HEALTHCARE COMMON PROCEDURE CODING SYSTEM

HCPCS SPECIAL BULLETIN

2026 EDITION

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Contents

2026 HCPCS Implementation

On January 1, 2026, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2026 annual Healthcare Common Procedure Coding System (HCPCS) updates that were effective for dates of service on or after January 1, 2026.

This combined Special Bulletin includes the HCPCS updates for Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program. This bulletin notifies providers of program and coding changes related to the 2026 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.

Note: *Additions for ambulatory surgical center/hospital ambulatory surgical center (ASC/HASC) facilities are listed in the "2026 HCPCS Procedure Code Additions" table on page 32 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 2026 HCPCS procedure codes are effective for dates of service on or after January 1, 2026. The new procedure codes that are designated with "Requires rate hearing" or "Requires rate review" in the "Medicaid Allowable" and the "CSHCN Allowable" columns of the "2026 HCPCS Procedure Code Additions" table on page 32 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 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:

- **https://pfd.hhs.texas.gov/rate-packets**
- **https://sos.state.tx.us/texreg/index.shtml**

Claims Filing

Claims for the new 2026 HCPCS procedure codes may be submitted beginning January 1, 2026, and must be submitted within the initial 95-day filing deadline. Services that are provided before the rate hearing is completed and expenditures are approved will be denied with 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, 2026.*

Once expenditures are approved, TMHP will identify and reprocess any claims that have been affected. Providers do not need to appeal the claims unless they are denied for other reasons after the claims reprocessing is complete. If there are any adjustments to claims reimbursement amounts, they will appear on future Remittance and Status (R&S) Reports.

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

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

Code Updates Web Page

Providers should refer to the Rate and Code Updates web page at **Rate and Code Updates | TMHP** for reimbursement rates, quarterly HCPCS updates, and all other notifications about HCPCS procedure codes. ■

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 (TMPPM)*
- Current *CSHCN Services Program Provider Manual*
- Articles published on the TMHP website at **tmhp.com**

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

For services that require prior authorization or authorization, providers must obtain a timely authorization or prior authorization for the services they provide. Providers must not wait until the rate hearing process is complete to request authorization or prior authorization. In this situation, TMHP does not grant retroactive prior authorization requests; the requests are denied as late submissions.

Refer to: *The TMPPM, section 5: Fee-For-Service Prior Authorizations,* subsection 5.11, "Guidelines for Procedures Awaiting Rate Hearing," for information about HCPCS prior authorizations.

Providers must also meet the initial 95-day claims filing deadline and ensure that the authorization or prior authorization number is on the claim the first time it is submitted to TMHP for consideration of reimbursement. TMHP will deny claims that providers submit without the proper authorization.

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 that have received prior authorization for the following discontinued 2026 HCPCS procedure codes for dates of service that occur on or after or encompass January 1, 2026, do not have to update prior authorization requests that TMHP approved on or before December 31, 2025. TMHP will automatically update affected prior authorization requests with the corresponding new procedure code that replaces the discontinued procedure code as follows:

Type of Service	Discontinued Procedure Code	Direct Replacement Procedure Code
1	S0013	J0013

New authorization requests that providers submit on or after January 1, 2026, must include 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 that are submitted with dates of service on or before December 31, 2025, must include the previous procedure codes that were in use on or before December 31, 2025, as authorized.
- Claims that are submitted with dates of service on or after January 1, 2026, must include the new 2026 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 that have received prior authorization for any of the following discontinued 2026 HCPCS procedure codes for dates of service that occur on or after or encompass January 1, 2026, must contact the TMHP Prior Authorization Department to update the procedure codes that are prior authorized for those services:

Type of Service	Discontinued Procedure Codes	Prior Authorization Requirements
1	G0511	Medicaid
1	S0189	Medicaid

Refer to: The “TMHP Telephone and Fax Communication” section in the current TMPPM, Appendix A: State, Federal, and TMHP Contact Information, and section 1.1 “TMHP-CSHCN Services Program Contact Information” in the current CSHCN Services Program Provider Manual, for a list of Prior Authorization Department telephone numbers. ■

Texas Medicaid HCPCS Updates

The 2026 HCPCS updates, including authorization or prior authorization updates for Texas Medicaid, are included in the HCPCS tables in the "All Code Changes: Added, Discontinued, Replacement, and Revised" section of this bulletin beginning on page 32. The 2026 HCPCS deletions and replacements are effective January 1, 2026, for dates of service on or after January 1, 2026, for Texas Medicaid. Providers may refer to the "General Information" section in this bulletin for more information.

