgkin’s lymphoma or refractory non-Hodgkin’s lymphoma.

Ibritumomab tiuxetan may only be considered once per lifetime, any provider, and only one of the agents.

Lutetium Lu 177 dotatate (Lutathera) intravenous injection (procedure code A9513) is indicated for the treatment of adult clients who are 18 years of age or older with a diagnosis of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors. For all other indications, Lutetium Lu 177 dotatate (Lutathera) injection for intravenous use is not proven to be medically effective and is considered experimental. Lutetium lu 177 dotatate (Lutathera) must be administered under the control of an oncologist or a nuclear medicine specialist who is licensed and authorized to administer radiopharmaceuticals and must be administered in an outpatient setting.

Lutetium lu 177 dotatate (Lutathera) procedure code A9513 is limited to one service every 60 days for a total of four services per lifetime, any provider.

9.2.73.2 Other Limitations on Therapeutic Radiopharmaceuticals

Strontium-89 chloride (procedure code A9600) may be reimbursed when submitted with diagnosis code C7951 or C7952.

Strontium-89 chloride is limited to a total of 10 mci intravenously injected every 90 days, any provider.

Sodium phosphate P-32, therapeutic (procedure code A9563) may be reimbursed when submitted with the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| C7951 | C7952 | C9110 | C9112 | C9192 | C91Z2 | C9292 | C92Z2 |
| C9512 | C9592 | D45 | | | | | |

Chronic phosphate P-32 suspension (procedure code A9564) may be reimbursed when submitted with diagnosis codes C782 and C786.

An appropriate modifier may be used when billing for services more than once per day, same provider.

Iodine i-131 iobenguane procedure code A9590 is a benefit for clients who are 12 years of age and older.

Iodine i-131 iobenguane is a radiopharmaceutical indicated for the treatment of adult and pediatric clients who are 12 years of age and older with iobenguane scan positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma who require systemic anticancer therapy. Iodine i-131 iobenguane should be handled with appropriate safety measures to minimize radiation exposure and should be administered by or under the control of physicians who are licensed and authorized to administer radiopharmaceuticals.

Procedure code A9590 is limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | |
|-----------------|-------|-------|------|------|------|------|
| C7410 | C7411 | C7412 | C755 | C7A1 | C7A8 | D447 |

9.2.74 Urethral Dilation

If urethral dilation (procedure code 53600, 53601, 53605, 53620, 53621, 53660, 53661, or 53665) is billed on the same date of service by the same provider as procedure code 52000, the charges will be combined and processed as procedure code 52281.

Urethral dilation will be denied when billed on the same date of service by the same provider as any other cystoscopy.

9.2.75 Ventilation Assist and Management for the Inpatient

Use the following procedure codes and guidelines for reimbursement of ventilation assist and management: 94002 and 94003. Procedure codes 94002 and 94003 may be reimbursed only when the client is in observation or inpatient status. Respiratory care billed in any other POS will be denied.

Use the ventilation assist and management subsequent code (procedure code 94003) when respiratory support must be established for a patient in the postoperative period in the hospital (POS 3). Subsequent days of ventilation assistance are payable when documentation indicates a respiratory problem.

When the use of a ventilator is required as part of a major surgery, initial ventilation assist and management will be denied. It should be billed as ventilation assist and management subsequent procedure code 94003.

Procedure codes 94002 and 94003 apply only to hospital care for critically ill patients. They do not apply to routine recovery room ventilation services. Separate support service charges billed on the same day as ventilatory support are denied (for example, arterial or venous punctures; interpretations of arterial blood gases; or pulmonary function tests and management of the hemodynamic functions of the patient).

Use ventilation assist and management and initiation of pressure or volume preset ventilators for assisted or controlled breathing—first day (procedure code 94002) when respiratory support must be established for a patient. It is a one-time charge per hospitalization that may be paid when the claim documents that a respiratory problem exists (for example, respiratory distress, asphyxia). After the first day, use subsequent days (procedure code 94003).

9.2.76 Wearable Cardiac Defibrillator (WCD)

A WCD (procedure codes 93292, 93745, and K0606) are a benefit of Texas Medicaid.

The rental of a WCD (procedure code K0606) is limited to once per month and must be submitted with modifier RR.

Modifier 25 may be used to identify a significant separately identifiable evaluation and management service performed (for example, different diagnosis) on the same day as the initial set up of a WCD by the same provider for the same client. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Procedure code 93292 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

Procedure codes 93000, 93005, 93010, 93040, 93041, and 93042 will be denied as part of procedure code 93745 when submitted on the same date of service by any provider.

9.2.76.1 Prior Authorization for WCD

Prior authorization is required for the rental of WCD (procedure code K0606).

The WCD may be prior authorized for clients at high-risk of sudden cardiac arrest who meets one of the following criteria:

- Has completed electrophysiologic studies to determine the type of arrhythmia present and confirm that a wearable cardiac defibrillator is the best course of treatment.
- Is contraindicated for an implantable cardiac defibrillator (ICD) at the current time, such as with a systemic infection.
- Is waiting for ICD implantation.
- Is waiting for ICD implantation and is undergoing treatment for a systemic infection.
- Has had an ICD explantation due to pocket infection.
- Is waiting for heart transplantation.
- Has self-limiting arrhythmias from iatrogenic (drug loading with potentially pro-arrhythmic medications) or other causes.
- Has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy.
- Has had either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction (LVEF) less than or equal to 35 percent.
- Has received a documented diagnosis of any one of the following conditions:

- Clinically inducible hemodynamically significant ventricular tachycardia (HSVT) or ventricular fibrillation (VF), where drug treatment has been ineffective, or the side effects of the medication used to treat the arrhythmia are intolerable.
- Inducible VT or VF despite endocardial ablation or surgical excision when drug therapy has failed.
- VF or syncopal ventricular tachycardia.
- Specific ST-T wave changes, borderline CPK-MB isoenzymes, and dangerous ventricular arrhythmias are exhibited in a postmyocardial infarction patient.
- VT caused by ischemic heart disease not associated with an acute myocardial infarction, and where drug therapy or surgical therapy has failed.
- Recurrent syncope of undetermined etiology in a patient with HSVT or VF induced by EPS in whom no effective or tolerated drug is available or appropriate. Symptoms must be linked to HSVT or VF.
- Recurrent syncope of undetermined etiology with positive EPS studies where ventricular arrhythmia is documented as the cause.
- Palliative treatment for VT or VF in clients awaiting heart transplant.

