HCPCS Special Bulletin

2017 Healthcare Common Procedure Coding System (HCPCS) Special Bulletin

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2017 HCPCS Implementation

On January 1, 2017, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2017 annual Healthcare Common Procedure Coding System (HCPCS) updates that are effective for dates of service on or after January 1, 2017.

This combined Special Bulletin includes the HCPCS updates for Texas Medicaid, the Children with Special Health Care Needs (CSHCN) Services Program, and the Healthy Texas Women (HTW) program. This bulletin is intended to notify providers of program and coding changes related to the 2017 updates for HCPCS and Current Procedural Terminology (CPT®).

The applicable policy benefit updates for specific programs and provider types are discussed in designated sections of this bulletin. ■

Rate Hearings and Expenditure Review

New and increased benefits that are adopted by Texas Medicaid must complete the rate hearing process to receive comments on new and increased Texas Medicaid reimbursement rates. The CSHCN Services Program reviews the adopted Texas Medicaid rates to determine whether the rates are fiscally feasible for the CSHCN Services Program.

All new, revised, and discontinued 2017 HCPCS procedure codes are effective for dates of service on or after January 1, 2017. The new procedure codes that are designated with asterisks (*) in the "Medicaid Allowable" and the "CSHCN Allowable" columns of the table located on page 34 of this bulletin must complete the rate hearing process, and expenditures must be approved before the rates are adopted by Texas Medicaid and the CSHCN Services Program. Providers will be notified in a future banner message or web article if a new procedure code will not be reimbursed because the expenditures were not approved.

Providers may refer to the following resources for more information about the public rate hearings and approval of expenditures:

- http://legacy-hhsc.hhsc.state.tx.us/rad/rate-packets.shtml
- www.sos.state.tx.us/texreg/index.shtml

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Claims Filing

The new 2017 HCPCS procedure codes may be billed beginning January 1, 2017, and must be submitted within the initial 95-day claims filing deadline. Services provided before the rate hearing is completed and expenditures are approved will be denied with an explanation of benefits (EOB) code 02008, "This procedure code has been approved as a benefit pending the approval of expenditures. Providers will be notified of the effective dates of service in a future notification if expenditures are approved."

Note: *In the rare instance that expenditures are not approved for a particular procedure code, that procedure code will not be made a benefit effective January 1, 2017.*

Once expenditures are approved, TMHP will automatically reprocess the affected claims. Providers are not required to appeal the claims unless they are denied for other reasons after the claims reprocessing is complete. When the affected claims are reprocessed, providers may receive additional payment, which will be reflected on Remittance and Status (R&S) Reports.

Note: *If claims are denied with an EOB code other than 02008, providers are responsible for resolving any issues on appeal to receive consideration of payment.*

If the effective date of service changes for one or more of the new procedure codes, providers will be notified in a future article. The client cannot be billed for these services.

Important: *To avoid fraudulent billing, providers must submit the procedure codes that are most appropriate for the services provided.* ■

Code Updates Web Page

Providers are encouraged to refer to the TMHP Code Updates – HCPCS web page at www.tmhp.com/Pages/CodeUpdates/HCPCS_2017.aspx for reimbursement rates, quarterly HCPCS updates, and all other notifications about HCPCS procedure codes. ■

PRIOR AUTHORIZATION CHANGES

Authorization or Prior Authorization

For procedure codes that require authorization or prior authorization but are awaiting a rate hearing and approval of expenditures, providers must follow the established authorization or prior authorization processes as defined in the following:

- Current *Texas Medicaid Provider Procedures Manual*
- Current *Children with Special Health Care Needs (CSHCN) Services Program Provider Manual*
- Articles published on the Texas Medicaid & Healthcare Partnership (TMHP) web page at www.tmhp.com

For services that require prior authorization or authorization, providers must obtain a timely authorization or prior authorization for the services that they provide. Services that are submitted without the proper authorization will be denied.

Important: *Authorization or prior authorization is a condition for reimbursement; it is not a guarantee of payment.*

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Prior Authorization for Discontinued Procedure Codes That Do Not Need to be Updated by the Provider

Providers who have received prior authorization for any of the following 2017 Healthcare Common Procedure Coding System (HCPCS) discontinued procedure codes for dates of service that occur on, after, or encompass January 1, 2017, do not have to update prior authorization requests that were approved on or before December 31, 2016. TMHP will automatically update affected prior authorization requests with the corresponding new procedure code that replaces the discontinued procedure code(s) as follows:

TOS	Discontinued Procedure Code	Direct Replacement Procedure Code
1/C	97002	97164
1/C	97004	97168
9	A4466	A4467
J/L	B9000	B9002
1	C9473	J2182
9/J	K0901	L1851
9/J	K0902	L1852
TOS = Type of service		

Important: *For STAR Kids clients, providers must contact the clients' STAR Kids Managed Care Organization (MCO) for direction concerning prior authorization requests.*

New authorization requests submitted on or after January 1, 2017, must be submitted with the new procedure codes as applicable.

To submit claims for the procedures indicated in the above table, providers must use the procedure code that was payable at the time the service was rendered, as follows:

- Claims submitted with dates of service *on or before December 31, 2016*, must be submitted with the *previous* procedure codes that were payable on or before December 31, 2016, as authorized.
- Claims submitted with dates of service *on or after January 1, 2017*, must be submitted with the *new* 2017 HCPCS procedure codes, as applicable. The previously-approved authorizations will be automatically updated to the corresponding new procedure codes.

Prior Authorization for Discontinued Procedure Codes that Require the Provider to Update the Request

Providers who have received prior authorization or authorization for any of the following 2017 HCPCS discontinued procedure codes for dates of service that occur on, after, or encompass January 1, 2017, must contact the TMHP Prior Authorization Department to update the procedure codes that are prior authorized for those services:

TOS	Discontinued Procedure Code	Prior Authorization Requirements
9	A9544	MD
9	A9545	MD
1	G3001	MD
J/L	E0628	MD, CSHCN
TOS = Type of service, CSHCN = Prior authorization required for the CSHCN Services Program, MD = Prior authorization required for Texas Medicaid.		

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As a reminder, for procedure codes that require prior authorization or authorization but are awaiting a rate hearing, providers must follow the established prior authorization process as defined in the applicable provider manual. Providers must obtain a timely prior authorization for services provided. *Providers must not wait until the rate hearing process is complete to request authorization or prior authorization. In this situation, retroactive prior authorization requests are not granted; the requests are denied as late submissions.* Providers are also responsible for meeting the initial 95-day claims filing deadline and for ensuring that the authorization or prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement.

Refer to: The *Texas Medicaid Provider Procedures Manual*, subsection 5.11, "Guidelines for Procedures Awaiting Rate Hearing," for information about HCPCS prior authorizations.

The "TMHP Telephone and Fax Communication" section in the current *Texas Medicaid Provider Procedures Manual, Appendix A: State, Federal, and TMHP Contact Information*, and "TMHP-CSHCN Services Program Contact Information" in the current *CSHCN Services Program Provider Manual*, on page 1-2, for a list of Prior Authorization Department telephone numbers. ■

MEDICAID FEE-FOR-SERVICE AND MANAGED CARE PROVIDERS

Texas Medicaid HCPCS Updates

The 2017 Healthcare Common Procedure Coding System (HCPCS) updates including authorization or prior authorization updates for Texas Medicaid are included in the HCPCS tables in the "All Code Changes: Added, Revised, Replacement, and Discontinued" section of this bulletin beginning on page 34. The 2017 HCPCS deletions and replacements are effective January 1, 2017, for dates of service on or after January 1, 2017, for Texas Medicaid.

Refer to: The "General Information" section starting on page 1 in this bulletin for more information.

Authorization and Prior Authorization Update Reminder

Effective January 1, 2017, the 2017 HCPCS discontinued procedure codes are no longer reimbursed by Texas Medicaid. Unless otherwise indicated on page 4 of this bulletin, providers who have received authorization or prior authorization for dates of service that occur on, after, or encompass January 1, 2017, must submit a written request on the appropriate, completed Texas Medicaid prior authorization request form to update the HCPCS procedure codes authorized for those services.

Refer to: The "Prior Authorization Changes," section in this bulletin for information about obtaining authorization or prior authorization.

Texas Medicaid Benefit Changes

The following Texas Medicaid benefit changes have been made to support the 2017 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2017. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Note: *These changes apply to Texas Medicaid fee-for-service and Medicaid managed care claims and authorization requests that are submitted to TMHP for processing.*

The policy articles in this bulletin contain the following information:

- ***Revised:*** The description has been revised for these procedure codes. Providers may refer to the appropriate copyright holder for the revised descriptions.

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- ***Discontinued:*** Discontinued procedure codes are no longer reimbursed after December 31, 2016.
- ***Added:*** Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS).
- ***Limitations:*** Additional benefit and limitation information for the added procedure codes.

Blood Factor Products

Added Procedure Codes					
C9140	J7175	J7179	J7202	J7207	J7209

Limitations for added procedure codes: Procedure codes C9140, J7175, J7179, J7202, J7207, and J7209 may be reimbursed as follows:

- To physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), and physician providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Procedure codes C9140, J7175, J7179, J7202, J7207, and J7209 must be submitted with a valid, rebatable National Drug Code (NDC).

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians and Physician Assistants Handbook,* subsection 9.2.39.14, “Blood Factor Products,” for additional information.

Diagnostic Doppler Sonography

Discontinued Procedure Code
93965

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.27, “Diagnostic Doppler Sonography,” for additional information.

Diagnostic Endoscopies

Added Procedure Codes							
31551	31552	31553	31554	31572	31573	31574	31591

Limitations for added procedure codes: Procedure codes 31551 and 31553 may be reimbursed for services rendered to clients who are 11 years of age and younger as follows:

- To physician providers in the inpatient and outpatient hospital settings.
- To freestanding and hospital-based ambulatory surgical centers in the outpatient setting.

Procedure codes 31552 and 31554 may be reimbursed for services rendered to clients who are 12 years of age and older as follows:

- To physician providers in the inpatient and outpatient hospital settings.
- To freestanding and hospital-based ambulatory surgical centers in the outpatient setting.

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Procedure codes 31572, 31573, and 31574 may be reimbursed with prior authorization for services rendered to clients of all ages as follows:

- To NP, CNS, PA, and physician providers in the office, inpatient hospital, and outpatient hospital settings.
- To freestanding and hospital-based ambulatory surgical centers in the outpatient setting.

Procedure codes 31591 may be reimbursed for services rendered to clients of all ages as follows:

- To physician providers in the inpatient and outpatient hospital settings.
- To freestanding and hospital-based ambulatory surgical centers in the outpatient setting.

Genetic Testing for Colorectal Cancer

Added Procedure Code
81327

Limitations for added procedure code: Procedure code 81327 may be reimbursed to independent laboratory providers in the laboratory setting.

Procedure code 81327 may be reimbursed when submitted with the most appropriate, valid diagnosis code.

Note: *Diagnosis code Z800 is not a valid diagnosis code for other Medicaid services but may be submitted with genetic testing for colorectal cancer procedure codes.*

Prior authorization is required. Procedure code 81327 is limited to once per lifetime; additional services will not be authorized.

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* subsection 9.2.15.3, "Genetic Testing for Colorectal Cancer," for additional information.

Gynecological and Reproductive Health Services

Added Procedure Codes
58674

Limitations for added procedure code: Procedure code 58674 may be reimbursed for services rendered to female clients as follows:

- The surgical component may be reimbursed to NP, CNS, PA, and physician providers for services rendered in the outpatient and inpatient hospital settings.
- The assistant surgery component may be reimbursed to NP, CSN, PA, and physician providers for services rendered in the inpatient and outpatient hospital settings.
- To ambulatory surgical center (freestanding and hospital-based) providers for services rendered in the outpatient setting.

Refer to: The *Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook,* subsection 5.3, "Laparoscopic Procedures," and *Inpatient and Outpatient Hospital Services Handbook*, subsection 5.2.14 "Gynecological and Reproductive Health and Family Planning Services," for additional information.

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Injections and Injection Administration

Added Procedure Code
96377

Limitations for added procedure code: Procedure code 96377 may be reimbursed as follows:

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

Procedure code 96377 must be billed with procedure code J2505 on the same day by the same provider.

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians and Physician Assistants Handbook*, subsection 9.2.18, "Casting, Splinting, and Strapping," subsection 9.2.36.2, "Vaccine and Toxoid Procedure Codes," subsection 9.2.37, "Immunizations for Clients Who Are 21 Years of Age and Older," subsection 9.2.49, "Osteopathic Manipulative Treatment (OMT)," and subsection 9.3.2.1, "Additional Payable Procedure Codes," for additional information.

The *Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook*, subsection 2.2.6, "Drugs and Supplies," and subsection 2.2.6.4, "Injection Administration," for additional information.

The *Texas Medicaid Provider Procedures Manual, Women's Health Services Handbook*, section 3.3, "Services, Benefits, Limitations, and Prior Authorization," for additional information.

Monoclonal Antibodies – Asthma & Chronic Idiopathic Urticaria

Added Procedure Codes	
J2182	J2786
Discontinued Procedure Codes	
C9473	C9481*

* Discontinued procedure code C9481 was created by CMS for the third quarter 2016 HCPCS update but was not made a benefit of Texas Medicaid. Procedure code J2786 replaces discontinued procedure code C9481, and will be made a benefit. Providers can refer to the *Texas Medicaid Provider Procedures Manual* for information about mepolizumab; the same information will apply for procedure code J2786 as currently applies to procedure code C9481.

