# HCPCS Special Bulletin

2018 Healthcare Common Procedure Coding System (HCPCS) Special Bulletin

JANUARY 2018 NO. 13

## 2018 HCPCS Implementation

On January 1, 2018, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2018 annual Healthcare Common Procedure Coding System (HCPCS) updates that are effective for dates of service on or after January 1, 2018.

This combined Special Bulletin includes the HCPCS updates for Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program. This bulletin is intended to notify providers of program and coding changes related to the 2018 updates for HCPCS and Current Procedural Terminology© (CPT).

Policy updates for a specific program or provider type are discussed in designated sections of the 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 2018 HCPCS procedure codes are effective for dates of service on or after January 1, 2018. The new procedure codes that are designated with asterisks (*) in the "Texas Medicaid Allowable" and the "CSHCN Services Program Allowable" columns of the table located on page 28 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
- http://www.sos.state.tx.us/texreg/index.shtml

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# Contents

# GENERAL INFORMATION

## Claims Filing

The new 2018 HCPCS procedure codes may be billed beginning January 1, 2018, and must be submitted within the initial 95-day filing deadline. Services provided before the rate hearing is completed and expenditures are approved will be denied with an explanation of benefits (EOB) 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, 2018.*

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.

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_2018.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) website 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.*

## 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 2018 Healthcare Common Procedure Coding System (HCPCS) discontinued procedure codes for dates of service that occur on, after, or encompass January 1, 2018, do not have to update prior authorization requests that were approved on or before December 31, 2017. 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 | C9484 | J1428 |
| 1 | C9489 | J2326 |

TOS = Type of service

**Important:** For managed care clients, providers must contact the client's Texas Medicaid managed care organization (MCO) for direction concerning prior authorization requests.

New authorization requests submitted on or after January 1, 2018, 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, 2017, must be submitted with the previous procedure codes that were payable on or before December 31, 2017, as authorized.
- Claims submitted with dates of service on or after January 1, 2018, must be submitted with the new 2018 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 for any of the following 2018 HCPCS discontinued procedure codes for dates of service that occur on, after, or encompass January 1, 2018, 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 |
|---|---|---|
| F | 55450 | CSHCN |
| 2 | 64565 | MD |
| F | 64565 | MD |
| 6 | 77422 | MD |
| 1 | 97762 | MD, CSHCN |
| W | D5510 | CSHCN |

TOS = Type of service, CSHCN = Prior authorization required for the CSHCN Services Program, MD = Prior authorization required for Texas Medicaid.

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 1-3, for a list of Prior Authorization Department telephone numbers. ■

## MEDICAID FEE-FOR-SERVICE AND MANAGED CARE PROVIDERS

### Texas Medicaid HCPCS Updates

The 2018 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 28. The 2018 HCPCS deletions and replacements are effective January 1, 2018, for dates of service on or after January 1, 2018, for Texas Medicaid.

**Refer to:** The "General Information" section starting on page 3 in this bulletin for more information.

#### Authorization and Prior Authorization Update Reminder

Effective January 1, 2018, the 2018 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, 2018, 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 2018 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2018. 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:

- ***Discontinued:*** Discontinued procedure codes are no longer reimbursed after December 31, 2017.

- ***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.

## Allergy Testing

| Added Procedure Code |
|---|
| 86008 |

***Limitations for added procedure code:*** Procedure code 86008 may be reimbursed as follows:

- To physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), physician, and certified nurse midwife (CNM) 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 86008 is a benefit when the test is performed for a reason that includes, but is not limited to, the following:

- The client is unable to discontinue medications.
- An allergy skin test is inappropriate for the client because the client is pediatric, disabled, or suffers from a skin condition such as dermatitis.

Procedure code 86008 will be limited to 30 allergens per rolling year, any provider. Prior authorization is not required unless the limit is exceeded.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* subsection 9.2.4.2, "Allergy Testing," for additional information.

## Anesthesia Reimbursement

| Added Procedure Codes | | | | |
|---|---|---|---|---|
| 00731 | 00732 | 00811 | 00812 | 00813 |
| **Discontinued Procedure Codes** | | | | |
| 00740 | 00810 | 01180 | 01190 | 01682 |

***Limitations for added procedure codes:*** Procedure codes 00731, 00732, 00811, 00812, and 00813 may be reimbursed to certified registered nurse anesthetist and physician providers for services rendered in the office, inpatient, and outpatient hospital settings.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.6, "Anesthesia," for additional information.

## Antisense Oligonucleotides

| Added Procedure Codes | |
|---|---|
| J1428 | J2326 |

| Discontinued Procedure Codes | |
|---|---|
| C9484 | C9489 |

***Limitations for added procedure codes:*** Procedure code J1428 for eteplirsen replaces discontinued procedure code C9484, and procedure code J2326 for nusinersen replaces discontinued procedure code C9489. Procedure codes J1428 and J2326 require prior authorization and 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 code J1428 may be reimbursed for clients who are birth through 19 years of age.

Procedure code J2326 may be reimbursed for clients who are birth through 20 years of age.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* subsection 9.2.38.13, "Antisense Oligonucleotides," for additional information.

## Blood Factor Products

| Added Procedure Codes | |
|---|---|
| J7210 | J7211 |
| **Discontinued Procedure Codes** | |
| C9140 | |

***Limitations for added procedure codes:*** Procedure code J7210 replaces discontinued procedure code C9140. Procedure codes J7210 and J7211 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.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* subsection 9.2.38.15, "Blood Factor Products," for additional information.

## Brachytherapy

| Added Procedure Codes |
|---|
| 55874 |

***Limitations for added procedure code:*** Procedure code 55874 may be reimbursed for male clients as follows:

- To physician and radiation therapy center providers for services rendered in the office setting.
- To physician providers for services rendered in the inpatient hospital setting.
- To physician, radiation therapy center, hospital-based rural health clinic (RHC), and ambulatory surgical center (ASC) providers for services rendered in the outpatient hospital setting.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.60.1, "Brachytherapy," and the *Inpatient and Outpatient Hospital Services Handbook,* subsection 5.2.11, "Brachytherapy," for additional information.

## Cytopathology Studies

| Discontinued Procedure Code |
|---|
| 88154 |

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook* subsection 6.15, "Pap Smear (Cytopathology Studies)," for additional information.

## Doctor of Dentistry Services as a Limited Physician

| Added Procedure Codes | | |
|---|---|---|
| 15730 | 15733 | J1555 |
| **Discontinued Procedure Code** | | |
| 15732 | | |

***Limitations for added procedure codes:*** Procedure code 15730 may be reimbursed as follows:

- To physician providers for services rendered in the inpatient and outpatient hospital settings.
- To ASC providers for services rendered in the outpatient hospital setting.

Procedure code 15733 may be reimbursed as follows:

- To physician and dentist providers for services rendered in the office, inpatient, and outpatient hospital settings.
- To ASC providers for services rendered in the outpatient hospital setting.

Procedure code J1555 may be reimbursed as follows:

- To PA, NP, CNS, and physician providers for services rendered in the office setting.
- To medical supplier (DME) providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* subsection 9.3.2.1," Additional Payable Procedure Codes," for additional information.

## Edaravone (Radicava®)

| Added Procedure Code |
|---|
| C9493 |

***Limitations for added procedure code:*** Procedure code C9493 requires prior authorization and may be covered when all of the following criteria is met:

- The client has a diagnosis of amyotrophic lateral sclerosis (ALS).
- The client is 18 years of age or older.

## Gynecological and Reproductive Health Services

| Added Procedure Codes | |
|---|---|
| 58575 | J7296 |
| **Discontinued Procedure Code** | |
| Q9984 | |

***Limitations for added procedure codes:*** Procedure code 58575 may be reimbursed for services rendered to female clients as follows:

- The surgical component to physician providers for services rendered in the outpatient and inpatient hospital settings.

Procedure code J7296 replaces discontinued procedure code Q9984. Procedure code J7296 may be reimbursed for female clients who are 10 through 55 years of age as follows:

- To PA, NP, CNS, physician, CNM, federally qualified health center (FQHC), family planning clinic, and RHC providers for services rendered in the office setting.
- To FQHC, hospital, family planning clinic, and RHC providers for services rendered in the outpatient hospital setting.