The WCD is contraindicated in clients with an active ICD and should not be used in clients who meet the following criteria:

- Have a vision or hearing problem that may interfere with the perception of alarms or messages from the WCD.
- Is taking medications that would interfere with responding to the alarms or message from the WCD by depressing buttons.
- Is unwilling or unable to wear the device continuously, except when bathing or showering.
- Is pregnant or breastfeeding.
- Is of childbearing age and is not attempting to prevent pregnancy.

The WCD is considered investigational and not medically necessary for all other indications, including but not limited to, the following:

- Clients with drug-refractory class IV congestive heart failure who is not candidates for heart transplantation.
- Clients who have a history of psychiatric disorders that interfere with the necessary care and follow-up.
- Clients in whom a reversible triggering factor for VT/VF can be definitely identified, such as ventricular tachyarrhythmias in evolving acute myocardial infarction or electrolyte abnormalities.
- Clients with terminal illnesses.

A completed Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form (Title XIX Form) prescribing the DME and/or medical supplies must be signed and dated by the ordering physician familiar with the client prior to requesting authorization.

- The completed Title XIX Form must be maintained by the DME provider.
- The ordering physician must maintain the completed, originally signed and dated Title XIX Form in the client's medical record.
- The completed Title XIX Form must include the procedure codes and quantities requested for the services.

To complete the prior authorization process the provider must submit the completed Title XIX Form by fax to the Home Health Unit at 1-512-514-4209 or in writing to the following address:

Texas Medicaid & Healthcare Partnership
Home Health Services
PO Box 202977
Austin, TX 78720-2977

When a WCD is not covered as a home health service, it may be considered for reimbursement through the CCP for clients who are 20 years of age and younger. All of the following criteria must be met for CCP reimbursement for a WCD:

- The client is eligible for CCP benefits.
- The documentation submitted with the request supports the determination of medical necessity based on the criteria listed in the policy.
- Federal financial participation is available.
- The client's cardiac status would be compromised without the requested equipment.
- The requested equipment is safe in the home setting.

***Note:** For clients who are 21 years of age or older, requests for a WCD that does not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Rental of an automatic external defibrillator, with integrated electrocardiogram analysis, garment type (procedure code K0606) may be prior authorized (initially for up to three months) with documentation supporting the medical necessity and appropriateness of the device.

The provider may be reimbursed only for the length of time the device is used even though the authorization for the rental may be for a longer period of time.

The rental of the device includes the monitor, electrode belt (four sensors or electrodes and three treatment pads), garment, two rechargeable batteries, a battery charger and modem.

The purchase of a replacement battery (procedure code K0607), the purchase of a garment (procedure code K0608), and electrodes (procedure code K0609) will be considered part of the rental.

Prior authorization extensions for WCDs beyond the initial three-month rental may be considered by the medical director when documentation supports continued medical necessity for the device. Providers must submit new documentation to support continued medical necessity for an extension of the rental to be considered.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the device. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the WCD.

Retrospective review may be performed to ensure documentation supports the medical necessity of the service when billing the claim.

9.2.77 Wound Care Management

Wound care management includes the care of acute and chronic wounds, which include, but are not limited to, open ulcers (venous pressure or diabetic ulcers), fistulas, or erosion of skin related to cancer. Acute and chronic wounds are defined as the following:

- Acute wounds: Wounds taking less than 30 days for complete healing
- Chronic wounds: Wounds taking more than 30 days for complete healing

Wound care includes the following:

- Optimization of nutritional status
- Debridement by any means to remove devitalized tissue
- Maintenance of a clean, moist bed of granulation tissue
- Necessary treatment to resolve any infection that may be present

For clients with an ulcer, wound care may include the following:

- Frequent repositioning of a client who has a pressure ulcer
- Off-loading pressure and good glucose control for a client who has a diabetic ulcer
- Establishment of adequate circulation for a client who has an arterial ulcer
- Use of a compression system for clients who have a venous ulcer

Wound care management includes first- and second-line therapies. First-line wound care is used for acute wounds. If the wound does not improve with first-line treatment, adjunctive second-line therapy may be used. Measurable signs of improved healing include the following:

- A decrease in wound size, either in surface area or volume
- A decrease in amount of exudate
- A decrease in amount of necrotic tissue

Wound care must be performed by a licensed health professional who is qualified to safely and effectively provide the medically necessary care. Providers are expected to exercise their clinical judgment to render the most appropriate care in accordance with their scope of practice as designated by their regulatory and governing boards.

The following services are not a benefit of Texas Medicaid:

- Infrared therapy
- Ultraviolet therapy
- Topical hyperbaric oxygen therapy
- Low-energy ultrasound wound cleanser (MIST therapy)
- Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
- Electrical stimulation and electromagnetic therapy

9.2.77.1 First-Line Wound Care Therapy

First-line wound care therapy includes the following:

- Cleansing, antibiotics, and pressure off-loading
- Compression
- Debridement
- Dressing
- Whirlpool for burns

9.2.77.1.1 Cleansing, Antibiotics, and Pressure Off-loading

Wound cleansing helps to create an optimal healing environment and decreases the potential for infection by loosening and removing cellular debris and residual topical agents from previous dressings.

Wound cleansing agents may include normal saline, commercial wound cleansers, providone iodine, hydrogen peroxide, or sodium hydrochlorite. Cleansing solutions and methods vary based on effectiveness and individual client needs.

Systemic or topical antibiotics may be used to prevent or treat wound infections and to aid in the healing of wounds.

Pressure off-loading devices, such as pillows, boots, mattresses, and protectors, may also be used as part of first-line wound care therapy to prevent or relieve pressure on the wound.

Procedure code 29445 may be reimbursed for pressure off-loading performed as part of wound care management.

9.2.77.1.2 Compression

Compression performed as a part of wound care management is a benefit and may be reimbursed when billed with procedure code 29580 or 29581.

9.2.77.1.3 Debridement

Wound debridement includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the client on the date of service.