Limitations for added procedure code: Procedure code J2182 for mepolizumab replaces discontinued procedure code C9473. Procedure code J2786 for reslizumab replaces discontinued code C9481. Procedure codes J2182 and J2786 may be reimbursed as follows:

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

Procedure codes J2182 and J2786 require prior authorization, and must be submitted with a valid, rebatable NDC.

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.39.30, "Monoclonal Antibodies—Asthma and Chronic Idiopathic Urticaria," for benefit and limitation requirements for mepolizumab.

Reslizumab is an injectable drug that is Food and Drug Administration (FDA)-approved and indicated for the treatment of clients who are 18 years of age and older and have severe asthma (as defined by the National Heart, Lung, and Blood Institute's Guidelines for the Diagnosis and management of Asthma) with an eosinophilic phenotype and requires prior authorization.

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Documentation supporting medical necessity for treatment of asthma with reslizumab must be submitted with the request.

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.39.30.5, "Prior Authorization Criteria for Asthma: Moderate to Severe (Omalizumab) and Severe (Mepolizumab)," for prior authorization requirements that apply for Mepolizumab and Reslizumab related to severe asthma.

Additional Requirements for Reslizumab

The following additional documentation must be submitted with the request for prior authorization for treatment with reslizumab:

- Has an eosinophilic phenotype as determined by blood eosinophils of 400 cells/microliter or higher prior to initiation of therapy (within 3-4 weeks of dosing). **Note:** *1 microliter (ul) is equal to 1 cubic millimeter (mm3).*
- Prior authorization for an initial request for reslizumab will be considered when the client has had an inadequate response after being compliant for six months of treatment with omalizumab and meets the criteria for reslizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

  Note: *Exceptions may be considered for clients who meet the requirements for treatment with reslizumab but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range and/or negative skin test/Radioallergosorbent Test [RAST] to a perennial aeroallergen) must be submitted along with the documentation for treatment with reslizumab as described above.*

- When requesting prior authorization, the exact dosage must be included with the request.

Continuation of Therapy Requirements for Reilzumab

For continuation of therapy with reslizumab after six continuous months, the requesting provider must submit documentation of the client's compliance and satisfactory clinical response to reslizumab to qualify for additional authorizations.

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.39.30.6, "Requirements for Continuation of Therapy," for the applicable requirements.

Limitations

Procedure codes J2182, J2357, and J2786 may not be billed in any combination for the same date of service by any provider.

Reslizumab may not be used concurrently with omalizumab or any other interleukin-5 antagonist. Providers may not bill for an office visit if the only reason for the visit is a reslizumab injection.

Providers may not bill for an office visit if the only reason for the visit is an omalizumab, mepolizumab, or reslizumab injection.

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.39.30, "Monoclonal Antibodies—Asthma and Chronic Idiopathic Urticaria," for additional information.

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Outpatient Mental Health Services

Added Modifier
95
Modifier No Longer Used for Telemedicine and Telehealth Services
GT

Certain outpatient mental health services may be provided by distant site providers through telemedicine or telehealth when billed with modifier 95.

Refer to: The "Telemedicine and Telehealth Services" section on page 12 of this bulletin for more information about modifier 95 and telemedicine and telehealth services.

The article titled "Outpatient Mental Health Services to Change for Texas Medicaid," which was posted on this website November 2, 2016, for more information about the January 1, 2017, benefit changes for outpatient mental health services.

The article titled "New Prior Authorization Form for Outpatient Mental Health Services to be Effective January 1, 2017," which was posted on this website November 2, 2016, for more information about the updated prior authorization form.

Pathology and Laboratory Services – Drug Testing and Therapeutic Drug Assays

Added Procedure Codes							
80305	80306	80307	G0659				
Discontinued Procedure Code							
80300	80301	80302	80303	80304	G0477	G0478	G0479

Limitations for added procedure code: Procedure codes 80305, 80306, and 80307 may be reimbursed as follows:

- To certified nurse midwife (CNM), licensed midwife, and physician providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.
- To independent laboratory providers for services rendered in the laboratory setting.

Procedure code G0659 may be reimbursed as follows:

- To physician providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.
- To independent laboratory providers for services rendered in the laboratory setting, and is limited to one per day, any provider.

The following drug assay procedure codes will be denied when billed on the same date of service, by the same provider as procedure code G0659:

Procedure Codes									
80305	80306	80307	80320	80323	80326	80329	80332	80337	80338
80339	80342	80345	80358	80363	80365	80368	80369	80370	80375
80377									

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Refer to: The *Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook,* section 2.2.8, "Drug Testing and Therapeutic Drug Assays," for additional information.

Pathology and Laboratory Services - Microbiology

Added Procedure Codes
G0499

Limitations for added procedure code: Procedure code G0499 may be reimbursed as follows:

- To PA, NP, CNS, family planning, and physician providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.
- To independent laboratory providers for services rendered in the laboratory setting.

Refer to: The *Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook,* section 2.2.13, "Microbiology," for additional information.

Screening and Diagnostic Studies of the Breast

Added Procedure Codes				
77065	77066	77067		
Discontinued Procedure Codes				
77051	77052	77055	77056	77057

Limitations for added procedure code: Procedure codes 77065, 77066, and 77067 may be reimbursed as follows:

- The total radiology component may be reimbursed to PA, NP, CNS, physician, family planning clinic, and portable X-ray, radiological lab, and physiological lab providers for services rendered in the office setting; and to hospital and family planning clinic providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to PA, NP, CNS, physician, and family planning clinic providers for services rendered in the office setting; to physician providers for services rendered in the inpatient hospital setting; and to physician and family planning clinic providers for services rendered in the outpatient hospital settings.
- The technical component may be reimbursed to NP, PA, CNS, physician, family planning clinic, and portable X-ray, radiological lab, and physiological lab providers for services rendered in the office setting.

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. Additional studies are studies done in addition to screening mammograms and include diagnostic mammograms using procedure codes 77067, G0204, and G0206. Screening procedure code 77067 and diagnostic procedure codes 77065 and 77066 may include computer-aided detection (CAD).

The following procedure codes in Column A will be denied if they are billed with the same date of service as the corresponding procedure codes in Column B:

Column A (Denied if Billed with Procedure Codes in Column B)	Column B
77067	G0202

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Column A (Denied if Billed with Procedure Codes in Column B)	Column B
77065	77066, G0204, or G0206
77066	G0204
G0206	77065 or G0204

Reimbursement may be considered for a screening mammogram (procedure code 77067 or G0202) performed on the same patient on the same day as a diagnostic mammogram (procedure code 77065, 77066, G0204, or G0206), by submitting the diagnostic mammography code 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, G0204, and G0206 may be considered for reimbursement.

Refer to: *The Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physicians Assistants Handbook,* subsection 9.2.15.4, "Mammography (Screening and Diagnostic Studies of the Breast," and *Women's Health Services Handbook* subsection 3.3, "Services, Benefits, Limitations, and Prior Authorization," for additional information.

Telemedicine and Telehealth Services

Added Modifier
95
Modifier No Longer Used for Telemedicine and Telehealth Services
GT

Modifier 95 must be appended to the following procedure codes for distant site providers:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90838	90951	90952
90954	90955	90957	90958	90960	90961	97802	97803	97804	99201
99202	99203	99204	99205	99211	99212	99213	99214	99215	99241
99242	99243	99244	99245	99251	99252	99253	99254	99255	G0406
G0407	G0408	G0425	G0426	G0427	G0459	S9470			

Modifier GT will no longer be used for telemedicine and telehealth services.

Refer to: The *Texas Medicaid Provider Procedures Manual,* Telecommunication Services Handbook, subsection 3.1.1, "Distant Site," and subsection 3.2.1, "Distant Site," for additional information.

Therapeutic Radiopharmaceuticals

Discontinued Procedure Code
A9545

Refer to: The *Texas Medicaid Provider Procedures Manual, Inpatient and Outpatient Hospital Services Handbook,* subsection 4.2.19.1, "Radiopharmaceuticals," for additional information.

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Vaccines and Toxoids

Added Procedure Codes							
90674							
Revised Procedure Codes							
90655	90656	90657	90658	90685	90686	90687	90688

Limitations for added procedure code: Procedure code 96074 may be reimbursed for services rendered to clients of any age when accompanied by the appropriate vaccine administration code as follows:

- To PA, NP, CNS, pharmacist, physician, CNM, licensed midwife, and comprehensive care program (CCP) providers for services rendered in the office setting.
- To PA, NP, CNS, physician, and CCP providers for services rendered in the home setting and the “other location” setting.
- To hospital providers for services rendered in the outpatient hospital setting.

For clients who are birth through 20 years of age, procedure code 90674 may be reimbursed to federally qualified health center (FQHC) and Texas Health Steps (THSteps) providers for THSteps services rendered in the office, home, outpatient, and “other location” settings.

Procedure code 90674 is not available through the Texas Vaccines for Children (TVFC) program at this time. For clients who are birth through 18 years of age, procedure code 90674 must be submitted with modifier U1 and the appropriate vaccine administration procedure code to be considered for reimbursement.

The descriptions of the following procedure codes have been revised, but the current age restrictions continue to apply:

Procedure code	Age restriction:
90655	6 through 35 months of age
90656	3 years of age and older.
90657	6 through 35 months of age
90658	3 years of age and older.
90685	6 through 35 months of age
90686	3 years of age and older.
90687	6 through 35 months of age
90688	3 years of age and older.

Refer to: The *Texas Medicaid Provider Procedures Manual, Children’s Services Handbook,* subsection 5.3.11.3, “Immunizations,” and subsection B.3.2.2 “Immunizations (Vaccine/Toxoids),”and the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.35.1, “Administration Fee,” subsection 9.2.36.2, “Vaccine and Toxoid Procedure Codes,” and subsection 9.2.37, “Immunizations for Clients Who Are 21 Years of Age or Older,” for additional information.

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Vision Services - Nonsurgical

Added Procedure Code
92242

Limitations for added procedure code: Procedure code 92242 may be reimbursed as follows:

- The medical component may be reimbursed to PA, NP, CNS, physician, optometrist, and FQHC providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.
- The professional interpretation component may be reimbursed to PA, NP, CNS, physician, and optometrist providers for services rendered in the inpatient and outpatient hospital settings.
- The technical component may be reimbursed to PA, NP, CNS, physician, and optometrist providers for services rendered in the office setting.

Procedure code 92242 may be reimbursed for a quantity of two if both the left and right eyes are evaluated. Modifiers LT and RT must be included on the claim to identify the eye on which the service was performed.

Procedure code 92242 will be limited to one service per eye, per day and two services per eye, per calendar year any provider.

Refer to: The *Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook,* subsection 4.3.5.10, “Ophthalmoscopy and Extended Ophthalmoscopy,” for additional information.

Wound Care Management Services

Discontinued Procedure Code
Q4129

Refer to: The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.77.1.4, “Dressings and Metabolically Active Skin Equivalents,” for additional information. ■

Ambulatory Surgical Center/Hospital Ambulatory Surgical Center (ASC/HASC) Code Additions

Additions for ambulatory surgical center/hospital ambulatory surgical center (ASC/HASC) facilities are listed in the “All Code Changes: Added, Revised, Replacement, and Discontinued” section located on page 58 of this bulletin.

For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126. ■

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TEXAS MEDICAID PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

Texas Medicaid Physical and Occupational Therapy for Clients of Any Age

The new 2017 Healthcare Common Procedure Coding System (HCPCS) physical therapy (PT) evaluation procedure codes 97161, 97162, and 97163 will replace discontinued procedure code 97001. Occupational therapy (OT) evaluation procedure codes 97165, 97166, and 97167 will replace discontinued procedure code 97003.

The three replacement evaluation codes for each discipline's previous single evaluation code reflect the complexity level of the evaluation performed. Providers may only choose one of the three codes.

Documentation of the therapist's evaluation must be kept in the client's record and must:

- Include a signed and dated physician's order for the evaluation.
- Support a medical need for the therapy evaluation.
- Be available when requested.

Refer to: The Centers for Medicare & Medicaid Services (CMS) HCPCS-General Information web page or American Medical Association (AMA) Coding and Billing web page for additional information about procedure coding and descriptions. Additional information can also be found at the CMS Therapy Services web page and the CMS web page for the 2017 Annual Update to the Therapy Code List.

The therapist performing the evaluation, using professional clinical judgement, decides which evaluation procedure code to use. The selection must be based on professional clinical judgement and may not be made by staff other than the rendering therapist.

Physical Therapy Evaluations

PT evaluation procedure code 97001 has been discontinued and replaced as follows:

Service	Old Procedure Code	New Procedure Code(s)
PT Evaluation	97001	97161, 97162, 97163

There will be no change in the providers who can perform and receive reimbursement for a PT evaluation.

Procedure codes 97161, 97162, and 97163 may each be reimbursed once every three years.

A PT evaluation will not be reimbursed when billed with the same date of service as the PT service. Therapy evaluation procedure codes 97161, 97162, and 97163 will be denied if billed with the same date of service as the following PT service procedure codes:

Procedure Code – Modifier							
97012-GP	97014-GP	97016-GP	97018-GP	97022-GP	97024-GP	97026-GP	97028-GP
97032-GP	97033-GP	97034-GP	97035-GP	97036-GP	97039-GP	97110-GP	97112-GP
97113-GP	97116-GP	97124-GP	97139-GP	97140-GP	97150-GP	97530-GP	97535-GP
97537-GP	97542-GP	97750-GP	97755-GP	97760-GP	97761-GP	97762-GP	97799-GP
S8990-GP							

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Occupational Therapy Evaluations

OT evaluation procedure code 97003 has been discontinued and replaced as follows:

Service	Old Procedure Code	New Procedure Code(s)
OT Evaluation	97003	97165, 97166, 97167

There will be no change in the providers who can perform and receive reimbursement for an OT evaluation.