Procedure code J7296 is limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Z30011 | Z30013 | Z30014 | Z30015 | Z30016 | Z30017 | Z30018 | Z3002 | Z3009 | Z302 |
| Z3040 | Z3041 | Z3042 | Z30430 | Z30431 | Z30432 | Z30433 | Z3044 | Z3045 | Z3046 |
| Z3049 | Z308 | Z309 | Z9851 | Z9852 | | | | | |

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook*, subsection 2.2.2.1, "FQHC Reimbursement for Other Family Planning Office or Outpatient Visits," subsection 2.2.2.2, "RHC Reimbursement for Other Family Planning Office or Outpatient Visits," and subsection 2.2.5.4, "Immediate Postpartum Insertion of IUDs and Implantable Contraceptive Capsules," and the *Clinics and Other Outpatient Facility Services Handbook*, subsection 4.4.1, "Claims Information," and subsection 7.2.1.4, "Family Planning Services," for additional information.

## Hearing Devices

| Added Procedure Codes | |
|---|---|
| L8625 | L8694 |

***Limitations for added procedure codes:*** Procedure codes L8625 and L8694 may be reimbursed with prior authorization as follows:

- To home health DME and DME providers for services rendered in the office and home settings.
- To ASC providers for services rendered in the outpatient hospital setting.

Procedure code L8694 may be reimbursed for clients who are 5 years of age and older.

Procedure code L8694 will be denied when billed by any provider for the same date of service as procedure code L8690.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook,* subsection 3.2.3, "Bone-Anchored Hearing Aid (BAHA)," for additional information.

## Injections - Immune Globulins

| Added Procedure Code |
|---|
| J1555 |

***Limitations for added procedure code:*** Procedure code J1555 may be reimbursed as follows:

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

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* subsection 9.2.38.22, "Immune Globulin," for additional information.

## Inotuzumab ozogamicin (Besponsa®)

| Added Procedure Code |
|---|
| C9028 |

***Limitations for added procedure code:*** Procedure code C9028 requires prior authorization and may be covered when all of the following criteria is met:

- The client has a diagnosis of precursor B-cell acute lymphoblastic leukemia (ALL) that is refractory or in relapse.
- The client is 18 years of age or older.
- The prescriber agrees to monitor the client for signs and symptoms of hepatic veno-occlusive disease (VOD) during treatment of Besponsa.
- The treatment has been prescribed by an oncologist or in consultation with an oncologist.

## Obstetric Services

| Added Procedure Codes | |
|---|---|
| J1726 | J1729 |
| **Discontinued Procedure Codes** | |
| J1725 | |

***Limitations for added procedure codes:*** Procedure codes J1726 and J1729 may be reimbursed for female clients who are 10 through 55 years of age as follows:

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

Reimbursement for procedure codes J1726 and J1729 is limited to diagnosis codes O09211, O09212, O09213, and O09219. Modifier U1 is no longer required when submitting a claim for the compounded version of hydroxyprogesterone caproate.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Gynecological, Obstetrics, And Family Planning Title XIX Services Handbook* subsection 4.1.12, "Hydroxyprogesterone Caproate," for additional information.

## Pathology and Laboratory Services - Microbiology

| Added Procedure Codes | | | |
|---|---|---|---|
| 86794 | 87634 | 87662 | |
| **Discontinued Procedure Codes** | | | |
| 87277 | 87470 | 87477 | 87515 |

***Limitations for added procedure codes:*** Procedure codes 86794, 87634, and 87662 may be reimbursed as follows:

- To PA, NP, CNS, CNM, 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 codes 86794, 87634, and 86772 may be reimbursed once per day by the same provider.

When billing for Zika virus testing, providers must use procedure codes 86794 and 87662.

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

## Pathology and Laboratory Services – Urinalysis/Chemistry

| Discontinued Procedure Codes | |
|---|---|
| 83499 | 84061 |

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Radiology and Laboratory Services Handbook* subsection 2.2.16, "Urinalysis and Chemistry," for additional information.

## Physical, Occupational, and Speech Therapy – Children (Acute and Chronic)

| Added Procedure Code |
|---|
| 97763 |
| **Discontinued Procedure Code** |
| 97762 |

***Limitations for added procedure code:*** Procedure code 97763 requires prior authorization and may be reimbursed for clients who are birth through 20 years of age as follows:

- To early childhood intervention (ECI), physician, podiatrist, physical therapist, physical therapy group, and occupational therapist providers for services rendered in the office setting.
- To ECI, physical therapist, physical therapy group, occupational therapist, and home health agency providers for services rendered in the home, prescribed pediatric extended care center (PPECC), and "other location" settings.

- To physician, outpatient hospital/clinic, and outpatient rehabilitation center (includes comprehensive outpatient rehabilitation facility [CORF] and outpatient rehabilitation facility [ORF]) providers for services rendered in the outpatient hospital setting.

Procedure code 97763 must be submitted with modifier GO or GP.

A therapy evaluation or re-evaluation will be denied when billed by any provider on the same date of service as procedure code 97763.

Procedure code 97763 is payable as a 15-minute unit. All time-based physical therapy and occupational therapy treatment procedure codes are cumulatively limited to four units (one hour) per date of service, per discipline.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook,* subsection 5, "Children's Therapy Services, Clients birth through 20 years of age," for additional information.

## Pulmonary Function Studies

| **Added Procedure Codes** | |
|---|---|
| 94617 | 94618 |
| **Discontinued Procedure Code** | |
| 94620 | |

***Limitations for added procedure codes:*** Procedure codes 94617 and 94618 may be reimbursed as follows:

- The total component may be reimbursed:
  - To PA, NP, CNS, physician, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To PA, NP, CNS, and hospital providers for services rendered in the outpatient hospital setting.
- The professional component may be reimbursed:
  - To PA, NP, CNS, and physician providers for services rendered in the office setting.
  - To physician providers for services rendered in the inpatient and outpatient hospital settings.
- The technical component may be reimbursed:
  - To PA, NP, CNS, physician, radiation therapy center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To radiation therapy center providers for services rendered in the outpatient hospital setting.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Inpatient and Outpatient Hospital Services Handbook,* subsection 4.2.20.4, "Pulmonary Function Studies," for additional information.

## Renal Dialysis Services

| **Added Procedure Codes** | | | |
|---|---|---|---|
| 71045 | 71046 | 71047 | 71048 |
| **Discontinued Procedure Codes** | | | |
| 71010 | 71020 | | |

***Limitations for added procedure codes:*** The added procedure codes are considered necessary, nonroutine tests to be performed every six months. They must be billed separately from the dialysis charge when performed in the chronic renal disease (CRD) facility. All nonroutine radiology tests beyond the recommended frequencies require medical justification.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Clinics and Other Outpatient Facility Services Handbook* subsection 6.2.9.2, "In-Facility Dialysis-Nonroutine Laboratory," and subsection 6.2.9.3 "CAPD Laboratory" for additional information.

## Screening and Diagnostic Studies of the Breast

| Discontinued Procedure Codes | | |
|---|---|---|
| G0202 | G0204 | G0206 |

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* subsection 9.2.14.4, "Mammography (Screening and Diagnostic Studies of the Breast)," for additional information.

## Stereotactic Radiosurgery

| Discontinued Procedure Code |
|---|
| 77422 |

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical and Nursing Specialists, Physicians, and Physician Assistants Services Handbook*, subsection 9.2.60.2.1, "Prior Authorization for Stereotactic Radiosurgery," for additional information.

## Therapeutic Apheresis

| Discontinued Procedure Code |
|---|
| 36515 |

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Medical And Nursing Specialists, Physicians, And Physician Assistants Handbook* subsection 9.2.71, "Therapeutic Apheresis," for additional information.

## Tisagenlecleucel (Kymriah®)

| Added Procedure Code |
|---|
| Q2040 |

***Limitations for added procedure code:*** Procedure code Q2040 requires prior authorization and may be covered when all of the following criteria is met:

- The client has a diagnosis of precursor B-cell acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.
- The client is younger than 26 years of age.
- The client does not have an active infection or inflammatory disorder.

- The health-care facility has enrolled in the Kymriah Risk Evaluation and Mitigation Strategies (REMS) and training has been given to the provider on the management of cytokine release syndrome (CRS) and neurological toxicities.
- The treatment has been prescribed by an oncologist or in consultation with an oncologist.