Selective debridement consists of the following:

- Conservative sharp debridement
- High-pressure lavage to selected areas

Non-selective debridement consists of the following:

- Autolytic debridement
- Blunt debridement
- Enzymatic debridement
- Hydrotherapy and wound immersion
- Mechanical debridement

The following procedure codes may be reimbursed for wound debridement:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 11000 | 11001 | 11042 | 11043 | 11044 | 11045 | 11046 | 11047 | 97597 | 97598 |
| 97602 | | | | | | | | | |

Professional services for selective wound debridement (procedure codes 97597 and 97598) may be reimbursed to a licensed physical therapist, when it is determined to be within the provider's scope of practice, and the service is prescribed by a Medicaid-enrolled supervising physician or qualified non-physician provider.

The following procedure codes may be reimbursed for debridement of partial-thickness burns:

| Procedure Codes | | |
|-----------------|-------|-------|
| 16020 | 16025 | 16030 |

Prior authorization is not required for debridement of partial-thickness burns (procedure codes 16020, 16025, or 16030).

Prior authorization is required for wound debridement procedure codes 11042, 11043, and 11044. A request for prior authorization must be submitted to TMHP with the Special Medical Prior Authorization (SMPA) Request Form before the procedure is performed. Providers must retain a copy of the

signed and dated form in the client's medical record at the provider's place of business. The requesting provider may be asked for additional information to clarify or complete a request for the equipment/supply requested.

Requests for prior authorization for wound debridement procedure codes 11042, 11043, and 11044 must include the following documentation:

- Location of the wound
- Characteristics of the wound, which include all of the following:
 - Dimensions (diameter and depth)
 - Drainage (amount and type)
 - Related signs and symptoms (swelling, pain, inflammation)
 - Presence of necrotic tissue/slough

When submitting an initial prior authorization request, the treating provider (registered nurse, physician, physical therapist) must submit a signed and dated wound care treatment plan or letter of medical necessity that includes all the following documentation:

- Planned interventions for the problem identified
- Treatment goals
- Expected outcomes

The treatment plan or letter of medical necessity is considered current when it is signed and dated within 30 calendar days prior to or on the date the procedure is performed. Otherwise, a new treatment plan must be submitted.

Retroactive authorization requests for wound debridement performed on an urgent or emergent basis (procedure code 11042, 11043, or 11044) will be denied if not submitted within 14 calendar days, beginning the day after the procedure is performed.

For retroactive authorization to be considered, the treatment plan or letter of medical necessity must be signed and dated within 14 calendar days beginning the day after the procedure is performed. If the treatment plan is not signed and dated within the 14-calendar-day period, the request will be denied.

For procedure codes 11043 and 11044, at least one of the following conditions must be present and documented:

- Stage III or IV wounds
- Venous or arterial insufficiency ulcers
- Dehisced wounds or wounds with exposed hardware or bone
- Neuropathic ulcers
- Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment

Wound debridement procedure codes 11042, 11043, and 11044 are not appropriate and will not be approved for the following:

- Washing bacteria or fungal debris from the feet
- Paring or cutting of corns or calluses
- Incision and drainage of an abscess
- Trimming or debridement of nails, or avulsion of nail plates

- Acne surgery
- Destruction of warts
- Burn debridement

Prior authorization requests must be submitted by the provider within 30 calendar days prior to, or on the date the procedure is performed. If the prior authorization request is not submitted within 30 calendar days prior to, or on the date the procedure is performed, the request will be denied.

The physician's signature on the Special Medical Prior Authorization (SMPA) Request Form is considered current when signed and dated within 30 calendar days prior to, or on the date the procedure is performed. If the physician's signature is not signed and dated within the 30-calendar-day period prior to or on the date the procedure is performed, the request will be denied.

Prior authorization requests for procedure codes 11042, 11043, and 11044 will be considered for 7 calendar days, beginning on the requested procedure date.

Retroactive authorization is required for wound debridement procedure codes 11042, 11043, and 11044 that are performed on an urgent or emergent basis. The provider must submit a request for retroactive authorization within 14 calendar days, beginning the day after the procedure is performed.

For retroactive authorization requests, the physician's signature on the Special Medical Prior Authorization (SMPA) Request Form is considered current when signed and dated within 14 calendar days, beginning the day after the procedure is performed. Requests with the physician's signature not signed and dated within the 14-calendar-day period will be denied.

Prior authorization requests for subsequent debridement will be considered on a case-by-case basis with documentation of medical necessity. These requests will be reviewed by the Medical Director.

The wound debridement procedure code submitted on the prior authorization or retroactive authorization request must reflect the level of debrided tissue, e.g., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle, and/or bone, and not the extent, depth, or grade of the ulcer or wound.

9.2.77.1.4 Dressings and Metabolically Active Skin Equivalents

Wound dressings may include wet and dry dressings.

All dressings applied to the wound during a wound debridement procedure are considered part of the service for wound debridement.

9.2.77.1.5 Whirlpool for Burns

Whirlpool may be a benefit when used as first-line wound care therapy for the treatment of burn wounds.

9.2.77.2 Second-Line Wound Care Therapy

Second-line wound care therapy is limited to chronic Stage III or IV wounds and may be covered only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second line wound care measures as indicated by the client's medical condition.

Second-line wound care therapy includes the following:

- Whirlpool
- Irrigation, including pulsatile jet irrigation
- Application of metabolically active skin equivalents/skin substitutes

9.2.77.2.1 Pulsatile-Jet Irrigation

Pulsatile-jet irrigation is a benefit for the treatment of Stage III or IV wounds when other forms of treatment have failed. Removal of devitalized tissue using pulsatile-jet irrigation may be reimbursed when claims are submitted for procedure code 97597 or 97598.

9.2.77.2.2 Skin Substitutes and Surgical Wound Preparation

The application of skin substitutes is a benefit for the treatment of chronic Stage 3 or 4 wounds that have failed to respond to standard wound care treatment after 30 days. A failed response is defined as a wound that has increased in size or depth, or has not changed in baseline size or depth, and shows no measurable signs of healing improvements after 30 days of appropriate wound-care measures.

Use of the appropriate specific skin substitute product(s) for the episode of each documented wound is expected. Compliance with the Food and Drug Administration (FDA) assessments and submitted guidelines for the specific skin substitute product(s) used is expected. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental and/or investigational. All wound care services require documentation of the wound, and a comprehensive treatment plan is required to be maintained in the client's medical record.