Procedure codes 97165, 97166, and 97167 may each be reimbursed once every three years.

An OT evaluation will not be reimbursed when billed with the same date of service as the OT service. Therapy evaluation procedure codes 97165, 97166, and 97167 will be denied if billed with the same date of service as the following OT service procedure codes:

Procedure Code – Modifier							
97012-GO	97014-GO	97016-GO	97018-GO	97022-GO	97024-GO	97026-GO	97028-GO
97032-GO	97033-GO	97034-GO	97035-GO	97036-GO	97039-GO	97110-GO	97112-GO
97113-GO	97116-GO	97124-GO	97139-GO	97140-GO	97150-GO	97530-GO	97535-GO
97537-GO	97542-GO	97750-GO	97755-GO	97760-GO	97761-GO	97762-GO	97799-GO
S8990-GO							

Therapy Re-evaluations Authorization Requirements

The following therapy re-evaluation procedure codes replace discontinued procedure codes 97002 and 97004

Service	Discontinued Procedure Code(s)	New Procedure Code(s)	Authorization Requirements
OT Re-evaluation	97004	97168	Re-evaluation procedure codes require authorization and must be submitted with the recertification request or when discharging a client.
PT Re-evaluation	97002	97164	Re-evaluation procedure codes require authorization and must be submitted with the recertification request or when discharging a client.

Providers must bill claims as follows:

- Claims submitted with dates of service on or before December 31, 2016, must be submitted with procedure codes 97002 and 97004.
- Claims submitted with dates of service on or after January 1, 2017, must be submitted with new 2017 HCPCS procedure codes 97164 and 97168, as applicable. Any previously-approved authorizations will be automatically updated to the corresponding new procedure codes.

Providers are not required to update authorization requests that include procedure code 97002 or 97004 and were approved on or before December 31, 2016. TMHP will automatically update the impacted prior authorization requests.

Note: *Authorization requests submitted on or after January 1, 2017, must be submitted with the new procedure codes as applicable.*

Refer to: The *Texas Medicaid Provider Procedures Manual,* Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook, for more information about OT and PT services.

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EARLY CHILDHOOD INTERVENTION (ECI) PHYSICAL AND OCCUPATIONAL THERAPY SERVICES

ECI Physical Therapy (PT) and Occupational Therapy (OT) Evaluations and Re-evaluations

Physical therapy (PT) evaluation procedure code 97001 and re-evaluation procedure code 97002, and occupational therapy (OT) evaluation procedure code 97003 and reevaluation code 97004 are being discontinued by the 2017 HCPCS code updates. The three replacement evaluation procedure codes for each discipline's previous single evaluation procedure code reflect the complexity level of the evaluation performed. Providers may only choose one of the three codes.

Refer to: The Centers for Medicare & Medicaid Services (CMS) HCPCS-General Information web page or American Medical Association (AMA) Coding and Billing web page for additional information about procedure coding and descriptions. Additional information can also be found at the CMS Therapy Services web page and the CMS web page for the 2017 Annual Update to the Therapy Code List.

The therapist performing the evaluation, using professional clinical judgement, decides which evaluation procedure code to use. The selection must be based on professional clinical judgement and may not be made by staff other than the rendering therapist.

The following ECI therapy evaluation and re-evaluation procedure codes replace discontinued procedure codes 97001, 97002, 97003, and 97004 for services rendered in the home, office, or other community settings:

Service	Discontinued Procedure Code	New Procedure Code(s)
OT Evaluation	97003	97165, 97166, 97167
OT Re-evaluation	97004	97168
PT Evaluation	97001	97161, 97162, 97163
PT Re-evaluation	97002	97164

There will be no change in the places of service and no change in the providers who can perform and receive reimbursement for a PT or OT evaluation or re-evaluation.

As a reminder, ECI contractors must submit claims for PT and OT services using the ECI contractor's Texas Provider Identifier (TPI) and National Provider Identifier (NPI) and the ECI benefit code.

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook,* Section 6: Claims Filing subsection 6.3.6, for additional information about filing claims.

The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook*, subsection 2.7.2.1, "Therapy," for additional information about ECI therapy services. ■

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SCHOOL HEALTH AND RELATED SERVICES (SHARS) THERAPY SERVICES

SHARS Therapy Evaluation and Re-evaluation Benefit Changes

Physical therapy (PT) evaluation procedure code 97001, and occupational therapy (OT) evaluation procedure code 97003, are being discontinued by the 2017 HCPCS code updates. The following procedure code changes are occurring for physical and occupational evaluations:

Service	Discontinued Procedure Code	Replacement Procedure Codes
PT evaluation by a licensed physical therapist	97001	97161, 97162, 97163
OT evaluation by a licensed occupational therapist	97003	97165, 97166, 97167

Refer to: The Centers for Medicare & Medicaid Services (CMS) HCPCS General Information web page or American Medical Association (AMA) Coding and Billing web page for additional information about procedure coding and descriptions. Additional information can also be found at the CMS Therapy Services web page and the CMS web page for the 2017 Annual Update to the Therapy Code List. The therapist performing the evaluation, using professional clinical judgement, decides which evaluation code to use. The selection must be based on professional clinical judgement and may not be made by staff other than the rendering therapist.

SHARS providers billing for physical and occupational evaluations, must document the billable start and stop time, total billable minutes, and must note the activity that was performed (e.g., PT evaluation or OT evaluation).

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook*, subsection 3.3.7.2, "Description of Services," and subsection 3.3.5.2, "Description of Services," for additional information about SHARS PT and OT services. ■

HOME HEALTH AND COMPREHENSIVE CARE PROGRAM (CCP) PROVIDERS

Home Health and CCP Services Benefit Changes

The following Texas Medicaid Home Health Services benefit changes have been made to support the 2017 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2017. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Diabetic Equipment and Supplies – Home Health

Added Procedure Codes	
A4224	A4225

Limitations for added procedure code: Procedure codes A4224 and A4225 may be reimbursed as follows:

- Procedure code A4224 may be reimbursed for 4 per month to home health durable medical equipment (DME) and DME medical supplier providers for services rendered in the home setting.
- Procedure code A4225 may be reimbursed for 15 per month to home health DME and DME medical supplier providers for services rendered in the home setting.

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Refer to: The *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*, subsection 2.2.11, "Diabetic Equipment and Supplies," for additional information.

Mobility Aids – Home Health and CCP

Added Procedure Codes		
E0627		
Discontinued Procedure Codes		
97001	97003	E0628

Limitations for added procedure code: Seat lift mechanisms can be billed using new procedure code E0627 or currently payable procedure code E0629 as a replacement for discontinued procedure code E0628.

Procedure code E0627 may be reimbursed once every 5 years with prior authorization to home health DME and DME medical supplier providers for services rendered in the home setting.

Refer to: The *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*, subsection 2.2.15, "Mobility Aids," for additional information.

Mobility Aids Seating Assessments

Procedure codes 97001 and 97003 will be discontinued by the 2017 HCPCS code updates. Procedure codes 97001 and 97003 with modifier U1 will no longer be billed for reimbursement of the home health DME power wheelchair seating assessment when billed by the occupational therapist or physical therapist.

When an occupational therapist or physical therapist completes the Wheelchair/Scooter/Stroller Seating Assessment Form (CCP/Home Health Services), the therapist may bill for reimbursement for a seating assessment.

Procedure code 97542 may be reimbursed for a seating assessment performed by the occupational therapist or physical therapist when billed with the modifiers as follows:

Practitioner	Procedure Code	Modifiers
Occupational therapist	97542	GO and UC
Physical therapist	97542	GP and UC

Note: *Claims filing is only changing for procedure code 97542 when billed for wheeled mobility seating assessment services. All other services billed with 97542 will remain the same including billing for a seating assessment performed by a Qualified Rehabilitation Professional (QRP) and billing for wheeled mobility management performed by an OT or PT.*

Required Updates for the TMHP Claims Processing System and Claims Reprocessing for Seating Assessments:

Seating assessments do not require prior authorization; however, the current Texas Medicaid claims processing system requires prior authorization for procedure code 97542. TMHP is in the process of updating the claims processing system to accommodate the use of procedure code 97542 with modifier GP or GO and modifier UC without prior authorization.

Seating assessment claims billed with procedure code 97542 and modifiers GP and UC, or GO and UC, and dates of service on or after January 1, 2017, will initially be denied until the system has been updated. Providers must submit claims and not hold them until the system is updated to meet all timely filing deadlines. Providers are encouraged not to appeal the denied claims because TMHP will automatically reprocess impacted claims once the system has been updated.

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Note: *These system changes and automatic claims reprocessing are only related to seating assessments, and are not related to any other PT, OT, or speech therapy service.*

Refer to: The *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook*, subsection 2.2.15.10, "Seating Assessment for Manual and Power Custom Wheelchairs," and subsection 2.2.15.26, "Procedure Codes and Limitations for Mobility Aids."

The *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Children's Services Handbook*, subsection 2.6.10, "Mobility Aids," will be updated with the seating assessment changes for the February 2017 release which will be posted to this website February 15, 2017, for additional information.

Nutritional (Enteral) Products, Supplies, and Equipment – Home Health and CCP

Discontinued Procedure Code
B9000

Procedure code B9002 can be submitted in place of discontinued procedure code B9000. Procedure code B9002 may be reimbursed for a purchase once every 5 years and for a rental once a month.

Refer to: The *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook,* subsection 2.2.16.1, "Enteral Nutritional Products, Feeding Pumps, and Feeding Supplies," for additional information.

Orthoses - CCP

Added Procedure Codes	
L1851	L1852
Discontinued Procedure Codes	
K0901	K0902

Limitations for added procedure codes: Procedure codes L1851 and L1852 may be reimbursed with prior authorization for services rendered to clients who are 20 years of age and younger as follows:

- To orthotist and medical supplier DME providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Prior authorization is required for procedure codes L1851 and L1852. Procedure codes L1851 and L1852 replace discontinued procedure codes K0901 and K0902.

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook,* section 2.10," Orthotic and Prosthetic Services (CCP)," for additional information. ■

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THSTEPS DENTAL PROVIDERS

THSteps Dental Benefit Changes

The following Texas Health Steps (THSteps) dental services benefit changes have been made to support the 2017 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2017. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Texas Health Steps (THSteps) Diagnostic Dental Services

Discontinued Procedure Code
D0290

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook,* subsection 4.2.13, "Diagnostic Services," for additional information.

Texas Health Steps (THSteps) Dental Preventive Services

Added Procedure Code
D1575

Limitations for added procedure code: Procedure code D1575 may be reimbursed as follows for clients who are 3 through 7 years of age:

- To Federally Qualified Health Center (FQHC), THSteps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office and outpatient hospital settings.
- To THSteps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the inpatient hospital setting.

Space maintainers submitted with procedure code D1575 are limited to one per tooth ID, per client after premature loss of a deciduous/primary second molar (tooth identification [TID]: A, J, K, and T) for clients who are 3 through 7 years of age.

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook*, subsection 4.2.14, "Preventive Services," for additional information. ■

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THSTEPS MEDICAL PROVIDERS

THSteps Medical Services Benefit Changes

The following Texas Health Steps (THSteps) medical services benefit changes have been made to support the 2017 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2017. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Texas Health Steps Preventative Care Medical Checkups

Added Procedure Codes	
96160	96161
Discontinued Procedure Codes	
99420	

Limitations for added procedure code: Discontinued procedure code 99420 has been replaced by added procedure codes 96160 and 96161. Procedure codes 96160 and 96161 may be reimbursed as follows:

- For services rendered to clients who are 12 through 18 years of age.
- To Federally Qualified Health Center (FQHC) and THSteps providers for THSteps services rendered in the office setting.

Mental health screening for behavioral, social, and emotional development is required at each THSteps checkup. Mental health screening using one of the validated, standardized mental health screening tools recognized by THSteps is required once for all clients who are 12 through 18 years of age.

A mental health screening must be submitted with procedure code 96160 for a screening tool completed by the adolescent, or procedure code 96161 for a screening tool completed by the parent or caregiver on behalf of the adolescent. When claims with procedure code 96160 or 96161 are submitted for mental health screenings, one of the validated, standardized mental health screening tools recognized by THSteps must be used.

Only one procedure code (96160 or 96161) may be reimbursed for the mental health screening per client per lifetime based on the description of the procedure code and the service rendered. Procedure codes 96160 and 96161 will not be reimbursed for the same client for any date of service. Procedure code 96160 or 96161 must be submitted with the same date of service by the same provider as procedure code 99384, 99385, 99394, or 99395.

The client's medical record must include documentation identifying the tool that was used, the screening results, and any referrals that are made.

Refer to: The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook*, subsection 5.3.11.1, "Comprehensive Health and Developmental History," and subsection 5.3.11.1.3, "Mental Health Screening."

Clinics and Other Outpatient Facilities Services Handbook, subsection 4.2, "Services, Benefits, Limitations, and Prior Authorization," for additional information. ■

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STATE FUNDED FAMILY PLANNING PROGRAM (FPP) PROVIDERS

Family Planning Program Services Benefit Changes

The 2017 Healthcare Common Procedure Coding System (HCPCS) updates including added procedure codes for the Family Planning Program (FPP) are included in the HCPCS tables in the “All Code Changes: Added, Revised, Replacement, and Discontinued” section of this bulletin beginning on page 34. ■

HEALTHY TEXAS WOMEN (HTW) PROGRAM PROVIDERS

HTW Program Benefit Changes

The 2017 Healthcare Common Procedure Coding System (HCPCS) updates including added procedure codes for the HTW program. Updates for HTW are included in the HCPCS tables in the “All Code Changes: Added, Revised, Replacement, and Discontinued” section of this bulletin beginning on page 34.