## Tuberculosis Services

| Added Procedure Codes | | | | | |
|---|---|---|---|---|---|
| 71045 | 71046 | 71047 | 71048 | | |
| **Discontinued Procedure Codes** | | | | | |
| 71010 | 71020 | 71021 | 71022 | 71030 | 71035 |

***Limitations for added procedure codes:*** Procedure codes 71045, 71046, 71047, and 71048 may be reimbursed to tuberculosis clinic providers for services rendered in the office setting.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Clinics and Other Outpatient Facility Services Handbook* subsection 8.2.2, "Ancillary Services," for additional information.

## Vaccines and Toxoids

| Added Procedure Code |
|---|
| 90756 |

***Limitations for added procedure codes:*** Procedure code 90756 may be reimbursed for clients who are 4 years of age and older as follows:

- To PA, NP, CNS, physician, pharmacist, CNM, pharmacy, 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 and "other location" settings.
- To hospital providers for services rendered in the outpatient hospital setting.
- To FQHC and Texas Health Steps providers for Texas Health Steps services rendered in the office, home, outpatient, and "other location" settings.

Procedure code 90756 is available through the Texas Vaccines for Children (TVFC) program.

**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 (Vaccines/Toxoids)," and the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.34.1, "Administration Fee," subsection 9.2.35.2, "Vaccine and Toxoid Procedure Codes," and subsection 9.2.36, "Immunizations for Clients Who Are 21 Years of Age and Older," 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" table located on page 28 of this bulletin.

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

## HOME HEALTH AND COMPREHENSIVE CARE PROGRAM (CCP) PROVIDERS

### Home Health and CCP Services Benefit Changes

The following Texas Medicaid Home Health and CCP services benefit changes have been made to support the 2018 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2018. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

#### Early Childhood Intervention (ECI) Services – CCP

| Added Procedure Code |
|---|
| 97763 |
| **Discontinued Procedure Code** |
| 97762 |

***Limitations for added procedure code:*** Procedure code 97763 with modifier GO or GP may be reimbursed for clients who are 35 months of age and younger to ECI providers in the office, home, prescribed pediatric extended care center (PPECC), and "other location" settings.

Procedure code 97763 will deny if billed on the same date of service as an evaluation service.

When procedure code 97763 and a re-evaluation within the same discipline are billed on the same date of service, the re-evaluation procedure code will deny.

Procedure code 97763 is payable as a 15-minute unit.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook* subsection 2.8, "Early Childhood Intervention (ECI) Services," for additional information.

#### Mobility Aids – Home Health

| Added Procedure Codes | |
|---|---|
| E0953 | E0954 |

***Limitations for added procedure codes:*** Procedure codes E0953 and E0954 require prior authorization. Procedure code E0953 may be reimbursed as follows:

- To home health durable medical equipment (DME) and medical supplier (DME) providers for services rendered in the office and "other location" settings.
- To home health DME, medical supplier (DME), and specialized/custom wheeled mobility system providers for services rendered in the home setting.

Procedure code E0954 is limited to 2 per year, and may be reimbursed as follows:

- To home health DME, medical supplier (DME), and specialized/custom wheeled mobility system 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 2.2.16.26, "Accessories, Modifications, Adjustments and Repairs," and subsection 2.2.16.28, "Procedure Codes and Limitations for Mobility Aids," for additional information.

## Orthoses - CCP

| Added Procedure Code |
|---|
| L3761 |

***Limitations for added procedure code:*** Procedure code L3761 may be reimbursed as follows:

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

Procedure code L3761 requires prior authorization, and may be reimbursed for clients who are birth through 20 years of age.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment Handbook* subsection 2.2.18, "Orthotic Services (CCP)," for additional information.

## Prostheses - CCP

| Added Procedure Code |
|---|
| L7700 |

***Limitations for added procedure code:*** Procedure code L7700 may be reimbursed as follows:

- To medical supplier (DME) and prosthetist providers for services rendered in the home setting.

Procedure code L7700 requires prior authorization, and may be reimbursed for clients who are birth through 20 years of age.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Durable, Medical Equipment Handbook* subsection 2.2.19, "Prosthetic Services," for additional information. ■

# TEXAS HEALTH STEPS DENTAL PROVIDERS

## Texas Health Steps Dental Services Benefit Changes

The following Texas Health Steps dental services benefit changes have been made to support the 2018 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2018. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

### Texas Health Steps Therapeutic Dental Services

| Added Procedure Codes | | | | | |
|---|---|---|---|---|---|
| D5511 | D5512 | D5611 | D5612 | D9222 | D9239 |
| **Discontinued Procedure Codes** | | | | | |
| D5510 | D5610 | D5620 | | | |

***Limitations for added procedure codes:*** Procedure codes D5511 and D5512 may be reimbursed for clients who are 3 through 20 years of age to Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure codes D5611 and D5612 may be reimbursed for clients who are 3 through 20 years of age to federally qualified health center (FQHC), Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient, and outpatient hospital settings.

### Procedure Code D9222

Procedure code D9222 may be reimbursed for clients who are 1 through 20 years of age to Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient, and outpatient hospital settings.

For clients who are 6 years of age and younger, procedure code D9222 requires prior authorization.

**Note:** *Prior authorization requests that were approved before January 1, 2018, for procedure code D9223, will be automatically updated to include procedure code D9222 for the first 15 minutes of anesthesia. Prior authorization requests received on or after January 1, 2018, must include both procedure codes (procedure code D9222 for the first 15 minutes, and procedure code D9223 for each subsequent 15-minute increment).*

Procedure code D9222 will be limited to one per day and once per 6 calendar months, any provider.

Procedure codes D9222 and D9223 will be limited to a combined maximum of 3 hours per day. Add-on procedure code D9223 must be billed in conjunction with primary procedure code D9222, same provider.

**Note:** *Add-on procedure code D9223 will not be reimbursed until procedure code D9222 has completed the rate hearing process and expenditures have been approved. Once expenditures are approved, TMHP will automatically reprocess the affected claims.*

Procedure code D9222 will be denied if submitted for the same date of service as procedure code D9248.

Providers must have a Level 4 permit, a Texas State Board of Dental Examiners (TSBDE) portability permit, and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill an enhanced rate for procedure code D9222.

Providers who do not have the TSBDE portability permit and proof of anesthesiology residency on file with TMHP will still be eligible for reimbursement.

### Procedure Code D9239

Procedure code D9239 may be reimbursed for clients who are 1 through 20 years of age to Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure code D9239 will be limited to one per day, any provider.

Procedure codes D9239 and D9243 will be limited to a combined maximum of 1.5 hours per day. Add-on procedure code D9243 must be billed in conjunction with primary procedure code D9239, same provider.

**Note:** *Add-on procedure code D9243 will not be reimbursed until procedure code D9239 has completed the rate hearing process and expenditures have been approved. Once expenditures are approved, TMHP will automatically reprocess the affected claims.*

Procedure code D9239 will be denied if submitted for the same date of service as procedure code D9222 or D9248.

Providers must have a minimum anesthesia permit level of 3 to be reimbursed for procedure code D9239.

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Children's Services Handbook* subsections 4.2.24, "Dental Anesthesia," and 4.2.25, "Dental Therapy Under General Anesthesia," for additional information. ■

## STATE FUNDED FAMILY PLANNING PROGRAM (FPP) PROVIDERS

## Family Planning Program Services Benefit Changes

The 2018 Healthcare Common Procedure Coding System (HCPCS) updates including added procedure codes for the Family Planning Program are included in the HCPCS tables in the "All Code Changes: Added, Revised, Replacement, and Discontinued" section of this bulletin beginning on page 28. ■

## HEALTHY TEXAS WOMEN (HTW) PROGRAM PROVIDERS

## Healthy Texas Women Program Services Benefit Changes

The following HTW benefit changes have been made to support the 2018 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2018. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

### Healthy Texas Women

| Added Procedure Codes | | | | | | | |
|---|---|---|---|---|---|---|---|
| 71045 | 71046 | 74018 | 74019 | J7296 | | | |
| **Discontinued Procedure Codes** | | | | | | | |
| 71010 | 71020 | 74000 | 74010 | G0202 | G0204 | G0206 | Q9984 |

***Limitations for added procedure codes:*** Procedure codes 71045 and 71046 may be reimbursed as follows:

- The total component may be reimbursed:

  - To physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), physician, certified nurse midwife (CNM), radiation therapy center, hospital, nephrology (hemodialysis, renal dialysis), renal dialysis facility, portable X-ray supplier, radiological lab, physiological lab, and hospital-based rural health clinic (RHC) providers for services rendered in the office setting.
  - To radiation therapy center, hospital, nephrology (hemodialysis, renal dialysis), renal dialysis facility, portable X-ray supplier, radiological lab, physiological lab, and hospital-based RHC providers for services rendered in the outpatient hospital and nursing home (skilled nursing facility, intermediate care facility, or extended care facility) settings.
- The professional component may be reimbursed to PA, NP, CNS, physician, certified nurse midwife, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office, outpatient hospital, or nursing home (skilled nursing facility, intermediate care facility, or extended care facility) setting.
- The technical component may be reimbursed:
  - To PA, NP, CNS, physician, CNM, radiation therapy center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the nursing home (skilled nursing facility, intermediate care facility, or extended care facility) setting.