The following procedure codes may be reimbursed for the application of skin substitute grafts:

| Procedure Codes | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|
| 15271 | 15272 | 15273 | 15274 | 15275 | 15276 | 15277 | 15278 |

Approved skin substitute products used in wound care services that are provided in an office-based setting will be considered for separate reimbursement when submitted with an appropriate application procedure code from the table above.

The approved skin substitute product(s) must have a published average sales price, must be FDA cleared/approved or be designated as 361 HCT/P exempt, and should be used in accordance with each product's individualized labeling and application guidelines. The approved list of skin substitute products are reviewed and updated biannually. Providers should refer to the Center for Medicare & Medicaid Services (CMS) Medicare Part B Drug Average Sales Price web page at www.cms.gov for updates to the list of approved skin substitute products.

All skin substitute products used in wound care services that are provided in a facility setting are considered part of the application services and are not separately reimbursed.

Procedure code C9250 is considered part of the application services and will not be separately reimbursed, regardless of the setting.

Surgical Wound Preparation

Appropriate surgical wound preparation may be expected at least once at the initiation of care, prior to placement of the skin substitute graft. Repeated use of surgical preparation services in conjunction with skin substitute application codes will be considered not reasonable or necessary and will not be reimbursed.

Procedure codes 15002, 15003, 15004, 15005, 15040, and 15050 may be reimbursed for surgical wound preparation.

Note: Procedure code 15005 is not a benefit for ambulatory surgical center providers.

Limitations

The treatment of any chronic skin wound will typically last no more than 12 weeks.

Skin substitute applications and grafts are limited to 10 per episode of care in a 12-week period, per rolling year beginning on the first day of the first skin substitute application. If more than one specific product is used or a product change occurs during the 12-week period of care, the expectation remains that the cumulative number of applications will not exceed 10.

More than 10 skin substitute applications in a 12-week period will be considered on a case-by-case basis with documentation of medical necessity. These requests will be reviewed by the Medical Director.

Re-Treatment of Healed, Stage 3, or Stage 4 Chronic Wounds

Retreating healed skin wounds showing greater than 75 percent in size reduction and smaller than 0.5 square cm is not considered medically reasonable or necessary and will not be reimbursed.

Retreating a venous stasis ulcer or diabetic neuropathic foot ulcer with any skin substitute product(s) within one year of previous treatment is considered treatment failure. This unsuccessful treatment does not meet reasonable and necessary criteria for re-treatment and will not be reimbursed.

Unsuccessful treatment is defined as an increase in size or depth of an ulcer, or no change in baseline size or depth and no sign of improvement or indication that improvement is likely (such as granulation, epithelialization, or progress towards closing) for a period of 4 weeks past the start of therapy.

Contraindications

Skin substitute grafts are contraindicated for the following:

- Clients with known hypersensitivity to any component of the specific skin substitute graft (e.g., allergy to avian, bovine, porcine, or equine products).
- Skin substitute grafts will not be considered reasonable and necessary for clients with inadequate control of underlying conditions or exacerbating factors, such as the following:
 - Clients with uncontrolled diabetes
 - Clients with active infection
 - Clients with active Charcot arthropathy of the ulcer extremity
 - Clients with vasculitis
- Clients who continue smoking tobacco and have not received smoking cessation guidance from their physician

9.2.77.3 Documentation Requirements

For all wound care management services, documentation that supports the medical necessity of the service must be maintained in the client's medical records, which includes but is not limited to the following information:

- Accurate diagnostic information that pertains to the underlying diagnosis and condition as well as any other medical diagnoses and conditions, which include the client's overall health status.
- Appropriate medical history related to the current wound, including the following:
- Wound location
 - Wound measurements, which includes length, width, and depth, any tunneling and/or undermining
 - Wound color, drainage (type and amount), and odor, if present
 - The prescribed wound care regimen, which includes frequency, duration, and supplies needed
 - Treatment for infection, if present
 - All previous wound care therapy regimens, if appropriate

- The client's use of a pressure reducing support surface, mattress, and/or cushion, when appropriate

Documentation maintained in the client's medical record must support the level of debridement service provided.

Fewer than five surgical debridements that involve removal of muscle or bone are typically required for management of most wounds. Documentation that is maintained in the client's medical record must support the number of debridements involving muscle or bone that are performed.

9.2.77.3.1 Skin Substitutes

Documentation maintained in the client's medical record must support the need for skin substitute applications and the product used.

Documentation for all wound care treatments involving the application of skin substitute products must include, but is not limited to, the following:

- Wound treatments are accompanied by the appropriate adjunctive measures, and identify the specific adjunctive therapies being provided to the client as part of the wound treatment regimen.
- Clients who use tobacco must satisfy one of the following documentation requirements:
 - The client will have ceased smoking or have refrained from systemic tobacco intake for at least 4 weeks prior to beginning skin substitute applications and during the conservative wound care.
 - Smoking history, cessation counseling on the effects of smoking on surgical outcomes, treatment for smoking cessation (if applicable), and the outcome of counseling must be recorded in the client's medical record.
- Adequate circulation/oxygenation to support tissue growth/wound healing must be present as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30 millimeters of mercury [mmHg]).
- The wound has a skin deficit at least 1.0 square centimeter in size.
- For diabetic foot ulcers, the client's medical record reflects a diagnosis of Type 1 or Type 2 diabetes.
- Partial or full thickness ulcers must have a clean granular base without tendon and or muscle involvement, bone exposure, or sinus tracts.
- Documentation of the wound's response to the treatment is required at least every 30 days for each treatment episode. The documentation requirements must include measurements of the initial wound, measurements at the completion of appropriate wound care every 30 days, and measurements immediately prior to placement and with each subsequent placement of the skin substitute.

9.2.77.4 Exclusions

The following services are not a benefit of Texas Medicaid:

- Separately billed, repeated use of a skin substitute product after 12 weeks for a single wound or episode
- Skin substitute grafting for partial thickness loss with the retention of epithelial appendages is not covered, as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting

9.3 Doctor of Dentistry Practicing as a Limited Physician

This section outlines the guidelines for the Doctor of Dentistry practicing as a limited physician. The THSteps dental program is not addressed in these guidelines.