Healthy Texas Women

Added Procedure Codes						
77065	77066	77067				
Discontinued Procedure Codes						
77051	77052	77055	77056	77057	80300	80301

Limitations for added procedure code: Procedure code 77065, 77066, and 77067 may be reimbursed as follows:

- The total component may be reimbursed to physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), physician, family planning clinic, and portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting; and to hospital and family planning clinic providers for services rendered in the outpatient hospital setting.
- The professional interpretation component may be reimbursed to NP, CNS, PA, physician, and family planning clinic providers for services rendered in the office setting; and to physician and family planning clinic providers for services rendered in the outpatient hospital setting.
- The technical component may be reimbursed to NP, CNS, PA, physician, family planning clinic, and portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.

Refer to: The *Texas Medicaid Provider Procedures Manual, Women’s Health Services Handbook,* subsection 3.3, “Services, Benefits, Limitations, and Prior Authorization,” for additional information. ■

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CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM PROVIDERS

CSHCN Services Program Updates

The 2017 Healthcare Common Procedure Coding System (HCPCS) updates including authorization and prior authorization updates for the CSHCN Services Program are included in the HCPCS tables in the "All Code Changes: Added, Revised, Replacement, and Discontinued" section of this bulletin beginning on page 34. The 2017 HCPCS deletions and replacements are effective January 1, 2017, for dates of service on or after January 1, 2017, for the CSHCN Services Program. Providers may refer to the "General Information" section for more information.

Important: *New and increased benefits that are adopted by Texas Medicaid must complete the rate hearing process to receive comments on new and increased Texas Medicaid reimbursement rates. The CSHCN Services Program reviews the adopted Texas Medicaid rates to determine whether the rates are fiscally feasible for the CSHCN Services Program. The new procedure codes that are designated with asterisks (*) in the "CSHCN Allowable" columns of the table located on page 34 of this bulletin must complete the rate hearing process, and expenditures must be approved by the CSHCN Services Program before the rates are adopted. Providers will be notified in a future banner message or web article if a new procedure code will not be reimbursed because the expenditures were not approved.*

Authorization and Prior Authorization Update Reminder

Effective January 1, 2017, the 2017 HCPCS discontinued procedure codes are no longer reimbursed by the CSHCN Services Program. Unless otherwise indicated on page 3 of this bulletin, providers who have received authorizations or prior authorizations for dates of service that occur on, after, or encompass January 1, 2017, must submit a written request on the appropriate, completed CSHCN Services Program authorization or prior authorization request form to update the HCPCS procedure codes authorized for those services.

Refer to: The "Prior Authorization Changes," section in this bulletin, for information about obtaining authorization or prior authorization.

For more information, call the Texas Medicaid & Healthcare Partnership (TMHP)-CSHCN Services Program Contact Center 1-800-568-2413. ■

CSHCN Services Program Benefit Changes

The following CSHCN Services Program benefit changes have been made to support the 2017 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2017. For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-925-9126.

The policy articles below contain the following information:

- ***Revised:*** The description has been revised for these procedure codes. Providers may refer to the appropriate copyright holder for the revised descriptions.
- ***Discontinued:*** Discontinued procedure codes are no longer reimbursed after December 31, 2016.
- ***Added:*** Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS).
- ***Limitations:*** Additional benefit and limitation information for the added procedure codes.

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Note: *For the purposes of this section for CSHCN Services Program benefit changes, "advanced practice registered nurse (APRN)" includes nurse practitioner (NP) and clinical nurse specialist (CNS) providers only.*

Dental – Diagnostic Services

Discontinued Procedure Code
D0290

Refer to: The *CSHCN Services Program Provider Manual, Dental Handbook,* subsection 14.2.2.5, "Radiographs or Diagnostic Imaging," for additional information.

Dental – Preventive Services

Added Procedure Code
D1575

Limitations for added procedure code: Procedure code D1575 may be reimbursed without authorization or prior authorization for services rendered to clients who are 3 through 7 years of age as follows:

- To dentists and federally qualified health center (FQHC) providers for services rendered in the office and outpatient hospital settings.
- To dentist providers for services rendered in the inpatient hospital setting.

Space maintainers submitted with procedure code D1575 are limited to one per tooth ID, per client after premature loss of a deciduous/primary second molar (tooth identification [TID]: A, J, K, and T) for clients who are 3 through 7 years of age.

Refer to: The *CSHCN Services Program Provider Manual,* section 14.2.4.5, "Space Maintainers," for additional information.

Diabetic Equipment and Supplies

Added Procedure Codes	
A4224	A4225

Limitations for added procedure code: Procedure codes A4224 and A4225 may be reimbursed without prior authorization as follows:

- Procedure code A4224 may be reimbursed for 4 per month to home health durable medical equipment (DME), DME medical supplier, and custom DME providers for services rendered in the home setting.
- Procedure code A4225 may be reimbursed for 15 per month to home health DME, DME medical supplier, and custom DME providers for services rendered in the home setting.

Refer to: The *CSHCN Services Program Provider Manual*, section 15, "Diabetic Equipment and Supplies," for additional information about external insulin pumps.

Durable Medical Equipment

Added Procedure Codes
E0627

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Discontinued Procedure Codes		
97001	97003	E0628

Limitations for added procedure code: Seat lift mechanisms can be billed using new procedure code E0627 or currently payable procedure code E0629 as a replacement for discontinued procedure code E0628.

Procedure code E0627 may be reimbursed for new DME purchases with prior authorization as follows:

- To DME and custom DME providers for services rendered in the office setting.
- To home health DME, DME medical supplier, and custom DME providers for services rendered in the home setting.

Procedure code E0627 may be reimbursed for 1 every 3 rolling years.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 17.3.13, "Seat Lift Mechanism," for additional information.

Genetic Testing for Colorectal Cancer

Added Procedure Code
81327

Limitations for added procedure code: Procedure code 81327 may be reimbursed once per lifetime to independent laboratory providers for services rendered in the independent laboratory setting. Additional tests will not be authorized.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 25, "Genetic Testing for Colorectal Cancer," for additional information.

Medications – Blood Factor Products

Added Procedure Codes					
C9140	J7175	J7179	J7202	J7207	J7209

***Limitations for added procedure code*s:** Procedure codes C9140, J7175, J7179, J7202, J7207, and J7209 may be reimbursed without prior authorization as follows:

- To physician assistant (PA), NP, CNS, and physician providers in the office setting.
- To medical supplier (DME) and hemophilia factor providers in the home setting.
- To hospital providers in the outpatient hospital setting.

Reimbursement for procedure codes J7175 is limited to the diagnosis codes listed in the following table:

Diagnosis Codes		
D682	D688	D689

Reimbursement for procedure codes J7202 is limited to the diagnosis codes listed in the following table:

Diagnosis Codes			
D66	D682	D688	D689

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Reimbursement for procedure codes J7179 is limited to the diagnosis codes listed in the following table:

Diagnosis Codes	
D66	D680

Reimbursement for procedure codes C9140, J7207, and J7209 is limited to the diagnosis codes listed in the following table:

Diagnosis Codes						
D66	D67	D681	D682	D68311	D688	D689

The following procedure codes must be billed with a valid, rebatable National Drug Code (NDC):

Procedure Codes					
C9140	J7175	J7179	J7202	J7207	J7209

Refer to: The *CSHCN Services Program Provider Manual, Hospital Handbook,* subsection 24.4.1.1, "Blood Factor Products," and subsection 31.2.9, "Blood Factor Products," for additional information.

Monoclonal Antibodies – Asthma & Chronic Idiopathic Urticaria

Added Procedure Code	
J2182	J2786
Discontinued Procedure Code	
C9473	C9481*

* Discontinued procedure code C9481 was created by CMS for the third quarter 2016 HCPCS update but was not made a benefit of the CSHCN Services Program. Procedure code J2786 replaces discontinued procedure code C9481, and will be made a benefit. Providers can refer to the *CSHCN Services Program Provider Manual* for information about mepolizumab; the same information will apply for procedure code J2786 as currently applies to procedure code C9481.

Limitations for added procedure code: Procedure code J2182 for mepolizumab replaces discontinued procedure code C9473. Procedure code J2786 for reslizumab replaces discontinued code C9481. Procedure codes J2182 and J2786 may be reimbursed as follows:

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

Procedure codes J2182 and J2786 require prior authorization and must be submitted with a valid, rebatable National Drug Code (NDC).

Additional Requirements for Reslizumab

Reslizumab procedure code J2182 is an injectable drug that is FDA-approved and indicated for the treatment of clients who are 18 years of age and older and have severe asthma with an eosinophilic phenotype.

Prior authorization for reslizumab will be considered for clients who are 18 years of age or older with severe asthma (as defined by the National Heart, Lung, and Blood institute's Guidelines for the Diagnosis and management of Asthma).

Refer to: The *CSHCN Services Program Provider Manual,* section 31.2.25.15, "Monoclonal Antibodies - Asthma and Chronic Idiopathic Urticaria," for information about prior authorization requirements for clients with severe asthma.

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The following additional documentation for treatment with reslizumab also must be submitted:

- Has an eosinophilic phenotype as determined by blood eosinophils of 400 cells/microliter or higher to initiation of therapy (within 3-4 weeks of dosing). **Note:** *1 microliter 9ul) is equal to 1 cubic millimeter (mm3).*
- Prior authorization for an initial request for reslizumab will be considered when the client has had an inadequate response after being compliant for 6 months of treatment with omalizumab and meets the criteria for reslizumab. Failure to respond to omalizumab must be documented in a letter, signed and dated by the prescribing provider and submitted with the request.

  Exceptions may be considered for clients who meet the requirements for treatment with reslizumab but who do not meet the criteria for omalizumab. Supporting documentation (IgE level falls outside of required range and/or negative skin test/RAST to a perennial aeroallergen) must be submitted along with the documentation for treatment with reslizumab as described above.
- When requesting prior authorization, the exact dosage must be included with the request.

Procedure codes J2182, J2357, and J2786, may not be billed in any combination for the same date of services by any provider.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 31.2.25.15, "Monoclonal Antibodies - Asthma and Chronic Idiopathic Urticaria," for additional information.

Orthoses and Prostheses

Added Procedure Codes	
L1851	L1852
Discontinued Procedure Codes	
K0901	K0902

***Limitations for added procedure code*s**: Procedure codes L1851 and L1852 may be reimbursed with prior authorization as follows:

- To home health durable medical equipment (DME), prosthetist, and orthotist and medical supplier DME providers for services rendered in the home setting.

Prior authorization is required for procedure codes L1851 and L1852. Procedure codes L1851 and L1852 replace discontinued procedure codes K0901 and K0902.

Refer to: The *CSHCN Services Program Provider Manual, Orthotic and Prosthetic Devices Handbook,* subsection 28.3.2., "Orthotic and Orthopedic Devices Procedure Codes," for additional information.

Pathology and Laboratory Services – Drug Testing and Drug Assays

Added Procedure Codes							
80305	80306	80307	G0659				
Discontinued Procedure Codes							
80300	80301	80302	80303	80304	G0477	G0478	G0479

Limitations for added procedure code: Procedure codes 80305, 80306, and 80307 may be reimbursed as follows:

- To physician providers for services rendered in the office setting.

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

Procedure code G0659 may be reimbursed as follows:

- To physician providers for services rendered in the office setting.
- To hospital providers for services rendered in the outpatient hospital setting.
- To independent laboratory providers for services rendered in the laboratory setting, and is limited to one per day, any provider.

The following drug assay procedure codes will be denied when billed on the same date of service, by the same provider as procedure code G0659:

Procedure Codes									
80305	80306	80307	80320	80323	80326	80329	80332	80337	80338
80339	80342	80345	80358	80363	80365	80368	80369	80370	80375
80377									

Procedure code 80305 and 80306 will be denied when billed with the same date of service

Refer to: The *CSHCN Services Program Provider Manual,* subsection 25.2.5.1, "Drug Testing and Therapeutic Drug Assays," for additional information.

Pathology and Laboratory Services - Microbiology

Added Procedure Codes
G0499

Limitations for added procedure code: Procedure code G0499 may be reimbursed as follows:

- To physician, radiation therapy center, nephrologist (hemodialysis, renal dialysis), and renal dialysis facility providers for services rendered in the office setting.
- To radiation therapy center, hospital, nephrologist (hemodialysis, renal dialysis), and renal dialysis facility providers for services rendered in the outpatient hospital setting.
- To independent laboratory providers for services rendered in the laboratory setting.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 2.2.13, "Microbiology," for additional information.

Physical Medicine and Rehabilitation

Added Procedure Codes							
97161	97162	97163	97164	97165	97166	97167	97168
Discontinued Procedure Codes							
97001	97002	97003	97004				

Limitations for added procedure code: The following therapy evaluation and re-evaluation procedure codes replace discontinued procedure codes 97001, 97002, 97003, and 97004:

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Service	Discontinued Procedure Code	New Procedure Code(s)
PT Evaluation	97001	97161, 97162, 97163
PT Re-evaluation	97002	97164
OT Evaluation	97003	97165, 97166, 97167
OT Re-evaluation	97004	97168

Physical Therapy Evaluations

Procedure codes 97161, 97162, and 97163 may be reimbursed as follows:

- To NP, CNS, PA, physician, physical therapy (PT), occupational therapy (OT), hospital, and rehabilitation center providers for services rendered in the office setting.
- NP, CNS, PA, home health DME, physician, PT, OT, home health agency, hospital, and rehabilitation center providers for services rendered in the home setting.
- NP, CNS, PA, physician, PT, OT, home health agency, and hospital providers for services rendered in the outpatient setting.