Procedure codes 74018 and 74019 may be reimbursed as follows:

- The total component may be reimbursed:
  - To PA, NP, CNS, physician, radiation therapy center, family planning clinic, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To radiation therapy center, and hospital providers for services rendered in the outpatient hospital setting.
- The professional component may be reimbursed:
  - To PA, NP, CNS, and physician providers for services rendered in the office setting.
  - To physician providers for services rendered in the inpatient and outpatient hospital settings.
- The technical component may be reimbursed:
  - To PA, NP, CNS, physician, radiation therapy center, portable X-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting.
  - To radiation therapy center providers for services rendered in the outpatient hospital setting.

Procedure code J7296 replaces discontinued procedure code Q9984. Procedure code J7296 may be reimbursed for HTW clients who are 15 through 44 years of age as follows:

- To PA, NP, CNS, physician, CNM, federally qualified health center (FQHC), family planning clinic, and RHC providers for services rendered in the office setting.
- To FQHC, hospital, family planning clinic, and RHC providers for services rendered in the outpatient hospital setting.

Procedure code J7296 is limited to the following diagnosis codes:

| Diagnosis Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Z30011 | Z30013 | Z30014 | Z30015 | Z30016 | Z30017 | Z30018 | Z3002 | Z3009 | Z302 |
| Z3040 | Z3041 | Z3042 | Z30430 | Z30431 | Z30432 | Z30433 | Z3044 | Z3045 | Z3046 |
| Z3049 | Z308 | Z309 | Z9851 | Z9852 | | | | | |

**Refer to:** The *Texas Medicaid Provider Procedures Manual, Women's Health Services Handbook* subsection 2.3, "Services, Benefits, Limitations and Prior Authorization," for additional information. ■

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

## CSHCN Services Program Updates

The 2018 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 28. The 2018 HCPCS deletions and replacements are effective January 1, 2018, for dates of service on or after January 1, 2018, 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 28 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, 2018, the 2018 HCPCS discontinued procedure codes are no longer reimbursed by the CSHCN Services Program. Unless otherwise indicated on page 28 of this bulletin, providers who have received authorizations or prior authorizations for dates of service that occur on, after, or encompass January 1, 2018, 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 at 1-800-568-2413. ■

## CSHCN Services Program Benefit Changes

The following CSHCN Services Program benefit changes have been made to support the 2018 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2018. For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-925-9126.

The policy articles below contain the following information:

- ***Discontinued:*** Discontinued procedure codes are no longer reimbursed after December 31, 2017.
- ***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.

**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.*

## Allergy Testing and Desensitization

| Added Procedure Code |
|---|
| 86008 |

*Limitations for added procedure code:* Procedure code 86008 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.

Procedure code 86008 will be limited to 30 allergens per rolling year, any provider. Prior authorization is not required unless the limit is exceeded.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 31.2.3, "Allergy Services," for additional information.

## Anesthesia Services

| Added Procedure Codes | | | | |
|---|---|---|---|---|
| 00731 | 00732 | 00811 | 00812 | 00813 |
| **Discontinued Procedure Codes** | | | | |
| 00740 | 00810 | 01180 | 01190 | 01682 |

***Limitations for added procedure codes:*** Procedure codes 00731, 00732, 00811, 00812, and 00813 may be reimbursed to certified registered nurse anesthetist and physician providers for services rendered in the office, inpatient, and outpatient hospital settings.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 31.2.5, "Anesthesia Services," for additional information.

## Bone Anchored Hearing Devices

| Added Procedure Code |
|---|
| L8694 |

***Limitations for added procedure code:*** Procedure code L8694 may be reimbursed with prior authorization as follows:

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

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

Procedure code L8694 will be denied if billed with the same date of service as procedure code L8690.

**Refer to:** The *CSHCN Services Program Provider Manual*, subsection 20.3.1, "Bone-Anchored Hearing Aid (BAHA)," for additional information.

## Cochlear Implants

| Added Procedure Code |
|---|
| L8625 |

***Limitations for added procedure code:*** Procedure code L8625 may be reimbursed with prior authorization as follows:

- To home health DME, medical supplier (DME), and custom DME providers for services rendered in the office setting.
- To ambulatory surgical center (ASC) providers for services rendered in the outpatient hospital setting.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 20.3.2.1, "Device, Implantation and Supplies," for additional information.

## Dental – Therapeutic Services

| Added Procedure Codes | | | | | |
|---|---|---|---|---|---|
| D5511 | D5512 | D5611 | D5612 | D9222 | D9239 |
| **Discontinued Procedure Codes** | | | | | |
| D5510 | D5610 | D5620 | | | |

***Limitations for added procedure codes:*** Procedure codes D5511 and D5512 require prior authorization and may be reimbursed for clients who are 1 year of age and older to dentist providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure codes D5611 and D5612 may be reimbursed for clients who are 3 years of age and older to dentist and federally qualified health center (FQHC) providers for services rendered in the office, inpatient, and outpatient hospital settings.

### Procedure Code D9222

Procedure code D9222 may be reimbursed to dentist providers for services rendered in the office, inpatient, and outpatient hospital settings.

For clients who are 6 years of age or younger, procedure code D9222 requires prior authorization.

**Note:** *Prior authorization requests that were approved before January 1, 2018, for procedure code D9223, will be automatically updated to include procedure code D9222 for the first 15 minutes of anesthesia. Prior authorization requests received on or after January 1, 2018, must include both procedure codes (procedure code D9222 for the first 15 minutes, and procedure code D9223 for each subsequent 15 minute increment).*

Procedure code D9222 will be limited to one per day and once per 6 calendar months, any provider.

Procedure codes D9222 and D9223 will be limited to a combined maximum of 3 hours per day. Add-on procedure code D9223 must be billed in conjunction with primary procedure code D9222, same provider.

**Note:** *Add-on procedure code D9223 will not be reimbursed until procedure code D9222 has completed the rate hearing process and expenditures have been approved. Once expenditures are approved, TMHP will automatically reprocess the affected claims.*

Procedure code D9222 will be denied if submitted for the same date of service as procedure code D9248.

Procedure code D9920 will be denied if submitted for the same date of service as procedure code D9222.

Providers must have a Level 4 permit, a Texas State Board of Dental Examiners (TSBDE) portability permit, and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure code D9222.

### Procedure Code D9239

Procedure code D9239 may be reimbursed to dentist providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure code D9239 will be limited to one per day, any provider.

Procedure codes D9239 and D9243 will be limited to a combined maximum of 1.5 hours per day. Add-on procedure code D9243 must be billed in conjunction with primary procedure code D9239, same provider.

**Note:** *Add-on procedure code D9243 will not be reimbursed until procedure code D9239 has completed the rate hearing process and expenditures have been approved. Once expenditures are approved, TMHP will automatically reprocess the affected claims.*

Procedure code D9239 will be denied if submitted for the same date of service as procedure code D9222 or D9248.

Procedure code D9920 will be denied if submitted for the same date of service as procedure code D9239.

Providers must have a minimum anesthesia permit level of 3 to be reimbursed for procedure code D9239.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsections 14.2.5.2, "Anesthesia Requirements for Clients who are Six Years of Age or Younger," 14.2.5.7, "Prosthodontics (Removable) and Maxillofacial Prosthetics," and 14.2.5.10, "Dental Anesthesia," for additional information.