Services by a dentist (DDS or DMD) are covered by Texas Medicaid in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1987 §4103 and Title 2 *Texas Human Resources Code* §32.054, if the services are furnished within the dentist's scope of practice as defined by Texas state law and would be covered under Texas Medicaid when provided by a licensed physician (MD or DO).

Dentist (DDS or DMD) who want to participate as a dentist-physician in Texas Medicaid must be separately enrolled as a Doctor of Dentistry practicing as a limited physician even if they are enrolled in the THSteps Dental Program.

Dual licensure (MD, DO, and DDS) is not required for a dentist to enroll as a limited physician. Medicare enrollment is required for a dentist to enroll as a limited physician.

9.3.1 Prior Authorization for General Dental Services Due to Life-Threatening Medical Condition

Reimbursement for general dental services by any provider, irrespective of the medical or dental qualifications of the provider, is not a Medicaid benefit for Medicaid clients who are 21 years of age and older (who do not reside in an ICF-IID facility).

The TMHP Medical Director or designee may allow an exception for a dental condition causally related to a life-threatening medical condition. *Mandatory prior authorization is required* and the dental diagnoses *must* be secondary to a life-threatening medical condition.

Examples of dental procedures that may be authorized for a *general dentist* who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement.

Examples of dental procedures that may be authorized for an *oral and maxillofacial surgeon* who is enrolled as a limited physician are:

- Extractions.
- Alveolectomies (in limited situations).
- Incision and drainage.
- Curettement maxillofacial surgeries to correct defects caused by accident or trauma.
- Surgical corrections of craniofacial dysostosis.

Note: *Therapeutic procedures such as restorations, dentures, and bridges are not a benefit of the program and will not be authorized.*

9.3.1.1 Guidelines for Requesting Mandatory Prior Authorization

The limited physician dentist must request the mandatory prior authorization, and the request must include:

- A treatment plan that clearly outlines the dental condition as related to the life-threatening medical condition.
- Narrative describing the current medical problem, client status, and medical need for requested services.
- The client name and Medicaid number.
- The limited physician dentist's provider identifier.

- The name and address of the facility.
- CPT procedure codes.
- The history and physical.
- The limited physician dentist's signature.

Note: The "limited physician" dentist who will perform the procedure(s) must submit the request for prior authorization.

All supporting documentation must be included with the request for authorization. Providers are to send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727
Fax: 1-512-514-4213

9.3.2 Benefits and Limitations

Dental procedure codes and their corresponding CPT procedures may not be billed on the same date of service by any provider.

Cosmetic procedures are not a benefit of Texas Medicaid. Certain procedure codes, including, but not limited to, the procedure codes in the following table, may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury for the purpose of:

- Reconstructing tissues/body structures.
- Repairing damaged tissues.

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 11950 | 11951 | 11952 | 11954 | 11970 | 15780 | 15781 | 15786 | 15787 | 15788 |
| 15789 | 15838 | 15876 | 21089 | 21497 | 41820 | 41821 | 41828 | 61501 | Q3031 |

9.3.2.1 Additional Payable Procedure Codes

The following procedure codes are a benefit when prior authorized and the dentist is qualified and licensed to perform the procedures:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Surgery | | | | | | | | | |
| 10004 | 10005 | 10006 | 10007 | 10008 | 10009 | 10010 | 10011 | 10012 | 10021 |
| 10060 | 10061 | 10120 | 10121 | 10140 | 10160 | 10180 | 11000 | 11001 | 11010 |
| 11011 | 11012 | 11042 | 11043 | 11044 | 11045 | 11046 | 11047 | 11102 | 11103 |
| 11104 | 11105 | 11106 | 11107 | 11200 | 11201 | 11305 | 11306 | 11307 | 11308 |
| 11310 | 11311 | 11312 | 11313 | 11420 | 11421 | 11422 | 11423 | 11424 | 11426 |
| 11440 | 11441 | 11442 | 11443 | 11444 | 11446 | 11620 | 11621 | 11622 | 11623 |
| 11624 | 11626 | 11640 | 11641 | 11642 | 11643 | 11644 | 11646 | 11900 | 11901 |
| 11950 | 11951 | 11952 | 11954 | 11960 | 11970 | 11971 | 12001 | 12002 | 12004 |
| 12005 | 12006 | 12007 | 12011 | 12013 | 12014 | 12015 | 12016 | 12017 | 12018 |
| 12020 | 12021 | 12031 | 12032 | 12034 | 12035 | 12036 | 12037 | 12051 | 12052 |
| 12053 | 12054 | 12055 | 12056 | 12057 | 13120 | 13121 | 13122 | 13131 | 13132 |
| 13133 | 13151 | 13152 | 13153 | 13160 | 14020 | 14021 | 14040 | 14041 | 14060 |