Procedure codes 97161, 97162, and 97163 will not be reimbursed when billed with the same date of service as procedure code G0151 submitted by a different provider.

Procedure codes 97161, 97162, and 97163 may *each* be reimbursed every 180 days when submitted by any provider.

A PT evaluation will not be reimbursed when billed with the same date of service as a hospice service or PT. Procedure codes 97161, 97162, and 97163 will be denied when billed with the same date of service as the following:

Hospice Revenue Codes							
651	652	655	656				
Physical Therapy Services Procedure Codes-Modifier							
97012-GP	97014-GP	97016-GP	97018-GP	97022-GP	97024-GP	97026-GP	97028-GP
97032-GP	97033-GP	97034-GP	97035-GP	97036-GP	97039-GP	97110-GP	97112-GP
97113-GP	97116-GP	97124-GP	97139-GP	97140-GP	97150-GP	97530-GP	97535-GP
97537-GP	97542-GP	97750-GP	97755-GP	97760-GP	97761-GP	97762-GP	97799-GP
S8990-GP							

Occupational Therapy Evaluations:

Procedure codes 97161, 97162, and 97163 may be reimbursed as follows:

- NP, CNS, PA, physician, podiatrist, PT, OT, CCP, hospital, and rehabilitation center providers may be reimbursed for services rendered in the office setting.
- NP, CNS, PA, home health DME, physician, podiatrist, PT, OT, home health agency, hospital, and rehabilitation center providers may be reimbursed for services rendered in the home setting.
- NP, CNS, PA, physician, podiatrist, PT, OT, home health agency, CCP, hospital, and rehabilitation center providers may be reimbursed for services rendered in the outpatient hospital setting.

Procedure codes 97165, 97166, and 97167 will not be reimbursed when billed with the same date of service as procedure code G0152 submitted by a different provider.

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Procedure codes 97165, 97166, and 97167 may each be reimbursed every 180 days when submitted by any provider.

An OT evaluation will not be reimbursed when billed with the same date of service as a hospice service or OT. Procedure codes 97165, 97166, and 97167 will be denied when billed with the same date of service as the following:

Hospice Revenue Codes							
651	652	655	656				
Physical Therapy Services Procedure Codes-Modifier							
97012-GO	97014-GO	97016-GO	97018-GO	97022-GO	97024-GO	97026-GO	97028-GO
97032-GO	97033-GO	97034-GO	97035-GO	97036-GO	97039-GO	97110-GO	97112-GO
97113-GO	97116-GO	97124-GO	97139-GO	97140-GO	97150-GO	97530-GO	97535-GO
97537-GO	97542-GO	97750-GO	97755-GO	97760-GO	97761-GO	97762-GO	97799-GO
S8990-GO							

Physical and Occupational Therapy Re-evaluations

Procedure codes 97164 may be reimbursed to NP, CNS, PA, physician, PT, OT, home health agency, hospital, and rehabilitation center providers for services rendered in the office, home, and outpatient settings.

Procedure code 97164 will be denied when billed with the same date of service as the following revenue codes and procedure codes:

Revenue Codes							
651	652	655	656				
Procedure Codes							
97012-GP	97014-GP	97016-GP	97018-GP	97022-GP	97024-GP	97026-GP	97028-GP
97032-GP	97033-GP	97034- GP	97035-GP	97036-GP	97039-GP	97110-GP	97112-GP
97113-GP	97116-GP	97124- GP	97139-GP	97140-GP	97150-GP	97161	97162
97163	97530-GP	97535-GP	97537-GP	97542-GP	97750- GP	97755-GP	97760-GP
97761-GP	97762-GP	97799-GP	G0151	S8990-GP			

Procedure code 97168 may be reimbursed to NP, CNS, PA, physician, podiatrist, PT, OT, home health agency, CCP, hospital, rehabilitation center, and hospital-based rural health center providers for services rendered in the outpatient settings.

Procedure code 97168 will be denied when billed with the same date of service as the following revenue codes and procedure codes:

Revenue Codes							
651	652	655	656				
Procedure Codes							
97012-GO	97014-GO	97016-GO	97018-GO	97022-GO	97024-GO	97026-GO	97028-GO
97032-GO	97033-GO	97034-GO	97035-GO	97036-GO	97039-GO	97110-GO	97112-GO
97113-GO	97116-GO	97124-GO	97139-GO	97140-GO	97150-GO	97165	97166
97167	97530-GO	97535-GO	97537-GO	97542-GO	97750-GO	97755-GO	97760-GO
97761-GO	97762-GO	97799-GO	G0152	S8990-GO			

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Preventative Care Medical Checkups

Added Procedure Codes	
96160	96161
Discontinued Procedure Codes	
99420	

Limitations for added procedure code: Procedure codes 96160 and 96161 replace discontinued procedure code 99420 and may be reimbursed for services rendered to clients who are 12 through 18 years of age as follows:

- To NP, CNS, PA, physician, and FQHC providers for services rendered in the office setting.

Procedure codes 96160 and 96161 will be denied if billed with the same date of service as procedure codes 99384, 99385, 99394, and 99395.

Providers must use procedure code 96160 or 96161 for the required mental health screening. Procedure codes 96160 and 96161 must be billed with the appropriate medical check-up procedure code.

Only one procedure code (96160 or 96161) may be reimbursed once per lifetime.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 19.2.2, "Preventative Care Medical Checkups," and subsection 31.2.18.10, "Preventative Care Medical Checkup Components" for additional information.

Telemedicine and Telehealth Services

Added Modifier
95
Modifier No Longer Used for Telemedicine and Telehealth Services
GT

Limitations for added modifier: Modifier 95 replaces modifier GT. The following procedure codes, when billed with modifier 95, are a benefit for distant-site providers:

Procedure Codes									
90791	90792	90832	90833	90834	90836	90837	90951	90952	90954
90955	90957	90958	90960	90961	97802	97803	97804	99201	99202
99203	99204	99205	99211	99212	99213	99214	99215	99241	99242
99243	99244	99245	99251	99252	99253	99254	99255	99354	99355
G0406	G0407	G0408	G0425	G0426	G0427	G0459	S9470		

Reimbursement for telemedicine and telehealth services will be made only when both the distant site provider and the patient site provider are enrolled in the CSHCN Services Program and can independently bill evaluation and management codes with modifier 95. Providers must bill using their individual national provider identifier (NPI)/ Texas provider identifier (TPI).

Modifier 95 must be appended to all codes billed as a telemedicine or telehealth service. Modifier GT will no longer be used for telemedicine and telehealth services.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 37.2.1.1, "Distant Site," and subsection 37.2.2.1, "Distant Site," for additional information.

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Vaccines and Toxoids

Added Procedure Codes							
90674							
Revised Procedure Codes							
90655	90656	90657	90658	90685	90686	90687	90688

Limitations for added procedure code: Procedure code 90674 may be reimbursed as follows:

- To PA, NP, CNS, physician, and pharmacy providers for services rendered in the office setting.
- To PA, NP, CNS, and physician providers for services rendered in the "other location" setting.
- To hospital providers for services rendered in the outpatient hospital setting.

The descriptions of the following procedure codes have been revised, but the current age restrictions continue to apply:

Procedure Code	Age Restriction
90655	6 through 35 months of age
90656	3 years of age and older.
90657	6 through 35 months of age
90658	3 years of age and older.
90685	6 through 35 months of age
90686	3 years of age and older.
90687	6 through 35 months of age
90688	3 years of age and older.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 31.2.24.9, "Vaccine and Toxoid Procedure Codes," for additional information.

Vision Services Nonsurgical

Added Procedure Codes
92242

Limitations for added procedure code: Procedure code 92242 may be reimbursed as follows:

- The medical component may be reimbursed to physician, optometrist, and Federally Qualified Health Center (FQHC) providers for services rendered in the office, and in the inpatient and outpatient hospital settings.
- The professional interpretation component may be reimbursed to NP, CNS, PA, physician, and optometrist providers for services rendered in the inpatient and outpatient hospital settings.
- The technical component may be reimbursed to NP, CNS, PA, physician, and optometrist providers for services rendered in the office setting.

Procedure code 92242 may be reimbursed for a quantity of two if both the left and right eyes are evaluated. Modifiers LT and RT must be included on the claim to identify the eye on which the service was performed. Modifier 50 may be used with the medical services component.

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Procedure code 92242 is limited to one service per eye, per day and two services per eye, per calendar year any provider.

Refer to: The *CSHCN Services Program Provider Manual,* subsection 39.2.3.6, "Opthalmoscopy," for additional information.

Wound Care Management Services

Discontinued Procedure Code
Q4129

Refer to: The *CSHCN Services Program Provider Manual,* subsection 31.2.42.2, "Second-Line Wound Care Therapy," for additional information. ■

ALL CODE CHANGES: ADDED, REVISED, REPLACEMENT, AND DISCONTINUED

2017 HCPCS Procedure Code Additions

The following is a list of new Healthcare Common Procedure Coding System (HCPCS) procedure codes that do not replace existing codes:

TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
2	22853	*	*		Add-on procedure code
8	22853	*	*		Add-on procedure code
2	22854	*	*		Add-on procedure code
8	22854	*	*		Add-on procedure code
2	22859	*	*		Add-on procedure code
8	22859	*	*		Add-on procedure code
2	22867	NC	NC		
8	22867	NC	NC		
F	22867	NC	NC		
2	22868	NC	NC		
8	22868	NC	NC		
2	22869	NC	NC		
F	22869	NC	NC		
2	22870	NC	NC		
8	22870	NC	NC		
2	27197	*	*		

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, FPP = Procedure code a benefit of the State-Funded Family Planning Program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
F	27197	*	*		
2	27198	*	*		
F	27198	*	*		
2	28291	*	*		
8	28291	*	*		
F	28291	*	*		
2	28295	*	*		
8	28295	*	*		
F	28295	*	*		
2	31551	*	*		(Medicaid) Diagnostic Endoscopies
F	31551	*	*		(Medicaid) Diagnostic Endoscopies
2	31552	*	*		(Medicaid) Diagnostic Endoscopies
F	31552	*	*		(Medicaid) Diagnostic Endoscopies
2	31553	*	*		(Medicaid) Diagnostic Endoscopies
F	31553	*	*		(Medicaid) Diagnostic Endoscopies
2	31554	*	*		(Medicaid) Diagnostic Endoscopies
F	31554	*	*		(Medicaid) Diagnostic Endoscopies
2	31572	*	*	MD	(Medicaid) Diagnostic Endoscopies
F	31572	*	*	MD	(Medicaid) Diagnostic Endoscopies
2	31573	*	*	MD	(Medicaid) Diagnostic Endoscopies
F	31573	*	*	MD	(Medicaid) Diagnostic Endoscopies
2	31574	*	*	MD	(Medicaid) Diagnostic Endoscopies
F	31574	*	*	MD	(Medicaid) Diagnostic Endoscopies
2	31591	*	*		(Medicaid) Diagnostic Endoscopies
F	31591	*	*		(Medicaid) Diagnostic Endoscopies
2	31592	*	*		
F	31592	*	*		
2	33340	*	*		
2	33390	*	*		
8	33390	*	*		
2	33391	*	*		
8	33391	*	*		
2	36456	*	*		
2	36473	*	*		
F	36473	*	*		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
2	36474	*	*		
2	36901	*	*		
F	36901	*	*		
2	36902	*	*		
F	36902	*	*		
2	36903	*	*		
F	36903	*	*		
2	36904	*	*		
F	36904	*	*		
2	36905	*	*		
F	36905	*	*		
2	36906	*	*		
F	36906	*	*		
2	36907	*	*		
2	36908	*	*		
2	36909	*	*		
2	37246	*	*		
F	37246	*	*		
2	37247	*	*		Add-on procedure code
2	37248	*	*		
F	37248	*	*		
2	37249	*	*		Add-on procedure code
2	43284	NC	NC		
F	43284	NC	NC		
2	43285	NC	NC		
8	43285	NC	NC		
F	43285	NC	NC		
2	58674	*	*		(Medicaid) Gynecological and Reproductive Health Services
8	58674	*	*		(Medicaid) Gynecological and Reproductive Health Services
F	58674	*	*		(Medicaid) Gynecological and Reproductive Health Services
2	62320	*	*		
F	62320	*	*		
2	62321	*	*		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
F	62321	*	*		
2	62322	*	*		
F	62322	*	*		
2	62323	*	*		
F	62323	*	*		
2	62324	*	*		
F	62324	*	*		
2	62325	*	*		
F	62325	*	*		
2	62326	*	*		
F	62326	*	*		
2	62327	*	*		
F	62327	*	*		
2	62380	*	*		
8	62380	*	*		
F	62380	*	*		
4	76706	*	*		
I	76706	*	*		
T	76706	*	*		
4	77065	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women
I	77065	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, FPP = Procedure code a benefit of the State-Funded Family Planning Program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
T	77065	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women
4	77066	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women
I	77066	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women
T	77066	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women
4	77067	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, FPP = Procedure code a benefit of the State-Funded Family Planning Program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
I	77067	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women
T	77067	*	*		Benefit for HTW, FFP Bureau of Radiation Control (BRC) Certification required (Medicaid) Screening and Diagnostic Studies of the Breast (Medicaid) Healthy Texas Women
5	80305	*	*		Lab certification required (Medicaid and CSHCN) Pathology and Laboratory Services – Drug Testing and Therapeutic Drug Assays
5	80306	*	*		Lab certification required (Medicaid and CSHCN) Pathology and Laboratory Services – Drug Testing and Therapeutic Drug Assays
5	80307	*	*		Lab certification required (Medicaid and CSHCN) Pathology and Laboratory Services – Drug Testing and Therapeutic Drug Assays
5	81327	*	*	MD	Lab certification required (Medicaid and CSHCN) Genetic Testing for Colorectal Cancer
5	81413	NC	NC		
5	81414	NC	NC		
5	81422	NC	NC		
5	81439	NC	NC		
5	81539	NC	NC		
5	84410	NC	NC		
5	87483	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	90674	*	*		Not covered by TVFC; modifier U1 required. (Medicaid and CSHCN) Vaccines and Toxoids
S	90674	*	*		Not covered by TVFC
1	90682	NC	NC		
S	90682	NC	NC		
1	90750	NC	NC		
1	90750	NC	NC		
1	92242	*	*		(Medicaid and CSHCN)_ Vision Services - Nonsurgical
2	93590	*	*		
8	93590	*	*		
F	93590	*	*		
2	93591	*	*		
F	93591	*	*		
2	93592	*	*		Add-on procedure code
8	93592	*	*		Add-on procedure code
1	96160	NC	*		(CSHCN) Preventive Care Medical Checkups
S	96160	*	NC		(Medicaid) Texas Health Steps Preventative Care Medical Checkups
1	96161	NC	*		(CSHCN) Preventive Care Medical Checkups
S	96161	*	NC		(Medicaid) Texas Health Steps Preventative Care Medical Checkups
1	96377	*	*		(MD) Injections and Injection Administration benefit
1	97161	*	*		SHARS benefit (Medicaid) Early Childhood Intervention Services
C	97161	*	*		
1	97162	*	*		SHARS benefit (Medicaid) Early Childhood Intervention Services
C	97162	*	*		