## Doctor of Dentistry Services as a Limited Physician

| Added Procedure Codes | |
|---|---|
| 15730 | 15733 |
| **Discontinued Procedure Code** | |
| 15732 | |

***Limitations for added procedure codes:*** Procedure code 15730 may be reimbursed as follows:

- To physician and oral maxillofacial surgeon providers for services rendered in the inpatient and outpatient hospital settings.
- To ASC providers for services rendered in the outpatient hospital setting.

Procedure code 15733 may be reimbursed as follows:

- To physician and dentist providers for services rendered in the office, inpatient, and outpatient hospital settings.
- To ASC providers for services rendered in the outpatient hospital setting.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 14.2.7.2, "Surgery," for additional information.

## Durable Medical Equipment

| Added Procedure Codes | |
|---|---|
| E0953 | E0954 |

***Limitations for added procedure codes:*** Procedure codes E0953 and E0954 require prior authorization and may be reimbursed to home health DME, medical supplier (DME), and custom DME providers for services rendered in the home setting.

Procedure code E0953 is limited to 1 per 3 years.

Procedure code E0954 is limited to 2 per year.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 17.3.19, "Wheelchairs," for additional information.

## Home Health Services

| Added Procedure Code |
|---|
| 97763 |
| **Discontinued Procedure Code** |
| 97762 |

***Limitations for added procedure code:*** Procedure code 97763 will be denied if billed on the same date of service as procedure code G0151 or G0152, by any provider.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 21.3.4.2, "Limitations for Occupational Therapy (OT) and Physical Therapy (PT)," for additional information.

## Immune Globulins

| Added Procedure Code |
|---|
| J1555 |

***Limitations for added procedure code:*** Procedure code J1555 may be reimbursed as follows:

- To physician assistant (PA), APRN, and physician providers for services rendered in the office setting.
- To medical supplier (DME) providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 31.2.25.12, "Immune Globulins," for additional information.

## Medications - Blood Factor Products

| Added Procedure Codes | |
|---|---|
| J7210 | J7211 |
| **Discontinued Procedure Code** | |
| C9140 | |

***Limitations for added procedure codes:*** Procedure code J7210 replaces discontinued procedure code C9140. Procedure codes J7210 and J7211 may be reimbursed as follows:

- To PA, APRN and physician providers for services rendered in the office setting.
- To medical supplier (DME) and hemophilia factor providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Procedure codes J7210 and J7211 are limited to the following diagnosis codes: D66, D67, D681, D682, D68311, D688, D689.

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

## Orthoses and Prostheses

| Added Procedure Codes | |
|---|---|
| L3761 | L7700 |

***Limitations for added procedure codes:*** Procedure code L3761 may be reimbursed as follows:

- To custom DME, medical supplier (DME), orthotist, and prothetist providers for services rendered in the home setting.
- To hospital providers for services rendered in the outpatient hospital setting.

Procedure code L7700 may be reimbursed to medical supplier (DME), orthotist, and prothetist providers for services rendered in the home setting.

Procedure codes L3761 and L7700 require prior authorization.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 28.3, "Orthoses and Related Services," and subsection 28.4, "Prostheses and Related Services," for additional information.

## Pathology and Laboratory Services – Microbiology

| Added Procedure Codes | | | |
|---|---|---|---|
| 86794 | 87634 | 87662 | |
| **Discontinued Procedure Codes** | | | |
| 87277 | 87470 | 87477 | 87515 |

***Limitations for added procedure codes:*** Procedure code 86794 may be reimbursed as follows:

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

Procedure codes 87634 and 87662 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.

Procedure codes 86794, 87634, and 87662 may be reimbursed once per day by the same provider.

When billing for Zika virus testing, providers must use procedure codes 86794 and 87662.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 25.2.11, "Microbiology," for additional information.

## Pathology and Laboratory Services – Urinalysis/Chemistry

| Discontinued Procedure Codes | |
|---|---|
| 83499 | 84061 |

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 25.2.14, "Urinalysis and Chemistry," for additional information.

## Physical Medicine and Rehabiliation

| Added Procedure Code |
|---|
| 97763 |
| **Discontinued Procedure Code** |
| 97762 |

***Limitations for added procedure code:*** Procedure code 97763 requires prior authorization and may be reimbursed as follows:

- To physician, physical therapist, and occupational therapist providers for services rendered in the office setting.
- To physical therapist, occupational therapist, and home health agency providers for services rendered in the home setting.
- To physician, physical therapist, occupational therapist, home health agency, hospital, and rehabilitation center providers for services rendered in the outpatient hospital setting.

Procedure code 97763 must be submitted with modifier GO or GP.

Procedure code 97763 will be denied if billed on the same date of service as procedure code G0151 or G0152, by any provider.

A therapy evaluation or re-evaluation will be denied when billed by any provider on the same date of service as procedure code 97763.

Procedure code 97763 is payable as a 15-minute unit. All time-based physical therapy and occupational therapy treatment procedure codes are cumulatively limited to four units (one hour) per date of service, per discipline.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 30.2.2, "Physical Therapy (PT), and Occupational Therapy (OT)," and subsection 30.2.3, "Time-based PT and OT Treatment Codes," for additional information.

## Radiation Therapy Services

| Added Procedure Code |
|---|
| 55874 |
| **Discontinued Procedure Code** |
| 77422 |

***Limitations for added procedure code:*** Procedure code 55874 may be reimbursed for services rendered to male clients as follows:

- To physician providers for services rendered in the office, inpatient, and outpatient hospital settings.
- To ASC providers for services rendered in the outpatient hospital setting.

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 34.2.2, "Clinical Brachytherapy," subsection 34.2.6, "Proton-Beam and Neutron-Beam Delivery," and subsection 34.2.7, "Radiation Treatment Management and Delivery," for additional information.

## Therapeutic Apheresis

| Discontinued Procedure Code |
|---|
| 36515 |

**Refer to:** The *CSHCN Services Program Provider Manual,* subsection 31.2.40, "Therapeutic Apheresis," for additional information.

## Vaccines/Toxoids

| Added Procedure Code |
|---|
| 90756 |

***Limitations for added procedure code:*** Procedure code 90756 may be reimbursed as follows:

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

Procedure code 90756 is reimbursed to clients who are 4 years of age and older.

**Refer to:** The *CSHCN Services Program Provider Manual*, section 31.2.24, "Immunizations (Vaccines and Toxoids)," for additional information. ■

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

## 2018 HCPCS Procedure Code Additions

The following is a list of new Healthcare Common Procedure Coding System (HCPCS) procedure codes:

| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 7 | 00731 | * | * | NC | NC | | MD, CSHCN |
| 7 | 00732 | * | * | NC | NC | | MD, CSHCN |
| 7 | 00811 | * | * | NC | NC | | MD, CSHCN |
| 7 | 00812 | * | * | NC | NC | | MD, CSHCN |
| 7 | 00813 | * | * | NC | NC | | MD, CSHCN |
| 2 | 15730 | * | * | NC | NC | | MD, CSHCN |
| F | 15730 | * | * | NC | NC | | MD, CSHCN |
| 2 | 15733 | * | * | NC | NC | | MD, CSHCN |
| F | 15733 | * | * | NC | NC | | MD, CSHCN |
| 2 | 19294 | * | * | NC | NC | | |
| 2 | 20939 | * | * | NC | NC | | |
| 2 | 31241 | * | * | NC | NC | | |
| 2 | 31253 | * | * | NC | NC | | |
| F | 31253 | * | * | NC | NC | | |
| 2 | 31257 | * | * | NC | NC | | |
| F | 31257 | * | * | NC | NC | | |
| 2 | 31259 | * | * | NC | NC | | |
| F | 31259 | * | * | NC | NC | | |
| 2 | 31298 | * | * | NC | NC | | |
| F | 31298 | * | * | NC | NC | | |
| 2 | 32994 | NC | NC | NC | NC | | |
| F | 32994 | NC | NC | NC | NC | | |
| 2 | 33927 | NC | NC | NC | NC | | |
| 8 | 33927 | NC | NC | NC | NC | | |
| 2 | 33928 | NC | NC | NC | NC | | |
| 8 | 33928 | NC | NC | NC | NC | | |
| 2 | 33929 | NC | NC | NC | NC | | |
| 8 | 33929 | NC | NC | NC | NC | | |
| 2 | 34701 | * | * | NC | NC | | |
| 8 | 34701 | * | * | NC | NC | | |
| 2 | 34702 | * | * | NC | NC | | |