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 14061 | 14301 | 14302 | 15004 | 15005 | 15115 | 15116 | 15120 | 15121 | 15135 |
| 15136 | 15155 | 15156 | 15157 | 15240 | 15241 | 15260 | 15261 | 15275 | 15276 |
| 15277 | 15278 | 15574 | 15576 | 15620 | 15630 | 15730 | 15733 | 15740 | 15750 |
| 15756 | 15757 | 15758 | 15760 | 15769 | 15770 | 15780 | 15781 | 15782 | 15783 |
| 15786 | 15787 | 15788 | 15789 | 15792 | 15793 | 15819 | 15820 | 15821 | 15822 |
| 15823 | 15838 | 15850 | 15851 | 15852 | 15876 | 16020 | 16025 | 16030 | 17000 |
| 17003 | 17004 | 17106 | 17107 | 17108 | 17110 | 17111 | 17250 | 17270 | 17271 |
| 17272 | 17273 | 17274 | 17276 | 17280 | 17281 | 17282 | 17283 | 17284 | 17286 |
| 20100 | 20200 | 20205 | 20220 | 20240 | 20520 | 20525 | 20550 | 20551 | 20552 |
| 20600 | 20604 | 20605 | 20606 | 20615 | 20650 | 20660 | 20661 | 20670 | 20680 |
| 20690 | 20692 | 20693 | 20694 | 20696 | 20697 | 20900 | 20902 | 20910 | 20912 |
| 20920 | 20922 | 20955 | 20956 | 20957 | 20962 | 20969 | 20970 | 20972 | 20973 |
| 20999 | 21010 | 21011 | 21012 | 21013 | 21014 | 21015 | 21016 | 21025 | 21026 |
| 21029 | 21030 | 21031 | 21032 | 21034 | 21040 | 21044 | 21045 | 21046 | 21047 |
| 21048 | 21049 | 21050 | 21060 | 21070 | 21073 | 21076 | 21079 | 21080 | 21081 |
| 21082 | 21083 | 21085 | 21087 | 21088 | 21089 | 21100 | 21110 | 21116 | 21120 |
| 21121 | 21122 | 21123 | 21125 | 21127 | 21137 | 21138 | 21139 | 21141 | 21142 |
| 21143 | 21145 | 21146 | 21147 | 21150 | 21151 | 21154 | 21155 | 21159 | 21160 |
| 21172 | 21175 | 21179 | 21180 | 21181 | 21182 | 21183 | 21184 | 21188 | 21193 |
| 21194 | 21195 | 21196 | 21198 | 21199 | 21206 | 21208 | 21209 | 21210 | 21215 |
| 21230 | 21235 | 21240 | 21242 | 21243 | 21244 | 21245 | 21246 | 21247 | 21255 |
| 21256 | 21260 | 21261 | 21263 | 21267 | 21268 | 21270 | 21275 | 21280 | 21282 |
| 21295 | 21296 | 21299 | 21310 | 21315 | 21320 | 21325 | 21330 | 21335 | 21336 |
| 21337 | 21338 | 21339 | 21340 | 21343 | 21344 | 21345 | 21346 | 21347 | 21348 |
| 21355 | 21356 | 21360 | 21365 | 21366 | 21385 | 21386 | 21387 | 21390 | 21395 |
| 21400 | 21401 | 21406 | 21407 | 21408 | 21421 | 21422 | 21423 | 21431 | 21432 |
| 21433 | 21435 | 21436 | 21440 | 21445 | 21450 | 21451 | 21452 | 21453 | 21454 |
| 21461 | 21462 | 21465 | 21470 | 21480 | 21485 | 21490 | 21497 | 21499 | 21501 |
| 21550 | 21552 | 21554 | 21555 | 21556 | 21558 | 21685 | 29800 | 29804 | 29999 |
| 30000 | 30020 | 30120 | 30124 | 30125 | 30150 | 30160 | 30200 | 30300 | 30310 |
| 30400 | 30410 | 30420 | 30430 | 30435 | 30450 | 30460 | 30462 | 30465 | 30520 |
| 30580 | 30600 | 30620 | 30630 | 30801 | 30802 | 30901 | 30903 | 30905 | 30906 |
| 30930 | 30999 | 31020 | 31030 | 31032 | 31080 | 31081 | 31084 | 31085 | 31086 |
| 31087 | 31225 | 31230 | 31600 | 31603 | 31605 | 31830 | 40490 | 40500 | 40510 |
| 40520 | 40525 | 40527 | 40530 | 40650 | 40652 | 40654 | 40700 | 40701 | 40702 |
| 40720 | 40761 | 40799 | 40800 | 40801 | 40804 | 40805 | 40806 | 40808 | 40810 |
| 40812 | 40814 | 40816 | 40818 | 40819 | 40820 | 40830 | 40831 | 40840 | 40842 |
| 40843 | 40844 | 40845 | 40899 | 41000 | 41005 | 41006 | 41007 | 41008 | 41009 |
| 41010 | 41015 | 41016 | 41017 | 41018 | 41100 | 41105 | 41108 | 41110 | 41112 |
| 41113 | 41114 | 41115 | 41116 | 41120 | 41130 | 41135 | 41140 | 41145 | 41150 |

| Procedure Codes | | | | | | | | | |
|------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 41153 | 41155 | 41250 | 41251 | 41252 | 41510 | 41520 | 41599 | 41800 | 41805 |
| 41806 | 41820 | 41821 | 41822 | 41823 | 41825 | 41826 | 41827 | 41828 | 41830 |
| 41850 | 41870 | 41872 | 41874 | 41899 | 42000 | 42100 | 42104 | 42106 | 42107 |
| 42120 | 42140 | 42145 | 42160 | 42180 | 42182 | 42200 | 42205 | 42210 | 42215 |
| 42220 | 42225 | 42226 | 42227 | 42235 | 42260 | 42280 | 42281 | 42299 | 42300 |
| 42305 | 42310 | 42320 | 42330 | 42335 | 42340 | 42400 | 42405 | 42408 | 42409 |
| 42410 | 42415 | 42420 | 42425 | 42426 | 42440 | 42450 | 42500 | 42505 | 42507 |
| 42509 | 42510 | 42550 | 42600 | 42650 | 42660 | 42665 | 42699 | 42700 | 42720 |
| 42725 | 42800 | 42804 | 42806 | 42808 | 42809 | 42810 | 42815 | 42842 | 42844 |
| 42845 | 42890 | 42892 | 42894 | 42900 | 42950 | 42960 | 42961 | 42962 | 42970 |
| 42999 | 61501 | 61559 | 61575 | 61576 | 61580 | 61581 | 61584 | 61586 | 61590 |
| 61592 | 62147 | 64400 | 64600 | 64612 | 64722 | 64736 | 64738 | 64740 | 67900 |
| 67914 | 67915 | 67916 | 67917 | 67921 | 67922 | 67923 | 67924 | 67930 | 67935 |
| 67950 | 67961 | 92511 | | | | | | | |
| Injections/Medications | | | | | | | | | |
| 90284 | 96360 | 96361 | 96369 | 96370 | 96372 | 96374 | J0121 | J0171 | J0280 |
| J0290 | J0295 | J0330 | J0360 | J0475 | J0558 | J0561 | J0670 | J0690 | J0692 |
| J0694 | J0696 | J0697 | J0698 | J0702 | J0720 | J0744 | J0780 | J1020 | J1030 |
| J1040 | J1100 | J1165 | J1170 | J1200 | J1364 | J1459 | J1555 | J1557 | J1559 |
| J1561 | J1566 | J1568 | J1569 | J1572 | J1599 | J1630 | J1631 | J1720 | J1790 |
| J1800 | J1810 | J1885 | J1940 | J2010 | J2060 | J2175 | J2360 | J2370 | J2400 |
| J2410 | J2510 | J2540 | J2550 | J2560 | J2690 | J2700 | J2765 | J2770 | J2800 |
| J2920 | J2930 | J2970 | J3000 | J3010 | J3260 | J3301 | J3303 | J3360 | J3370 |
| J3410 | J3430 | J3480 | J3485 | J3490 | | | | | |
| Pathology | | | | | | | | | |
| 88305 | 88331 | 88332 | | | | | | | |