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, FPP = Procedure code a benefit of the State-Funded Family Planning Program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	97163	*	*		SHARS benefit (Medicaid) Early Childhood Intervention Services
C	97163	*	*		
1	97164	*	*	MD - PA will be updated by TMHP	Replaces DC 97002 (Medicaid) Physical, Occupational, and Speech Therapy — Adult/Clients Age 21 and Over (Medicaid Physical, Occupational, and Speech Therapy—Children (Acute and Chronic) (Medicaid) Early Childhood Intervention Services (CSHCN) Physical Medicine and Rehabilitation SHARS benefit
C	97164	*	*	MD - PA will be updated by TMHP	Replaces DC 97002 (Medicaid) Physical, Occupational, and Speech Therapy — Adult/Clients Age 21 and Over (Medicaid Physical, Occupational, and Speech Therapy—Children (Acute and Chronic) (CSHCN) Physical Medicine and Rehabilitation
1	97165	*	*		SHARS benefit (Medicaid) Early Childhood Intervention Services
C	97165	*	*		
1	97166	*	*		SHARS benefit (Medicaid) Early Childhood Intervention Services
C	97166	*	*		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	97167	*	*		SHARS benefit (Medicaid) Early Childhood Intervention Services
C	97167	*	*		
1	97168	*	*	MD - PA will be updated by TMHP	Replaces DC 97004 (Medicaid) Physical, Occupational, and Speech Therapy — Adult/Clients Age 21 and Over (Medicaid Physical, Occupational, and Speech Therapy—Children (Acute and Chronic) (Medicaid) Early Childhood Intervention Services (CSHCN) Physical Medicine and Rehabilitation SHARS benefit
C	97168	*	*	MD - PA will be updated by TMHP	Replaces DC 97004 (Medicaid) Physical, Occupational, and Speech Therapy — Adult/Clients Age 21 and Over (Medicaid Physical, Occupational, and Speech Therapy—Children (Acute and Chronic) (CSHCN) Physical Medicine and Rehabilitation
1	97169	NC	NC		
1	97170	NC	NC		
1	97171	NC	NC		
1	97172	NC	NC		
1	99151	*	*		
1	99152	*	*		
1	99153	*	*		
1	99155	*	*		
1	99156	*	*		
1	99157	*	*		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
9	A4224	*	*		
9	A4225	*	*		
9	A4467	*	*	MD - PA will be updated by TMHP	Replaces DC A4466
9	A4553	NC	NC		
9	A9285	NC	NC		
J	A9285	NC	NC		
L	A9285	NC	NC		
9	A9286	NC	NC		
9	A9515	Info	Info		
9	A9587	Info	Info		
9	A9588	NC	NC		
9	A9597	Info	Info		
9	A9598	Info	Info		
J	C1889	NC	NC		
9	C1889	NC	NC		
1	C9140	*	*		Valid, rebatable NDC required (MD) Blood Factor Products benefit (CSHCN) Medications – Blood Factor Products benefit
1	C9482	*	*		Valid, rebatable NDC required
1	C9483	*	*		Valid, rebatable NDC required
4	C9744	*	*		
I	C9744	*	*		
T	C9744	*	*		
W	D0414	NC	NC		
W	D0600	NC	NC		
W	D1575	*	*		(Medicaid) Texas Health Steps (THSteps) Dental Preventive Services (CSHCN) Dental – Preventive Services benefit
W	D4346	NC	NC		
W	D6081	NC	NC		
W	D6085	NC	NC		
W	D9311	NC	NC		

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
W	D9991	NC	NC		
W	D9992	NC	NC		
W	D9993	NC	NC		
W	D9994	NC	NC		
9	E0627	*	*	MD, CSHCN - Provider must update PA	Replaces DC E0628 (CSHCN) Durable Medical Equipment
1	G0490	Info	NC		
1	G0491	Info	Info		Informational procedure code for HTW, FPP
1	G0492	Info	Info		Informational procedure code for HTW, FPP
1	G0493	NC	NC		
C	G0493	NC	NC		
1	G0494	NC	NC		
C	G0494	NC	NC		
1	G0495	NC	NC		
C	G0495	NC	NC		
1	G0496	NC	NC		
C	G0496	NC	NC		
5	G0499	*	*		(Medicaid and CSHCN) Pathology and Laboratory Services - Microbiology
1	G0500	Info	Info		Informational procedure code for HTW, FPP
1	G0501	Info	Info		Informational procedure code for HTW, FPP
1	G0502	Info	Info		Informational procedure code for HTW, FPP
1	G0503	Info	Info		Informational procedure code for HTW, FPP
1	G0504	Info	Info		Informational procedure code for HTW, FPP
1	G0505	Info	Info		Informational procedure code for HTW, FPP
1	G0506	Info	Info		Informational procedure code for HTW, FPP

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G0507	Info	Info		Informational procedure code for HTW, FPP
1	G0508	Info	Info		Informational procedure code for HTW, FPP
1	G0509	Info	Info		Informational procedure code for HTW, FPP
1	G0659	*	*		(Medicaid) Pathology and Laboratory Services – Drug Testing and Therapeutic Drug Assays (CSHCN) Pathology and Laboratory Services – Drug Testing and Drug Assays
1	G9481	Info	Info		Informational procedure code for HTW, FPP
1	G9482	Info	Info		Informational procedure code for HTW, FPP
1	G9483	Info	Info		Informational procedure code for HTW, FPP
1	G9484	Info	Info		Informational procedure code for HTW, FPP
1	G9485	Info	Info		Informational procedure code for HTW, FPP
1	G9486	Info	Info		Informational procedure code for HTW, FPP
1	G9487	Info	Info		Informational procedure code for HTW, FPP
1	G9488	Info	Info		Informational procedure code for HTW, FPP
1	G9489	Info	Info		Informational procedure code for HTW, FPP
1	G9490	Info	Info		
C	G9490	Info	Info		
1	G9678	Info	Info		Informational procedure code for HTW, FPP
1	G9679	Info	Info		Informational procedure code for HTW, FPP
1	G9680	Info	Info		Informational procedure code for HTW, FPP
1	G9681	Info	Info		Informational procedure code for HTW, FPP

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9682	Info	Info		Informational procedure code for HTW, FPP
1	G9683	Info	Info		Informational procedure code for HTW, FPP
1	G9684	Info	Info		Informational procedure code for HTW, FPP
1	G9685	Info	Info		Informational procedure code for HTW, FPP
1	G9686	Info	Info		Informational procedure code for HTW, FPP
1	G9687	Info	Info		Informational procedure code for HTW, FPP
1	G9688	Info	Info		Informational procedure code for HTW, FPP
1	G9689	Info	Info		Informational procedure code for HTW, FPP
1	G9690	Info	Info		Informational procedure code for HTW, FPP
1	G9691	Info	Info		Informational procedure code for HTW, FPP
1	G9692	Info	Info		Informational procedure code for HTW, FPP
1	G9693	Info	Info		Informational procedure code for HTW, FPP
1	G9694	Info	Info		Informational procedure code for HTW, FPP
1	G9695	Info	Info		Informational procedure code for HTW, FPP
1	G9696	Info	Info		Informational procedure code for HTW, FPP
1	G9697	Info	Info		Informational procedure code for HTW, FPP
1	G9698	Info	Info		Informational procedure code for HTW, FPP
1	G9699	Info	Info		Informational procedure code for HTW, FPP
1	G9700	Info	Info		Informational procedure code for HTW, FPP
1	G9701	Info	Info		Informational procedure code for HTW, FPP

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9702	Info	Info		Informational procedure code for HTW, FPP
1	G9703	Info	Info		Informational procedure code for HTW, FPP
1	G9704	Info	Info		Informational procedure code for HTW, FPP
1	G9705	Info	Info		Informational procedure code for HTW, FPP
1	G9706	Info	Info		Informational procedure code for HTW, FPP
1	G9707	Info	Info		Informational procedure code for HTW, FPP
1	G9708	Info	Info		Informational procedure code for HTW, FPP
1	G9709	Info	Info		Informational procedure code for HTW, FPP
1	G9710	Info	Info		Informational procedure code for HTW, FPP
1	G9711	Info	Info		Informational procedure code for HTW, FPP
1	G9712	Info	Info		Informational procedure code for HTW, FPP
1	G9713	Info	Info		Informational procedure code for HTW, FPP
1	G9714	Info	Info		Informational procedure code for HTW, FPP
1	G9715	Info	Info		Informational procedure code for HTW, FPP
1	G9716	Info	Info		Informational procedure code for HTW, FPP
1	G9717	Info	Info		Informational procedure code for HTW, FPP
1	G9718	Info	Info		Informational procedure code for HTW, FPP
1	G9719	Info	Info		Informational procedure code for HTW, FPP
1	G9720	Info	Info		Informational procedure code for HTW, FPP
1	G9721	Info	Info		Informational procedure code for HTW, FPP

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9722	Info	Info		Informational procedure code for HTW, FPP
1	G9723	Info	Info		Informational procedure code for HTW, FPP
1	G9724	Info	Info		Informational procedure code for HTW, FPP
1	G9725	Info	Info		Informational procedure code for HTW, FPP
1	G9726	Info	Info		Informational procedure code for HTW, FPP
1	G9727	Info	Info		Informational procedure code for HTW, FPP
1	G9728	Info	Info		Informational procedure code for HTW, FPP
1	G9729	Info	Info		Informational procedure code for HTW, FPP
1	G9730	Info	Info		Informational procedure code for HTW, FPP
1	G9731	Info	Info		Informational procedure code for HTW, FPP
1	G9732	Info	Info		Informational procedure code for HTW, FPP
1	G9733	Info	Info		Informational procedure code for HTW, FPP
1	G9734	Info	Info		Informational procedure code for HTW, FPP
1	G9735	Info	Info		Informational procedure code for HTW, FPP
1	G9736	Info	Info		Informational procedure code for HTW, FPP
1	G9737	Info	Info		Informational procedure code for HTW, FPP
1	G9738	Info	Info		Informational procedure code for HTW, FPP
1	G9739	Info	Info		Informational procedure code for HTW, FPP
1	G9740	Info	Info		Informational procedure code for HTW, FPP
1	G9741	Info	Info		Informational procedure code for HTW, FPP

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9742	Info	Info		Informational procedure code for HTW, FPP
1	G9743	Info	Info		Informational procedure code for HTW, FPP
1	G9744	Info	Info		Informational procedure code for HTW, FPP
1	G9745	Info	Info		Informational procedure code for HTW, FPP
1	G9746	Info	Info		Informational procedure code for HTW, FPP
1	G9747	Info	Info		Informational procedure code for HTW, FPP
1	G9748	Info	Info		Informational procedure code for HTW, FPP
1	G9749	Info	Info		Informational procedure code for HTW, FPP
1	G9750	Info	Info		Informational procedure code for HTW, FPP
1	G9751	Info	Info		Informational procedure code for HTW, FPP
1	G9752	Info	Info		Informational procedure code for HTW, FPP
1	G9753	Info	Info		Informational procedure code for HTW, FPP
1	G9754	Info	Info		Informational procedure code for HTW, FPP
1	G9755	Info	Info		Informational procedure code for HTW, FPP
1	G9756	Info	Info		Informational procedure code for HTW, FPP
1	G9757	Info	Info		Informational procedure code for HTW, FPP
1	G9758	Info	Info		Informational procedure code for HTW, FPP
1	G9759	Info	Info		Informational procedure code for HTW, FPP
1	G9760	Info	Info		Informational procedure code for HTW, FPP
1	G9761	Info	Info		Informational procedure code for HTW, FPP