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit, Info = Procedure code is informational only, 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. HTW in the Benefits Changes column indicates that additional information is available in the HTW section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.

| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 8 | 34702 | * | * | NC | NC | | |
| 2 | 34703 | * | * | NC | NC | | |
| 8 | 34703 | * | * | NC | NC | | |
| 2 | 34704 | * | * | NC | NC | | |
| 8 | 34704 | * | * | NC | NC | | |
| 2 | 34705 | * | * | NC | NC | | |
| 8 | 34705 | * | * | NC | NC | | |
| 2 | 34706 | * | * | NC | NC | | |
| 8 | 34706 | * | * | NC | NC | | |
| 2 | 34707 | * | * | NC | NC | | |
| 8 | 34707 | * | * | NC | NC | | |
| 2 | 34708 | * | * | NC | NC | | |
| 8 | 34708 | * | * | NC | NC | | |
| 2 | 34709 | * | * | NC | NC | | |
| 8 | 34709 | * | * | NC | NC | | |
| 2 | 34710 | * | * | NC | NC | | |
| 8 | 34710 | * | * | NC | NC | | |
| 2 | 34711 | * | * | NC | NC | | |
| 8 | 34711 | * | * | NC | NC | | |
| 2 | 34712 | * | * | NC | NC | | |
| 8 | 34712 | * | * | NC | NC | | |
| 2 | 34713 | * | * | NC | NC | | |
| 8 | 34713 | * | * | NC | NC | | |
| 2 | 34714 | * | * | NC | NC | | |
| 8 | 34714 | * | * | NC | NC | | |
| 2 | 34715 | * | * | NC | NC | | |
| 8 | 34715 | * | * | NC | NC | | |
| 2 | 34716 | * | * | NC | NC | | |
| 8 | 34716 | * | * | NC | NC | | |
| 2 | 36465 | * | * | NC | NC | | |
| F | 36465 | * | * | NC | NC | | |
| 2 | 36466 | * | * | NC | NC | | |
| F | 36466 | * | * | NC | NC | | |
| 2 | 36482 | NC | NC | NC | NC | | |
| F | 36482 | NC | NC | NC | NC | | |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 2 | 36483 | NC | NC | NC | NC | | |
| 2 | 38222 | * | * | NC | NC | | |
| F | 38222 | * | * | NC | NC | | |
| 2 | 38573 | * | * | NC | NC | | |
| 8 | 38573 | * | * | NC | NC | | |
| F | 38573 | * | * | NC | NC | | |
| 2 | 43286 | * | * | NC | NC | | |
| 8 | 43286 | * | * | NC | NC | | |
| 2 | 43287 | * | * | NC | NC | | |
| 8 | 43287 | * | * | NC | NC | | |
| 2 | 43288 | * | * | NC | NC | | |
| 8 | 43288 | * | * | NC | NC | | |
| 2 | 55874 | * | * | NC | NC | | MD, CSHCN |
| F | 55874 | * | * | NC | NC | | MD, CSHCN |
| 2 | 58575 | * | * | NC | NC | | MD |
| 2 | 64912 | * | * | NC | NC | | |
| 8 | 64912 | * | * | NC | NC | | |
| F | 64912 | * | * | NC | NC | | |
| 2 | 64913 | * | * | NC | NC | | |
| 8 | 64913 | * | * | NC | NC | | |
| 4 | 71045 | * | * | * | * | | MD, HTW |
| D | 71045 | * | * | * | NC | | MD, HTW |
| I | 71045 | * | * | * | * | | MD, HTW |
| T | 71045 | * | * | * | * | | MD, HTW |
| 4 | 71046 | * | * | * | * | | MD, HTW |
| D | 71046 | * | * | * | NC | | MD, HTW |
| I | 71046 | * | * | * | * | | MD, HTW |
| T | 71046 | * | * | * | * | | MD, HTW |
| 4 | 71047 | * | * | NC | NC | | MD |
| D | 71047 | * | * | NC | NC | | MD |
| I | 71047 | * | * | NC | NC | | MD |
| T | 71047 | * | * | NC | NC | | MD |
| 4 | 71048 | * | * | NC | NC | | MD |
| D | 71048 | * | * | NC | NC | | MD |
| I | 71048 | * | * | NC | NC | | MD |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| T | 71048 | * | * | NC | NC | | MD |
| 4 | 74018 | * | * | * | * | | HTW |
| I | 74018 | * | * | * | NC | | HTW |
| T | 74018 | * | * | * | NC | | HTW |
| 4 | 74019 | * | * | * | * | | HTW |
| I | 74019 | * | * | * | NC | | HTW |
| T | 74019 | * | * | * | NC | | HTW |
| 4 | 74021 | * | * | NC | NC | | |
| I | 74021 | * | * | NC | NC | | |
| T | 74021 | * | * | NC | NC | | |
| 5 | 81105 | * | * | NC | NC | | |
| 5 | 81106 | * | * | NC | NC | | |
| 5 | 81107 | * | * | NC | NC | | |
| 5 | 81108 | * | * | NC | NC | | |
| 5 | 81109 | * | * | NC | NC | | |
| 5 | 81110 | * | * | NC | NC | | |
| 5 | 81111 | * | * | NC | NC | | |
| 5 | 81112 | * | * | NC | NC | | |
| 5 | 81120 | * | * | NC | NC | | |
| 5 | 81121 | * | * | NC | NC | | |
| 5 | 81175 | NC | NC | NC | NC | | |
| 5 | 81176 | NC | NC | NC | NC | | |
| 5 | 81230 | NC | NC | NC | NC | | |
| 5 | 81231 | NC | NC | NC | NC | | |
| 5 | 81232 | NC | NC | NC | NC | | |
| 5 | 81238 | * | * | NC | NC | | |
| 5 | 81247 | * | * | NC | NC | | |
| 5 | 81248 | * | * | NC | NC | | |
| 5 | 81249 | * | * | NC | NC | | |
| 5 | 81258 | * | * | NC | NC | | |
| 5 | 81259 | * | * | NC | NC | | |
| 5 | 81269 | * | * | NC | NC | | |
| 5 | 81283 | NC | NC | NC | NC | | |
| 5 | 81328 | NC | NC | NC | NC | | |
| 5 | 81334 | * | * | NC | NC | | |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 5 | 81335 | NC | NC | NC | NC | | |
| 5 | 81346 | NC | NC | NC | NC | | |
| 5 | 81361 | * | * | NC | NC | MD, CSHCN | |
| 5 | 81362 | * | * | NC | NC | MD, CSHCN | |
| 5 | 81363 | * | * | NC | NC | | |
| 5 | 81364 | * | * | NC | NC | | |
| 5 | 81448 | NC | NC | NC | NC | | |
| 5 | 81520 | NC | NC | NC | NC | | |
| 5 | 81521 | NC | NC | NC | NC | | |
| 5 | 81541 | NC | NC | NC | NC | | |
| 5 | 81551 | NC | NC | NC | NC | | |
| 5 | 86008 | * | * | NC | NC | | MD, CSHCN |
| 5 | 86794 | * | * | NC | NC | | MD, CSHCN |
| 5 | 87634 | * | * | NC | NC | | MD, CSHCN |
| 5 | 87662 | * | * | NC | NC | | MD, CSHCN |
| 1 | 90587 | NC | NC | NC | NC | | |
| S | 90587 | NC | NC | NC | NC | | |
| 1 | 90756 | * | * | NC | NC | | MD, CSHCN |
| S | 90756 | * | * | NC | NC | | MD |
| 1 | 93792 | NC | NC | NC | NC | | |
| 1 | 93793 | NC | NC | NC | NC | | |
| 5 | 94617 | * | * | NC | NC | | MD |
| I | 94617 | * | * | NC | NC | | MD |
| T | 94617 | * | * | NC | NC | | MD |
| 5 | 94618 | * | * | NC | NC | | MD |
| I | 94618 | * | * | NC | NC | | MD |
| T | 94618 | * | * | NC | NC | | MD |
| 1 | 95249 | NC | NC | NC | NC | | |
| 1 | 96573 | * | * | NC | NC | | |
| 1 | 96574 | * | * | NC | NC | | |
| 1 | 97127 | NC | NC | NC | NC | | |
| C | 97127 | NC | NC | NC | NC | | |
| 1 | 97763 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| C | 97763 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| 1 | 99483 | NC | NC | NC | NC | | |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 1 | 99484 | NC | NC | NC | NC | | |
| 1 | 99492 | NC | NC | NC | NC | | |
| 1 | 99493 | NC | NC | NC | NC | | |
| 1 | 99494 | NC | NC | NC | NC | | |
| 1 | C9014 | * | NC | NC | NC | | |