9.3.2.2 Immune Globulin by a Doctor of Dentistry as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician may be reimbursed for immune globulin injection procedure code J1571 when billed with one of the following diagnosis codes:

| Diagnosis Codes | | | | | | | |
|-----------------|-------|------|------|------|--------|------|-------|
| D611 | D612 | D613 | D619 | D804 | D805 | D838 | D8982 |
| D8989 | G7000 | N19 | Z205 | Z206 | Z20828 | | |

9.3.2.3 Radiographs by a Doctor of Dentistry Practicing as a Limited Physician

When a Doctor of Dentistry Practicing as a Limited Physician uses appropriate radiograph equipment to produce required radiographs, the following procedure codes are eligible for reimbursement:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 70100 | 70110 | 70120 | 70130 | 70140 | 70150 | 70160 | 70190 | 70200 | 70250 |
| 70260 | 70300 | 70310 | 70320 | 70328 | 70332 | 70336 | 70350 | 70355 | 70370 |
| 70371 | 70380 | 70390 | 73100 | 70450 | 70460 | 70470 | 70480 | 70481 | 70482 |

| Procedure Codes | | | | | |
|-----------------|-------|-------|-------|-------|-------|
| 70486 | 70487 | 70488 | 70490 | 70491 | 70492 |

9.3.2.4 Dental Anesthesia by a Doctor of Dentistry Practicing as a Limited Physician

A Doctor of Dentistry Practicing as a Limited Physician who is licensed by the Texas State Board of Dental Examiners (TSBDE) practicing in Texas, who has obtained an Anesthesia Permit from the TSBDE in accordance with Title 22 TAC §§110.1 through 110.15, may be reimbursed for anesthesia services on clients having dental/oral and maxillofacial surgical procedures in the dental office or hospital in accordance with all applicable rules for physician administration and supervision of anesthesia services.

Dentists providing sedation/anesthesia services must have the appropriate permit from TSBDE for the level of sedation/anesthesia provided.

The following anesthesia services are payable to dentists as physician services:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 00100 | 00102 | 00160 | 00162 | 00164 | 00170 | 00190 | 00192 | 00300 | 99100 |
| 99116 | 99135 | 99140 | | | | | | | |

9.4 Documentation Requirements

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

9.5 Claims Filing and Reimbursement

9.5.1 Claims Information

Claims for physician and doctor 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 them.

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 and itemized statements are not accepted as claim supplements.

Physicians who submit a claim using the physician's own provider identifier for services provided by an NP, CNS, PA, or CNM must submit one of the following modifiers on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit:

- SA – Services were provided by an NP or CNS
- U7 – Services were provided by a physician assistant
- SB – Services were provided by a CNM

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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

9.5.2 National Drug Codes (NDC)

Referto: Subsection 6.3.4, “National Drug Code (NDC)” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

9.5.3 Reimbursement

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with 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.

Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by an NP, CNS, PA, or CNM if the physician does not make a decision regarding the client’s care or treatment on the same date of service as the billable medical visit. The 92 percent reimbursement rate will not apply to laboratory services, X-ray services, and injections provided by an NP, CNS, PA, or CNM.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare/Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

Reimbursement for these services will be 60 percent of the Texas Medicaid rate for the service furnished in the physician’s office. The following table identifies the services applicable to the 60-percent limitation when furnished in outpatient hospital settings:

| Procedure Codes | | | | | | | | | |
|-----------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 99202 | 99203 | 99204 | 99205 | 99211 | 99212 | 99213 | 99214 | 99215 | 99281 |
| 99282 | 99283 | | | | | | | | |

These procedures are designated with note code “1” in the current [physician fee schedule](#), which is available at www.tmhp.com. The following list shows the services excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs).
- Surgical services that are covered ambulatory surgical center (ASC)/hospital-based ambulatory surgical center (HASC) services.
- Anesthesiology and radiology services.
- Prenatal services when billed with modifier TH and the appropriate E/M procedure code to the highest level of specificity.
- Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
 - Serious jeopardy to the client’s health.
 - Serious impairment to bodily functions.
 - Serious dysfunction of any bodily organ or part.

Because of TEFRA, Texas Medicaid reimbursement for a payable nonemergency office service that is performed in the outpatient department of a hospital is limited to 60 percent of Texas Medicaid rate for that service. If the condition qualifies as an emergency or if the client is critically ill or critically injured, the 60 percent professional service reimbursement limit does not apply.

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.

Subsection 2.2.1.1, “Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*) for more information about conditions that are excluded from the 60-percent limitation.

Subsection 9.2.7, “Anesthesia” in this handbook for information on anesthesia services that are reimbursed according to relative value units (RVUs).

9.5.3.1 Affordable Care Act of 2010 (ACA) Rate Increase for Primary Care Services

To qualify for the Affordable Care Act of 2010 (ACA) rate increase for primary care services, a physician must have a specialty designated of general internal medicine, family practice, or pediatrics and must attest to one of the following:

- The provider has a certification recognized by the American Board of Allergy and Immunology (ABAI), American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), or American Osteopathic Association (AOA) and meets the requirements as required by federal and state regulation to receive the increased payment.
- The provider does not have a certification recognized by the ABAI, ABMS, ABPS, or AOA, but at least 60 percent of the provider’s Medicaid billings for the previous calendar year (or for the previous calendar month if the provider has been enrolled in Medicaid for less than one year) were for the evaluation and management (E/M) and vaccine administration procedure codes as published in the final federal and state regulations and the provider meets the requirement to receive payment.

Note: *New providers with no history of Medicaid billings can attest that 60 percent of their Medicaid billing will be for primary care services.*

Providers can attest using the Texas Medicaid Attestation for ACA Primary Care Services Rate Increases form. ABAI-certified allergists must indicate “ABAI-allergy” in the “List subspecialties” field of the attestation form.