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9762	Info	Info		Informational procedure code for HTW, FPP
1	G9763	Info	Info		Informational procedure code for HTW, FPP
1	G9764	Info	Info		Informational procedure code for HTW, FPP
1	G9765	Info	Info		Informational procedure code for HTW, FPP
1	G9766	Info	Info		Informational procedure code for HTW, FPP
1	G9767	Info	Info		Informational procedure code for HTW, FPP
1	G9768	Info	Info		Informational procedure code for HTW, FPP
1	G9769	Info	Info		Informational procedure code for HTW, FPP
1	G9770	Info	Info		Informational procedure code for HTW, FPP
1	G9771	Info	Info		Informational procedure code for HTW, FPP
1	G9772	Info	Info		Informational procedure code for HTW, FPP
1	G9773	Info	Info		Informational procedure code for HTW, FPP
1	G9774	Info	Info		Informational procedure code for HTW, FPP
1	G9775	Info	Info		Informational procedure code for HTW, FPP
1	G9776	Info	Info		Informational procedure code for HTW, FPP
1	G9777	Info	Info		Informational procedure code for HTW, FPP
1	G9778	Info	Info		Informational procedure code for HTW, FPP
1	G9779	Info	Info		Informational procedure code for HTW, FPP
1	G9780	Info	Info		Informational procedure code for HTW, FPP
1	G9781	Info	Info		Informational procedure code for HTW, FPP

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1	G9782	Info	Info		Informational procedure code for HTW, FPP
1	G9783	Info	Info		Informational procedure code for HTW, FPP
1	G9784	Info	Info		Informational procedure code for HTW, FPP
1	G9785	Info	Info		Informational procedure code for HTW, FPP
1	G9786	Info	Info		Informational procedure code for HTW, FPP
1	G9787	Info	Info		Informational procedure code for HTW, FPP
1	G9788	Info	Info		Informational procedure code for HTW, FPP
1	G9789	Info	Info		Informational procedure code for HTW, FPP
1	G9790	Info	Info		Informational procedure code for HTW, FPP
1	G9791	Info	Info		Informational procedure code for HTW, FPP
1	G9792	Info	Info		Informational procedure code for HTW, FPP
1	G9793	Info	Info		Informational procedure code for HTW, FPP
1	G9794	Info	Info		Informational procedure code for HTW, FPP
1	G9795	Info	Info		Informational procedure code for HTW, FPP
1	G9796	Info	Info		Informational procedure code for HTW, FPP
1	G9797	Info	Info		Informational procedure code for HTW, FPP
1	G9798	Info	Info		Informational procedure code for HTW, FPP
1	G9799	Info	Info		Informational procedure code for HTW, FPP
1	G9800	Info	Info		Informational procedure code for HTW, FPP
1	G9801	Info	Info		Informational procedure code for HTW, FPP

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9802	Info	Info		Informational procedure code for HTW, FPP
1	G9803	Info	Info		Informational procedure code for HTW, FPP
1	G9804	Info	Info		Informational procedure code for HTW, FPP
1	G9805	Info	Info		Informational procedure code for HTW, FPP
1	G9806	Info	Info		Informational procedure code for HTW, FPP
1	G9807	Info	Info		Informational procedure code for HTW, FPP
1	G9808	Info	Info		Informational procedure code for HTW, FPP
1	G9809	Info	Info		Informational procedure code for HTW, FPP
1	G9810	Info	Info		Informational procedure code for HTW, FPP
1	G9811	Info	Info		Informational procedure code for HTW, FPP
1	G9812	Info	Info		Informational procedure code for HTW, FPP
1	G9813	Info	Info		Informational procedure code for HTW, FPP
1	G9814	Info	Info		Informational procedure code for HTW, FPP
1	G9815	Info	Info		Informational procedure code for HTW, FPP
1	G9816	Info	Info		Informational procedure code for HTW, FPP
1	G9817	Info	Info		Informational procedure code for HTW, FPP
1	G9818	Info	Info		Informational procedure code for HTW, FPP
1	G9819	Info	Info		Informational procedure code for HTW, FPP
1	G9820	Info	Info		Informational procedure code for HTW, FPP
1	G9821	Info	Info		Informational procedure code for HTW, FPP

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1	G9823	Info	Info		Informational procedure code for HTW, FPP
1	G9824	Info	Info		Informational procedure code for HTW, FPP
1	G9825	Info	Info		Informational procedure code for HTW, FPP
1	G9826	Info	Info		Informational procedure code for HTW, FPP
1	G9827	Info	Info		Informational procedure code for HTW, FPP
1	G9828	Info	Info		Informational procedure code for HTW, FPP
1	G9829	Info	Info		Informational procedure code for HTW, FPP
1	G9830	Info	Info		Informational procedure code for HTW, FPP
1	G9831	Info	Info		Informational procedure code for HTW, FPP
1	G9832	Info	Info		Informational procedure code for HTW, FPP
1	G9833	Info	Info		Informational procedure code for HTW, FPP
1	G9834	Info	Info		Informational procedure code for HTW, FPP
1	G9835	Info	Info		Informational procedure code for HTW, FPP
1	G9836	Info	Info		Informational procedure code for HTW, FPP
1	G9837	Info	Info		Informational procedure code for HTW, FPP
1	G9838	Info	Info		Informational procedure code for HTW, FPP
1	G9839	Info	Info		Informational procedure code for HTW, FPP
1	G9840	Info	Info		Informational procedure code for HTW, FPP
1	G9841	Info	Info		Informational procedure code for HTW, FPP

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MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9842	Info	Info		Informational procedure code for HTW, FPP
1	G9843	Info	Info		Informational procedure code for HTW, FPP
1	G9844	Info	Info		Informational procedure code for HTW, FPP
1	G9845	Info	Info		Informational procedure code for HTW, FPP
1	G9846	Info	Info		Informational procedure code for HTW, FPP
1	G9847	Info	Info		Informational procedure code for HTW, FPP
1	G9848	Info	Info		Informational procedure code for HTW, FPP
1	G9849	Info	Info		Informational procedure code for HTW, FPP
1	G9850	Info	Info		Informational procedure code for HTW, FPP
1	G9851	Info	Info		Informational procedure code for HTW, FPP
1	G9852	Info	Info		Informational procedure code for HTW, FPP
1	G9853	Info	Info		Informational procedure code for HTW, FPP
1	G9854	Info	Info		Informational procedure code for HTW, FPP
1	G9855	Info	Info		Informational procedure code for HTW, FPP
1	G9856	Info	Info		Informational procedure code for HTW, FPP
1	G9857	Info	Info		Informational procedure code for HTW, FPP
1	G9858	Info	Info		Informational procedure code for HTW, FPP
1	G9859	Info	Info		Informational procedure code for HTW, FPP
1	G9860	Info	Info		Informational procedure code for HTW, FPP
1	G9861	Info	Info		Informational procedure code for HTW, FPP

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MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	G9862	Info	Info		Informational procedure code for HTW, FPP
1	J0570	*	NC		Valid, rebatable NDC required
1	J0883	*	*		Valid, rebatable NDC required
1	J0884	*	*		Valid, rebatable NDC required
1	J1130	*	*		Valid, rebatable NDC required
1	J1942	*	*		Valid, rebatable NDC required
1	J2182	*	*	MD, CSHCN - PA will be updated by TMHP	Valid, rebatable NDC required Replaces DC C9473 (Medicaid and CSHCN) Monoclonal Antibodies – Asthma & Chronic Idiopathic Urticaria
1	J2786	*	*		Replaces DC C9481 Valid, rebatable NDC required (Medicaid and CSHCN) Monoclonal Antibodies – Asthma & Chronic Idiopathic Urticaria
1	J2840	*	*		Valid, rebatable NDC required
1	J7175	*	*		Valid, rebatable NDC required (Medicaid) Blood Factor Products (CSHCN) Medications – Blood Factor Products
1	J7179	*	*		Valid, rebatable NDC required (Medicaid) Blood Factor Products (CSHCN) Medications – Blood Factor Products
1	J7202	*	*		Valid, rebatable NDC required (Medicaid) Blood Factor Products (CSHCN) Medications – Blood Factor Products

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, FPP = Procedure code a benefit of the State-Funded Family Planning Program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
1	J7207	*	*		Valid, rebatable NDC required (Medicaid) Blood Factor Products (CSHCN) Medications – Blood Factor Products
1	J7209	*	*		Valid, rebatable NDC required (Medicaid) Blood Factor Products (CSHCN) Medications – Blood Factor Products
1	J7320	*	*		
1	J7322	*	*		
1	J7342	NC	NC		
1	J8670	NC	NC		
1	J9034	*	*		Valid, rebatable NDC required
1	J9145	*	*		Valid, rebatable NDC required
1	J9176	*	*		Valid, rebatable NDC required
1	J9205	*	*		Valid, rebatable NDC required
1	J9295	*	*		Valid, rebatable NDC required
1	J9325	NC	NC		
1	J9352	*	*		Valid, rebatable NDC required
9	L1851	*	*	MD, CSHCN - PA will be updated by TMHP	(CSHCN) Orthoses and Prostheses Replaces DC K0901 (Medicaid) Orthoses-CCP
9	L1852	*	*	MD, CSHCN - PA will be updated by TMHP	(CSHCN) Orthoses and Prostheses Replaces DC K0901 (Medicaid) Orthoses-CCP
9	Q4166	NC	NC		
9	Q4167	NC	NC		
1	Q4168	NC	NC		
9	Q4169	NC	NC		
9	Q4170	NC	NC		
1	Q4171	NC	NC		
9	Q4172	NC	NC		
9	Q4173	NC	NC		

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, FPP = Procedure code a benefit of the State-Funded Family Planning Program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

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TOS	Procedure Code	Medicaid Allowable	CSHCN Allowable	Authorization Requirements	Comments and Additional Payable Programs
9	Q4174	NC	NC		
9	Q4175	NC	NC		
1	Q5102	NC	NC		
9	Q9982	NC	NC		
9	Q9983	NC	NC		
1	S0285	NC	NC		
1	S0311	NC	NC		
1	T1040	Info	NC		
1	T1041	Info	NC		
* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, FPP = Procedure code a benefit of the State-Funded Family Planning Program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required. MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.					

Note: *All new, revised, and discontinued 2017 HCPCS procedure codes are effective for dates of service on or after January 1, 2017. The new procedure codes that are indicated with an asterisk (*) in the above table are pending a rate hearing and approval of expenditures. Providers will be notified in a future notification if a new procedure code is not approved for reimbursement. Providers can refer to the section in this bulletin titled "Rate Hearings and Expenditure Review" for more information about benefits that are pending approval of expenditures.*

The following new procedure codes are used for reporting purposes and are informational only:

Procedure Codes									
Surgical Procedures									
0437T	0438T	0439T	0440T	0441T	0442T	0443T	0444T	0445T	0446T
0447T	0448T	0449T	0450T	0451T	0452T	0453T	0454T	0455T	0456T
0457T	0458T	0459T	0460T	0461T	0462T	0463T	0464T	0465T	0466T
0467T	0468T								

For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

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Discontinued Procedure Codes

The 2017 HCPCS discontinued procedure codes are no longer reimbursed after December 31, 2016. The following is a list of procedure codes that have been discontinued:

TOS	Discontinued Procedure Codes	Program(s)	Prior Authorization Requirement(s)	Replacement Procedure Code: Medicaid	Replacement Procedure Code: CSHCN
2	11752		None		
F	11752	MD, CSHCN	None		
2	21495	MD, CSHCN	None		
8	21495	CSHCN	None		
F	21495	CSHCN	None		
2	22305	MD, CSHCN	None		
F	22305	MD, CSHCN	None		
2	22851	MD, CSHCN	None		
8	22851	MD, CSHCN	None		
2	27193	MD, CSHCN	None		
F	27193	MD, CSHCN	None		
2	27194	MD, CSHCN	None		
F	27194	MD, CSHCN	None		
2	28290	MD, CSHCN	None		
F	28290	MD, CSHCN	None		
2	28293	MD, CSHCN	None		
8	28293	CSHCN	None		
F	28293	MD, CSHCN	None		
2	28294	MD, CSHCN	None		
8	28294	MD, CSHCN	None		
F	28294	MD, CSHCN	None		
2	31582	MD, CSHCN	None		
F	31582	MD, CSHCN	None		
2	31588	MD, CSHCN	None		
8	31588	MD	None		
F	31588	MD, CSHCN	None		
2	33400	MD, CSHCN	None		
8	33400	MD, CSHCN	None		
2	33401	MD, CSHCN	None		
8	33401	MD, CSHCN	None		
2	33403	MD, CSHCN	None		
8	33403	MD, CSHCN	None		

NAB = Procedure code was not a benefit on or before December 31, 2016, and is now being discontinued; MD = Medicaid; CSHCN = CSHCN Services Program; HTW = Healthy Texas Women program; FPP = (HHSC) Family Planning Program; None = No authorization or prior authorization requirements for the discontinued procedure code; Replacement procedure code: Medicaid = Medicaid's replacement for the discontinued procedure code; Replacement procedure code: CSHCN = CSHCN Services Program replacement for the discontinued procedure code.