| 1 | C9015 | * | * | NC | NC | | |
| 1 | C9016 | * | * | NC | NC | | |
| 1 | C9024 | * | * | NC | NC | | |
| 1 | C9028 | * | * | NC | NC | MD | MD |
| 1 | C9029 | * | * | NC | NC | | |
| 1 | C9488 | NC | NC | NC | NC | | |
| 1 | C9492 | * | * | NC | NC | | |
| 1 | C9493 | * | | NC | NC | MD | |
| 2 | C9738 | * | * | NC | NC | | |
| 2 | C9745 | * | * | NC | NC | | |
| 2 | C9746 | * | NC | NC | NC | | |
| 2 | C9747 | NC | NC | NC | NC | | |
| 2 | C9748 | * | * | NC | NC | | |
| W | D0411 | NC | NC | NC | NC | | |
| W | D5511 | * | * | NC | NC | CSHCN | MD, CSHCN |
| W | D5512 | * | * | NC | NC | CSHCN | MD, CSHCN |
| W | D5611 | * | * | NC | NC | | MD, CSHCN |
| W | D5612 | * | * | NC | NC | | MD, CSHCN |
| W | D5621 | NC | NC | NC | NC | | |
| W | D5622 | NC | NC | NC | NC | | |
| W | D6096 | NC | NC | NC | NC | | |
| W | D6118 | NC | NC | NC | NC | | |
| W | D6119 | NC | NC | NC | NC | | |
| W | D7296 | NC | NC | NC | NC | | |
| W | D7297 | NC | NC | NC | NC | | |
| W | D7979 | NC | NC | NC | NC | | |
| W | D8695 | NC | NC | NC | NC | | |
| W | D9222 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| W | D9239 | * | * | NC | NC | | MD, CSHCN |
| W | D9995 | NC | NC | NC | NC | | |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| W | D9996 | NC | NC | NC | NC | | |
| J | E0953 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| J | E0954 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| 1 | G0511 | Info | Info | Info | Info | | |
| 1 | G0512 | Info | Info | Info | Info | | |
| 1 | G0513 | Info | Info | Info | Info | | |
| 1 | G0514 | Info | Info | Info | Info | | |
| 1 | G0515 | Info | Info | Info | Info | | |
| 2 | G0516 | * | NC | NC | NC | | |
| 2 | G0517 | * | NC | NC | NC | | |
| 2 | G0518 | * | NC | NC | NC | | |
| 1 | G9890 | Info | Info | Info | Info | | |
| 1 | G9891 | Info | Info | Info | Info | | |
| 1 | G9892 | Info | Info | Info | Info | | |
| 1 | G9893 | Info | Info | Info | Info | | |
| 1 | G9894 | Info | Info | Info | Info | | |
| 1 | G9895 | Info | Info | Info | Info | | |
| 1 | G9896 | Info | Info | Info | Info | | |
| 1 | G9897 | Info | Info | Info | Info | | |
| 1 | G9898 | Info | Info | Info | Info | | |
| 1 | G9899 | Info | Info | Info | Info | | |
| 1 | G9900 | Info | Info | Info | Info | | |
| 1 | G9901 | Info | Info | Info | Info | | |
| 1 | G9902 | Info | Info | Info | Info | | |
| 1 | G9903 | Info | Info | Info | Info | | |
| 1 | G9904 | Info | Info | Info | Info | | |
| 1 | G9905 | Info | Info | Info | Info | | |
| 1 | G9906 | Info | Info | Info | Info | | |
| 1 | G9907 | Info | Info | Info | Info | | |
| 1 | G9908 | Info | Info | Info | Info | | |
| 1 | G9909 | Info | Info | Info | Info | | |
| 1 | G9910 | Info | Info | Info | Info | | |
| 1 | G9911 | Info | Info | Info | Info | | |
| 1 | G9912 | Info | Info | Info | Info | | |
| 1 | G9913 | Info | Info | Info | Info | | |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 1 | G9914 | Info | Info | Info | Info | | |
| 1 | G9915 | Info | Info | Info | Info | | |
| 1 | G9916 | Info | Info | Info | Info | | |
| 1 | G9917 | Info | Info | Info | Info | | |
| 1 | G9918 | Info | Info | Info | Info | | |
| 1 | G9919 | Info | Info | Info | Info | | |
| 1 | G9920 | Info | Info | Info | Info | | |
| 1 | G9921 | Info | Info | Info | Info | | |
| 1 | G9922 | Info | Info | Info | Info | | |
| 1 | G9923 | Info | Info | Info | Info | | |
| 1 | G9924 | Info | Info | Info | Info | | |
| 1 | G9925 | Info | Info | Info | Info | | |
| 1 | G9926 | Info | Info | Info | Info | | |
| 1 | G9927 | Info | Info | Info | Info | | |
| 1 | G9928 | Info | Info | Info | Info | | |
| 1 | G9929 | Info | Info | Info | Info | | |
| 1 | G9930 | Info | Info | Info | Info | | |
| 1 | G9931 | Info | Info | Info | Info | | |
| 1 | G9932 | Info | Info | Info | Info | | |
| 1 | G9933 | Info | Info | Info | Info | | |
| 1 | G9934 | Info | Info | Info | Info | | |
| 1 | G9935 | Info | Info | Info | Info | | |
| 1 | G9936 | Info | Info | Info | Info | | |
| 1 | G9937 | Info | Info | Info | Info | | |
| 1 | G9938 | Info | Info | Info | Info | | |
| 1 | G9939 | Info | Info | Info | Info | | |
| 1 | G9940 | Info | Info | Info | Info | | |
| 1 | G9941 | Info | Info | Info | Info | | |
| 1 | G9942 | Info | Info | Info | Info | | |
| 1 | G9943 | Info | Info | Info | Info | | |
| 1 | G9944 | Info | Info | Info | Info | | |
| 1 | G9945 | Info | Info | Info | Info | | |
| 1 | G9946 | Info | Info | Info | Info | | |
| 1 | G9947 | Info | Info | Info | Info | | |
| 1 | G9948 | Info | Info | Info | Info | | |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 1 | G9949 | Info | Info | Info | Info | | |
| 1 | G9954 | Info | Info | Info | Info | | |
| 1 | G9955 | Info | Info | Info | Info | | |
| 1 | G9956 | Info | Info | Info | Info | | |
| 1 | G9957 | Info | Info | Info | Info | | |
| 1 | G9958 | Info | Info | Info | Info | | |
| 1 | G9959 | Info | Info | Info | Info | | |
| 1 | G9960 | Info | Info | Info | Info | | |
| 1 | G9961 | Info | Info | Info | Info | | |
| 1 | G9962 | Info | Info | Info | Info | | |
| 1 | G9963 | Info | Info | Info | Info | | |
| 1 | G9964 | Info | Info | Info | Info | | |
| 1 | G9965 | Info | Info | Info | Info | | |
| 1 | G9966 | Info | Info | Info | Info | | |
| 1 | G9967 | Info | Info | Info | Info | | |
| 1 | G9968 | Info | Info | Info | Info | | |
| 1 | G9969 | Info | Info | Info | Info | | |
| 1 | G9970 | Info | Info | Info | Info | | |
| 1 | G9974 | Info | Info | Info | Info | | |
| 1 | G9975 | Info | Info | Info | Info | | |
| 1 | G9976 | Info | Info | Info | Info | | |
| 1 | G9977 | Info | Info | Info | Info | | |
| 1 | J0565 | * | * | NC | NC | | |
| 1 | J0604 | NC | NC | NC | NC | | |
| 1 | J0606 | NC | NC | NC | NC | | |
| 1 | J1428 | * | NC | NC | NC | MD | MD |
| 1 | J1555 | * | * | NC | NC | | MD, CSHCN |
| 1 | J1627 | * | * | NC | NC | | |
| 1 | J1726 | * | NC | NC | * | | MD |
| 1 | J1729 | * | NC | NC | * | | MD |
| 1 | J2326 | * | | NC | NC | MD | MD |
| 1 | J2350 | * | * | NC | NC | | |
| 1 | J3358 | * | * | NC | NC | | |
| 1 | J7210 | * | * | NC | NC | | MD, CSHCN |
| 1 | J7211 | * | * | NC | NC | | MD, CSHCN |