Important: *By signing the form, providers attest that they qualify for the rate increase, and that the increase will be applied to paid claims for primary care services on or after the effective date. Payment of the rate increase may be subject to retrospective review and recoupment if it is determined at a later time that the provider did not qualify for the ACA primary care services rate increase. Federal regulations require states to conduct an annual audit of provider attestations.*

Non-physician practitioners who are under the supervision of a provider who has self-attested, are not required to submit a separate provider attestation form. Increased payment may be available to the supervising physician when the following conditions are met:

- The non-physician practitioner renders services under the personal supervision of a provider who has self-attested to meeting the requirements.
- Services are billed under the qualifying provider’s provider identification number.

10 Physician Assistant

10.1 Enrollment

To enroll in Texas Medicaid, a PA must be licensed and recognized as a PA by the Texas Physician Assistant Board. Texas Medicaid accepts a signed letter of certification from the Texas Physician Assistant Board as acceptable documentation of appropriate licensure and certification for enrollment. The PA must identify their supervising physician in the appropriate field of the enrollment application.

Providers cannot be enrolled if their license is due to expire within 30 days.

Enrollment as an individual provider is optional. PAs currently treating clients and billing under the supervising physician's provider identifier may continue this billing arrangement.

All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

All providers of laboratory services must comply with the rules and regulations of CLIA. Providers not complying with CLIA are not reimbursed for laboratory services.

PAs may enroll as providers of THSteps medical checkups.

Referto: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 4.2, "Enrollment" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about enrolling as a THSteps provider.

PAs may be included as primary care providers in the provider network for Medicaid and CHIP programs (both fee-for-service and managed care), regardless of whether the physician supervising the PA is enrolled in Medicaid or in the provider network.

10.2 Services, Benefits, Limitations, and Prior Authorization

Services performed by PAs are covered if the services meet the following criteria:

- Are within the scope of practice for PAs, as defined by Texas state law
- Are consistent with rules and regulations promulgated by the Texas Medical Board or other appropriate state licensing authority
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO)
- Are reasonable and medically necessary as determined by HHSC or its designee

Services provided to Medicaid clients must be documented in the client's medical record to include the following:

- Services provided
- Date of service
- Pertinent information about the client's condition supporting the need for service
- The individual practitioner of the service

PAs who are employed or remunerated by a physician, hospital, facility, or other provider must not bill Texas Medicaid for their services if the billing results in duplicate payment for the same services.

Physicians who submit a claim using the physician's own provider identifier for services provided by a PA must submit modifier U7 on each claim detail if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits and claims must be received within 95 days from the date of service.

Note: *Payment to providers for supplies is not a benefit of Texas Medicaid. Costs of supplies are included in the reimbursement for office visits.*

Referto: Section 2, "Medicaid Title XIX Family Planning Services" in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

Section 9, "Physician" in this handbook.

Section 4, "THSteps Medical" in the *Children's Services Handbook (Vol. 2, Provider Handbooks)*.

10.2.1 Prior Authorization

Services performed by a PA are subject to the same prior authorization guidelines as services performed by other provider types.

10.3 Documentation Requirements

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

10.4 Claims Filing and Reimbursement

10.4.1 Claims Information

Claims for PA services must include modifier U7 on the claim details to indicate that the client was treated by a PA.

PA services must be submitted to TMHP in an approved electronic format or on the CMS-1500 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*) for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

10.4.2 Reimbursement

According to 1 TAC §355.8093, the Medicaid rate for PAs is 92 percent of the rate paid to a physician (MD or DO) for the same professional service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections.

Note: *PA providers who are enrolled in Texas Medicaid as THSteps providers also receive 92 percent of the rate paid to a physician for THSteps services when a claim is submitted with their THSteps provider identifier as the billing provider.*

PAs who bill Medicaid directly for services they perform must use their individual provider identifier. If the services were performed by the PA but billed by a physician or physician group, the billing provider is the physician or physician group. Physicians may be reimbursed 92 percent of the established reimbursement rate for services provided by a PA if the physician does not make a decision regarding the client's care or treatment on the same date of service as the billable medical visit. This 92 percent reimbursement rate does not apply to laboratory services, X-ray services, or injections provided by a PA.

Providers can refer to the [online fee lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com. To request a hard copy, call the TMHP Contact Center at 1-800-925-9126.

Texas Medicaid implemented mandated rate reductions for certain services. The 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/resources/rate-and-code-updates.

Referto: Subsection 1.1, "Provider Enrollment" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on how to obtain electronic fee schedules from the TMHP website.

11 Claims Resources

| Resource | Location |
|--|--|
| Acronym Dictionary | "Appendix C: Acronym Dictionary" (<i>Vol. 1, General Information</i>) |
| 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>) |
| Family Planning Claim Form Examples | Section 10, "Claim Form Examples" in the <i>Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook</i> (<i>Vol. 2, Provider Handbooks</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>) |

| Resource | Location |
|--|---|
| UB-04 CMS-1450 Paper Claim Filing Instructions | Subsection 6.6, “UB-04 CMS-1450 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>) |

12 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.

13 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:

| Forms |
|---|
| Abortion Certification Statements Form |
| DME Certification and Receipt Form |
| Hospital Report (Newborn Child or Children) (Form 7484) |
| Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information |
| Medicaid Certificate of Medical Necessity for Reduction Mammoplasty |
| Non-emergency Ambulance Exception Form |
| Non-emergency Ambulance Prior Authorization Request |
| Obstetric Ultrasound Prior Authorization Request Instructions |
| Obstetric Ultrasound Prior Authorization Request |
| Special Medical Prior Authorization (SMPA) Request Form |
| Sterilization Consent Form Instructions |
| Sterilization Consent Form (English) |
| Sterilization Consent Form (Spanish) |
| THSteps Dental Mandatory Prior Authorization Request Form |
| Criteria for Dental Therapy Under General Anesthesia |

14 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 |
|---|
| Anesthesia |
| Certified Nurse-Midwife (CNM) |
| Certified Registered Nurse Anesthetist (CRNA) |
| Chiropractic Services |
| Dental (Doctor of Dentistry) |
| Dialysis Training |

| Claim Form Examples |
|-----------------------------------|
| Genetics |
| Radiation Therapy |
| Surgery |