Authorization and Prior Authorization Update Reminder

Effective January 1, 2026, Texas Medicaid is no longer reimbursing claims for the discontinued 2026 HCPCS procedure codes. Unless otherwise indicated in the "Prior Authorization for Discontinued Procedure Codes That Do Not Need to be Updated by the Provider" section on page 5 of this bulletin, providers that have received authorization or prior authorization for dates of service that occur on or after or encompass January 1, 2026, must submit a written request on the appropriate, completed Texas Medicaid prior authorization request form to update the HCPCS procedure codes that have been 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

Texas Medicaid has made the following benefit changes to support the 2026 HCPCS and CPT updates. These changes are effective for dates of service on or after January 1, 2026. For more information, call the TMHP Contact Center at **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 information about the following:

- Discontinued procedure codes that are no longer reimbursed after December 31, 2025
- Added procedure codes, which are new procedure codes that have been added by the Centers for Medicare & Medicaid Services (CMS)
- Additional benefit and limitation information for the added procedure codes

Biopsy of the Prostate

Added Procedure Codes									
55707	55708	55709	55710	55711	55712	55713	55714	55715	

Limitations for Added Procedure Codes

Claims for the added prostate biopsy procedure codes are restricted to male clients who are 20 years of age or older.

Claims for procedure codes 55707 and 55711 may be reimbursed when they are submitted by the following providers:

- Physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or physician providers for services rendered in the office setting
- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting
- Ambulatory surgical center (ASC) providers for services rendered in the outpatient hospital setting

Claims for procedure codes 55708, 55709, 55710, 55712, and 55714 may be reimbursed when they are submitted by the following providers:

- Physician providers for services rendered in the office, inpatient hospital, or outpatient hospital setting
- ASC providers for services rendered in the outpatient hospital setting

Claims for procedure code 55713 may be reimbursed when they are submitted by the following providers:

- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting
- ASC providers for services rendered in the outpatient hospital setting

Claims for procedure code 55715 may be reimbursed when they are submitted by the following providers:

- PA, NP, CNS, or physician providers for services rendered in the office setting
- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting

Clinician-Administered Drug – Elivaldogene Autotemcel (Skysona)

Added Procedure Code									
J3387									

Limitations for Added Procedure Code

Procedure code J3387 replaces procedure code J3590 in claims for elivaldogene autotemcel (Skysona). Claims for procedure code J3387 require prior authorization.

Claims may be reimbursed when they are submitted by hospital providers for services rendered in the outpatient hospital setting.

Claims for procedure code J3387 may be reimbursed for male clients who are 4 through 17 years of age.

Refer to: *The TMPPM, Outpatient Drug Services Handbook,* subsection 6.42.1, "Prior Authorization Requirements" for additional information.

Clinician-Administered Drug – Esketamine (Spravato)

Added Procedure Code									
J0013									

Discontinued Procedure Code									
S0013									

Limitations for Added Procedure Code

Procedure code J0013 replaces discontinued procedure code S0013. Claims for procedure code J0013 require prior authorization.

Claims may be reimbursed when they are submitted by the following providers:

- PA, NP, CNS, or physician providers for services rendered in the office setting
- Durable medical equipment (DME) pharmacy providers for services rendered in the home setting
- Hospital providers for services rendered in the outpatient hospital setting

Claims for procedure code J0013 may be reimbursed for clients who are 18 years of age or older.

Refer to: *The TMPPM, Outpatient Drug Services Handbook,* subsection 6.48.1, "Prior Authorization" for additional information.

Clinician-Administered Drugs—Limitations for Other Procedure Codes

Claims for procedure code C9307 may be reimbursed for clients who are 18 years of age or older. The procedure code is also restricted to diagnosis codes C9000 and C9002.

Procedure code J1073 requires prior authorization. Hormonal therapy agents are not a benefit when submitted with diagnosis code F640, F641, F642, F648, or F649.

Claims for procedure code J2711 may be reimbursed for clients who are two years of age or older.

Claims for procedure code J9256 may be reimbursed for clients who are 12 years of age or older. The procedure code is also restricted to diagnosis codes G7000 and G7001.

Claims for procedure codes J9282 and J9326 may be reimbursed for clients who are 18 years of age or older.

Collaborative Care Model

Discontinued Procedure Code									
G0512									

Refer to: *The TMPPM, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.3, "Collaborative Care Model (CoCM)" for additional information.

Computed Tomography and Magnetic Resonance Imaging and Related Services

Added Procedure Codes									
70471	70472	70473	75577						

Limitations for Added Procedure Codes

Claims for procedure codes 70471, 70472, 70473, and 75577 require prior authorization.