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| TOS | Procedure Code | Medicaid Allowable | CSHCN Allowable | HTW Allowable | FPP Allowable | Authorization Requirements | Benefit Changes |
|---|---|---|---|---|---|---|---|
| 1 | J7296 | * | NC | * | * | | MD, HTW |
| 1 | J7345 | NC | NC | NC | NC | | |
| 1 | J9022 | * | * | NC | NC | | |
| 1 | J9023 | * | | NC | NC | | |
| 1 | J9203 | * | * | NC | NC | | |
| 1 | J9285 | * | * | NC | NC | | |
| 9 | K0553 | NC | NC | NC | NC | | |
| J | K0553 | NC | NC | NC | NC | | |
| L | K0553 | NC | NC | NC | NC | | |
| 9 | K0554 | NC | NC | NC | NC | | |
| J | K0554 | NC | NC | NC | NC | | |
| L | K0554 | NC | NC | NC | NC | | |
| 9 | L3761 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| 9 | L7700 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| 9 | L8625 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| J | L8625 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| 9 | L8694 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| J | L8694 | * | * | NC | NC | MD, CSHCN | MD, CSHCN |
| 0 | P9073 | NC | NC | NC | NC | | |
| 0 | P9100 | NC | NC | NC | NC | | |
| J | Q0477 | * | NC | NC | NC | MD | |
| 1 | Q2040 | * | NC | NC | NC | MD | MD |
| 9 | Q4176 | NC | NC | NC | NC | | |
| 9 | Q4177 | NC | NC | NC | NC | | |
| 9 | Q4178 | NC | NC | NC | NC | | |
| 9 | Q4179 | NC | NC | NC | NC | | |
| 9 | Q4180 | NC | NC | NC | NC | | |
| 9 | Q4181 | NC | NC | NC | NC | | |
| 9 | Q4182 | NC | NC | NC | NC | | |

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***Note:*** *All new, revised, and discontinued 2018 HCPCS procedure codes are effective for dates of service on or after January 1, 2018. 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:

| Medical Procedure Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 0011U | 0472T | 0473T | 0475T | 0476T | 0477T | 0478T | 0481T | 0485T | 0486T |
| 0487T | 0488T | 0493T | 0495T | 0496T | 0497T | 0498T | 0501T | 0502T | 0503T |
| 0504T | | | | | | | | | |
| **Surgical Procedure Codes** | | | | | | | | | |
| 0474T | 0479T | 0480T | 0483T | 0484T | 0489T | 0490T | 0491T | 0492T | 0494T |
| 0499T | | | | | | | | | |
| **Radiological Procedure Codes** | | | | | | | | | |
| 0469T | 0470T | 0471T | 0482T | | | | | | |
| **Laboratory Procedure Codes** | | | | | | | | | |
| 0001U | 0002U | 0003U | 0004U | 0005U | 0006U | 0007U | 0008U | 0009U | 0010U |
| 0012U | 0013U | 0014U | 0015U | 0016U | 0017U | 0018U | 0019U | 0020U | 0021U |
| 0022U | 0023U | 0500T | | | | | | | |
| **Professional Component Procedure Codes** | | | | | | | | | |
| 0469T | 0470T | 0471T | 0485T | 0486T | | | | | |
| **Technical Component Procedure Codes** | | | | | | | | | |
| 0469T | 0470T | 0471T | 0485T | 0486T | | | | | |

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. ■

## Discontinued Procedure Codes

The 2018 HCPCS discontinued procedure codes are no longer reimbursed after December 31, 2017. The following is a list of procedure codes that have been discontinued:

| Procedure Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 00740 | 00810 | 01180 | 01190 | 01682 | 15732 | 29582 | 29583 | 31320 | 34800 |
| 34802 | 34803 | 34804 | 34805 | 34806 | 34825 | 34826 | 34900 | 36120 | 36515 |
| 55450 | 64565 | 69820 | 69840 | 71010 | 71015 | 71020 | 71021 | 71022 | 71023 |
| 71030 | 71034 | 71035 | 74000 | 74010 | 74020 | 75658 | 75952 | 75953 | 75954 |
| 77422 | 78190 | 83499 | 84061 | 86185 | 86243 | 86378 | 86729 | 86822 | 87277 |
| 87470 | 87477 | 87515 | 88154 | 93982 | 94620 | 97532 | 97762 | 99363 | 99364 |
| A9599 | C9140 | C9483 | C9484 | C9485 | C9486 | C9489 | C9490 | C9491 | C9494 |
| D5510 | D5610 | D5620 | G0202 | G0204 | G0206 | G0364 | G0502 | G0503 | G0504 |
| G0505 | G0507 | G8696 | G8697 | G8698 | G8879 | G8947 | G8971 | G8972 | G9381 |
| G9496 | J1725 | J9300 | P9072 | Q9984 | Q9985 | Q9986 | Q9987 | Q9988 | Q9989 |

The following informational reporting procedure codes have been discontinued:

| Procedure Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 0051T | 0052T | 0053T | 0178T | 0179T | 0180T | 0255T | 0293T | 0294T | 0299T |
| 0300T | 0301T | 0302T | 0303T | 0304T | 0305T | 0306T | 0307T | 0309T | 0310T |
| 0340T | 0438T | | | | | | | | |

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, 2018, the following procedure code descriptions have changed:

| Procedure Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 17250 | 31276 | 31645 | 31646 | 32998 | 34812 | 34820 | 34833 | 34834 | 36140 |
| 36468 | 36470 | 36471 | 36516 | 36908 | 38220 | 38221 | 43112 | 57240 | 57260 |
| 57265 | 64550 | 76000 | 76881 | 76882 | 80305 | 80306 | 80307 | 81257 | 81400 |
| 81432 | 81439 | 82042 | 82043 | 82044 | 86003 | 86005 | 94621 | 95250 | 95251 |
| 95930 | 96567 | 97760 | 97761 | 99217 | 99218 | 99219 | 99220 | D1354 | D2740 |
| D3320 | D3330 | D3347 | D3421 | D4230 | D4231 | D4355 | D7111 | D7980 | D9223 |
| D9243 | E0950 | E1639 | G8430 | G8433 | G8442 | G8535 | G8540 | G8808 | G8869 |
| G8880 | G8938 | G8939 | G8941 | G8967 | G8968 | G8969 | G9227 | G9256 | G9257 |
| G9258 | G9259 | G9260 | G9261 | G9262 | G9263 | G9313 | G9348 | G9384 | G9504 |
| G9541 | G9607 | G9624 | G9637 | G9638 | G9656 | G9716 | G9717 | G9744 | G9745 |
| G9758 | G9762 | G9763 | G9764 | G9765 | G9784 | G9785 | G9786 | G9794 | G9814 |
| G9815 | G9816 | G9817 | G9840 | G9841 | G9843 | J0720 | J2274 | J2510 | J7321 |
| L3760 | L8618 | L8624 | L8691 | Q4121 | Q4132 | Q4133 | Q4148 | Q4156 | Q4158 |
| Q4162 | Q4163 | | | | | | | | |

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

| Reporting Procedure Codes - Informational | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 0464T | 0465T | 0466T | 0467T | 0468T | 3372F | 3494F | 3495F | 3496F | 4151F |

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 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 92 | 95 | 96 | 97 | FY | JG | QQ | TB | VM | X1 |
| X2 | X3 | X4 | X5 | ZC | | | | | |
| **Revised Modifiers** | | | | | | | | | |
| Q5 | Q6 | | | | | | | | |
| **Discontinued Modifiers** | | | | | | | | | |
| CP | SZ | | | | | | | | |

New modifiers are effective for dates of service on or after January 1, 2018. Providers may contact the appropriate copyright holder to obtain modifier descriptions. ■