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TOS	Discontinued Procedure Codes	Program(s)	Prior Authorization Requirement(s)	Replacement Procedure Code: Medicaid	Replacement Procedure Code: CSHCN
2	35450	MD	None		
8	35450	MD	None		
2	35452	MD, CSHCN	None		
8	35452	MD	None		
2	35458	MD, CSHCN	None		
8	35458	MD	None		
2	35460	MD, CSHCN	None		
2	35471	MD, CSHCN	None		
2	35472	MD, CSHCN	None		
2	35475	MD, CSHCN	None		
F	35475	MD, CSHCN	None		
2	35476	MD, CSHCN	None		
F	35476	MD, CSHCN	None		
2	36147	MD, CSHCN	None		
8	36147	MD, CSHCN	None		
2	36148	MD, CSHCN	None		
8	36148	MD, CSHCN	None		
2	36870	MD, CSHCN	None		
F	36870	MD, CSHCN	None		
2	62310	MD, CSHCN	None		
F	62310	MD, CSHCN	None		
2	62311	MD, CSHCN	None		
F	62311	MD, CSHCN	None		
2	62318	MD, CSHCN	None		
F	62318	MD, CSHCN	None		
2	62319	MD, CSHCN	None		
F	62319	MD, CSHCN	None		
4	75791	MD, CSHCN	None		
I	75791	MD, CSHCN	None		
T	75791	MD, CSHCN	None		
4	75962	MD, CSHCN	None		
I	75962	MD, CSHCN	None		
T	75962	MD, CSHCN	None		
4	75964	MD, CSHCN	None		
I	75964	MD, CSHCN	None		
T	75964	MD, CSHCN	None		

NAB = Procedure code was not a benefit on or before December 31, 2016, and is now being discontinued; MD = Medicaid; CSHCN = CSHCN Services Program; HTW = Healthy Texas Women program; FPP = (HHSC) Family Planning Program; None = No authorization or prior authorization requirements for the discontinued procedure code; Replacement procedure code: Medicaid = Medicaid's replacement for the discontinued procedure code; Replacement procedure code: CSHCN = CSHCN Services Program replacement for the discontinued procedure code.

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TOS	Discontinued Procedure Codes	Program(s)	Prior Authorization Requirement(s)	Replacement Procedure Code: Medicaid	Replacement Procedure Code: CSHCN
4	75966	MD, CSHCN	None		
I	75966	MD, CSHCN	None		
T	75966	MD, CSHCN	None		
4	75968	MD, CSHCN	None		
I	75968	MD, CSHCN	None		
T	75968	MD, CSHCN	None		
4	75978	MD, CSHCN	None		
I	75978	MD, CSHCN	None		
T	75978	MD, CSHCN	None		
4	77051	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
I	77051	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
T	77051	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
4	77052	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
I	77052	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
T	77052	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
4	77055	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
I	77055	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
T	77055	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
4	77056	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
I	77056	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
T	77056	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
4	77057	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
I	77057	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067
T	77057	MD, HTW, FPP, CSHCN	None	77065, 77066, 77067	77065, 77066, 77067

NAB = Procedure code was not a benefit on or before December 31, 2016, and is now being discontinued; MD = Medicaid; CSHCN = CSHCN Services Program; HTW = Healthy Texas Women program; FPP = (HHSC) Family Planning Program; None = No authorization or prior authorization requirements for the discontinued procedure code; Replacement procedure code: Medicaid = Medicaid's replacement for the discontinued procedure code; Replacement procedure code: CSHCN = CSHCN Services Program replacement for the discontinued procedure code.

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TOS	Discontinued Procedure Codes	Program(s)	Prior Authorization Requirement(s)	Replacement Procedure Code: Medicaid	Replacement Procedure Code: CSHCN
5	80300	MD, HTW, FPP, CSHCN	None		
5	80301	MD, HTW, FPP, CSHCN	None		
5	80302	MD, CSHCN	None		
5	80303	MD, CSHCN	None		
5	80304	MD, CSHCN	None		
5	81280	MD, CSHCN	None		
5	81281	MD, CSHCN	None		
5	81282	MD, CSHCN	None		
4	93965	MD, CSHCN	None		
I	93965	MD, CSHCN	None		
T	93965	MD, CSHCN	None		
1	97001	MD, CSHCN	None	97161, 97162, 97163 Wheeled mobility seating assessment: Use 97542 and GP/UC modifiers or GO/UC modifiers	97161, 97162, 97163
C	97001	MD, CSHCN	None	97161, 97162, 97163	97161, 97162, 97163
1	97002	MD, CSHCN, SHARS, ECI	MD - PA will be updated by TMHP	97164	97164
C	97002	MD, CSHCN	MD - PA will be updated by TMHP	97164	97164
1	97003	MD, CSHCN	None	97165, 97166, and 97167 Wheeled mobility seating assessment: Use 97542 and GP/UC modifiers or GO/UC modifiers	97165, 97166, and 97167
C	97003	MD, CSHCN	None	97165, 97166, and 97167	97165, 97166, and 97167
1	97004	MD, CSHCN, SHARS, ECI	MD - PA will be updated by TMHP	97168	97168
C	97004	MD, CSHCN	MD - PA will be updated by TMHP	97168	97168

NAB = Procedure code was not a benefit on or before December 31, 2016, and is now being discontinued; MD = Medicaid; CSHCN = CSHCN Services Program; HTW = Healthy Texas Women program; FPP = (HHSC) Family Planning Program; None = No authorization or prior authorization requirements for the discontinued procedure code; Replacement procedure code: Medicaid = Medicaid's replacement for the discontinued procedure code; Replacement procedure code: CSHCN = CSHCN Services Program replacement for the discontinued procedure code.

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TOS	Discontinued Procedure Codes	Program(s)	Prior Authorization Requirement(s)	Replacement Procedure Code: Medicaid	Replacement Procedure Code: CSHCN
1	99143	MD, CSHCN	None		
1	99144	MD, CSHCN	None		
1	99145	MD, CSHCN	None		
1	99420	CSHCN	None		
9	A4466	MD, CSHCN	MD - PA will be updated by TMHP	A4467	A4467
9	A9544	MD	MD - Provider must update PA	Most appropriate	Most appropriate
9	A9545	MD,	MD - Provider must update PA	Most appropriate	Most appropriate
J	B9000	MD, CSHCN	MD - PA will be updated by TMHP	B9002	B9002
L	B9000	MD, CSHCN	MD - PA will be updated by TMHP	B9002	B9002
1	C9139	MD	None		
1	C9461	Informational	None		
1	C9473	MD, CSHCN	MD, CSHCN - PA will be updated by TMHP	J2182	J2182
1	C9481	MD, CSHCN	None	J2786	J2786
W	D0290	MD, CSHCN	None		
J	E0628	MD, CSHCN	MD, CSHCN - Provider must update PA	E0627, E0629	E0627, E0629
1	G0154	DC - 1/1/2016	None		
C	G0154	DC - 1/1/2016	None		
4	G0389	MD, CSHCN	None		
I	G0389	MD,	None		
T	G0389	MD	None		
1	G3001	MD	MD - Provider must update PA	Most appropriate	Most appropriate
1	G0477	MD, CSHCN	None	G0659	G0659
1	G0478	MD, CSHCN	None	G0659	G0659
1	G0479	MD, CSHCN	None	G0659	G0659
1	G8545	Informational	None		
1	G8548	Informational	None		
1	G8549	Informational	None		
1	G8551	Informational	None		
1	G9499	Informational	None		

NAB = Procedure code was not a benefit on or before December 31, 2016, and is now being discontinued; MD = Medicaid; CSHCN = CSHCN Services Program; HTW = Healthy Texas Women program; FPP = (HHSC) Family Planning Program; None = No authorization or prior authorization requirements for the discontinued procedure code; Replacement procedure code: Medicaid = Medicaid's replacement for the discontinued procedure code; Replacement procedure code: CSHCN = CSHCN Services Program replacement for the discontinued procedure code.

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TOS	Discontinued Procedure Codes	Program(s)	Prior Authorization Requirement(s)	Replacement Procedure Code: Medicaid	Replacement Procedure Code: CSHCN
1	G9572	Informational	None		
1	G9581	Informational	None		
1	G9619	Informational	None		
1	G9650	Informational	None		
1	G9652	Informational	None		
1	G9653	Informational	None		
1	G9657	Informational	None		
1	G9667	Informational	None		
1	G9669	Informational	None		
1	G9670	Informational	None		
1	G9671	Informational	None		
1	G9672	Informational	None		
1	G9673	Informational	None		
1	G9677	Informational	None		
1	J0760	MD, CSHCN	None		
1	J1590	MD, CSHCN	None		
9	K0901	MD, CSHCN	MD, CSHCN - PA will be updated by TMHP	L1851	L1851
9	K0902	MD, CSHCN	MD, CSHCN - PA will be updated by TMHP	L1852	L1852
1	Q4119	MD	None		
1	Q4120	MD	None		
1	Q4129	MD, CSHCN	None		
1	Q9980	MD, CSHCN	None		
4	S8032	DC - 10/1/2016	None		
I	S8032	DC - 10/1/2016	None		
T	S8032	DC - 10/1/2016	None		

NAB = Procedure code was not a benefit on or before December 31, 2016, and is now being discontinued; MD = Medicaid; CSHCN = CSHCN Services Program; HTW = Healthy Texas Women program; FPP = (HHSC) Family Planning Program; None = No authorization or prior authorization requirements for the discontinued procedure code; Replacement procedure code: Medicaid = Medicaid's replacement for the discontinued procedure code; Replacement procedure code: CSHCN = CSHCN Services Program replacement for the discontinued procedure code.

The following nonpayable procedure codes have been discontinued:

Procedure Codes									
11752	21495	22305	27193	27194	28290	28293	28294	31582	31588
33400	35450	35452	35458	35460	35471	35472	35475	35476	36147
36148	36870	62310	62311	62318	62319	81280	81281	81282	92140
97005	97006	99148	99149	99150	C9121	C9137	C9138	C9349	C9458
C9459	C9470	C9471	C9472	C9474	C9475	C9476	C9477	C9478	C9479

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Procedure Codes									
C9480	C9742	C9743	C9800	D0290	G0163	G0164	G0436	G0437	G8401
G8458	G8460	G8461	G8485	G8486	G8487	G8489	G8490	G8491	G8494
G8495	G8496	G8497	G8498	G8499	G8500	G8544	G8634	G8645	G8646
G8725	G8726	G8728	G8757	G8758	G8759	G8761	G8762	G8765	G8784
G8848	G8853	G8868	G8898	G8899	G8900	G8902	G8903	G8906	G8927
G8928	G8929	G8940	G8948	G8953	G8977	G9203	G9204	G9205	G9206
G9207	G9208	G9209	G9210	G9211	G9217	G9219	G9222	G9233	G9234
G9235	G9236	G9237	G9238	G9244	G9245	G9324	G9435	G9436	G9437
G9438	G9439	G9440	G9441	G9442	G9443	G9463	G9464	G9465	G9466
G9467	Q9981								

The following informational reporting only procedure codes have been discontinued:

Procedure Codes									
0010M	0019T	0169T	0171T	0172T	0281T	0282T	0283T	0284T	0285T
0286T	0287T	0288T	0289T	0291T	0292T	0336T	0392T	0393T	

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Procedure Code Description Changes

Effective for dates of service on or after January 1, 2017, the following procedure code descriptions have changed:

Procedure Codes									
20240	28289	31575	33405	33406	33410	36476	36479	58958	77003
78351	82105	83015	83018	83704	85220	88381	89055	89342	90644
90655	90656	90657	90658	90661	90685	90686	90687	90688	90734
90832	90833	90834	90836	90837	90838	90846	90847	92235	92240
94060	95076	99235	99500	A4221	A9599	B9002	D4263	D4264	D4274
D7210	D7250	D7280	D7292	D7293	D7294	D7485	D7780	D7873	D7874
D7875	D7876	D7877	D9630	E0149	E0627	E0629	E0740	E0955	E0967
E0995	E2206	E2220	E2221	E2222	E2224	G0202	G0204	G0206	G8427
G8428	G8430	G8431	G8432	G8433	G8510	G8511	G8598	G8599	G8649
G8653	G8655	G8656	G8657	G8658	G8659	G8660	G8661	G8662	G8665
G8669	G8671	G8672	G8673	G8674	G8697	G8815	G8924	G8925	G8968
G9229	G9231	G9232	G9239	G9264	G9307	G9308	G9326	G9327	G9359
G9361	G9381	G9416	G9417	G9497	G9500	G9501	G9519	G9520	G9531
G9532	G9547	G9549	G9551	G9554	G9555	G9556	G9557	G9584	G9585
G9595	G9596	G9607	G9609	G9610	G9611	G9625	G9626	G9627	G9628
G9629	G9630	G9632	G9633	G9642	J0573	J1745	J2510	J3357	J7201
J7297	J7298	J7301	J7340	J9033	K0015	K0019	K0037	K0042	K0043
K0044	K0045	K0046	K0047	K0050	K0051	K0052	K0069	K0070	K0071
K0072	K0077	K0098	K0552	L1906	P9072	Q2039	Q4105	Q4131	

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The descriptions of the following informational reporting procedure codes have changed:

Reporting Procedure Codes - Informational									
0274T	0275T	0295T	0408T	0409T	0410T	0411T	0412T	0413T	0414T
0415T	0416T	0417T	0418T	0419T	0420T	0421T	0422T	0423T	0435T
0436T									

Providers must contact the appropriate copyright holder to obtain procedure code descriptions.

For more information, call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Modifiers

The following table lists new, revised, and discontinued modifiers:

New Modifiers									
1P	2P	3P	8P	95	FX	PN	V1	V2	V3
ZB									
Revised Modifiers									
PO	Q2								
Discontinued Modifiers									
L1									

New modifiers are effective for dates of service on or after January 1, 2017. Providers may contact the appropriate copyright holder to obtain modifier descriptions.

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