Claims for the total component of procedure codes 70471, 70472, and 70473 may be reimbursed when they are submitted by the following providers:

- Physician, radiation therapy center, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the office setting
- Radiation therapy center, portable X-ray supplier, radiological lab, physiological lab, or hospital providers for services rendered in the outpatient hospital setting

Claims for the professional component of procedure codes 70471, 70472, and 70473 may be reimbursed when they are submitted by the following providers:

- Physician, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the office setting
- Physician or dentist providers for services rendered in the inpatient hospital setting
- Physician, dentist, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the outpatient hospital setting

Claims for the technical component of procedure codes 70471, 70472, and 70473 may be reimbursed when they are submitted by the following providers:

- Physician, radiation therapy center, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the office setting
- Radiation therapy center, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the outpatient hospital setting

Claims for the total component of procedure codes 75577 may be reimbursed when they are submitted by the following providers:

- Physician, radiation therapy center, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the office setting
- Radiation therapy center or hospital providers for services rendered in the outpatient hospital setting

Claims for the professional component of procedure code 75577 may be reimbursed when they are submitted by physician providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.

Claims for the technical component of procedure code 75577 may be reimbursed when they are submitted by physician, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the office setting.

Refer to: *The TMPPM, Radiology and Laboratory Services Handbook,* subsection 4.2.2, "Computed Tomography, Magnetic Resonance Imaging, and Related Services" for additional information.

Diagnostic Endoscopies

Discontinued Procedure Code									
C9751									

Doctor of Dentistry Services as a Limited Physician

Added Procedure Code									
J0162									

Limitations for Added Procedure Code

Claims for procedure code J0162 may be reimbursed when they are submitted by the following providers:

- PA, NP, CNS, or physician providers for services rendered in the office setting

- Hospital providers for services rendered in the outpatient hospital setting

Refer to: *The TMPPM, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.4, "Doctor of Dentistry Practicing as a Limited Physician" for additional information.

Hearing Devices

Added Procedure Codes									
92628	92629	92631	92632	92634	92635	92636	92637	92638	92639
92641									

Discontinued Procedure Codes									
92590	92591	92592	92593	92594	92595				

Limitations for Added Procedure Codes

Claims for procedure codes 92628, 92631, 92634, and 92636 must be submitted with modifier LT or RT to indicate which ear the service was performed for. If the service was performed for both ears, both modifiers must be submitted.

Claims for procedure codes 92628, 92629, 92631, and 92632 may be reimbursed when they are submitted by physician or audiologist providers for services rendered in the office, home, or nursing home (skilled nursing facility, intermediate care facility, or extended care facility) setting.

Claims for procedure codes 92634 and 92635 may be reimbursed when they are submitted by audiologist or hearing aid providers for services rendered in the office, home, or outpatient hospital setting.

A hearing aid fitting visit (procedure code 92634) is limited to one per hearing aid every five rolling years. A fitting follow-up check should be performed within five weeks after the initial hearing aid fitting visit. This evaluation is considered part of the hearing aid fitting visit and is not reimbursed separately.

Claims for procedure codes 92636 and 92637 may be reimbursed when they are submitted by audiologist or hearing aid providers for services rendered in the office or outpatient hospital setting.

Procedure code 92636 is limited to two per calendar year when billed by any provider. Additional hearing aid checks may be reimbursed with prior authorization.

Claims for procedure codes 92638, 92639, and 92641 may be reimbursed when they are submitted by physician, audiologist, or hearing aid providers for services rendered in the office or nursing home (skilled nursing facility, intermediate care facility, or extended care facility) setting.

Refer to: *The TMPPM, Vision and Hearing Services Handbook*, subsection 2.2.5, "Hearing Aid Services" for additional information.

Home Telemonitoring Services

Discontinued Procedure Code									
G0511									

Refer to: *The TMPPM, Telecommunication Services Handbook*, subsection 3.6, "Home Telemonitoring Services" for additional information.

Neurostimulators and Neuromuscular Stimulators

Added Procedure Code									
C1607									

Limitations for Added Procedure Code

Claims for procedure code C1607 may be reimbursed when they are submitted by the following providers:

- Medical supplier (DME) providers for services rendered in the home setting
- ASC providers for services rendered in the outpatient hospital setting

Procedure code C1607 requires prior authorization.

Only one similar implantable neurostimulator device may be reimbursed per date of service for any provider.

Procedure code C1607 must be billed on the same date of service as procedure code 43647, 43881, 61885, 61886, 64553, 64568, or 64590, by any provider.

Refer to: *The TMPPM, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.46.15, "Prior Authorization of Neurostimulator Devices Procedure Codes" for additional information.

Pathology and Laboratory Services – Microbiology

Added Procedure Codes									
87182	87494	87627	87812						

Limitations for Added Procedure Codes

Claims for procedure codes 87182 and 87627 may be reimbursed when they are submitted by the following providers:

- PA, NP, CNS, physician, certified nurse midwife (CNM), registered nurse (RN), nephrology (hemodialysis, renal dialysis), or renal dialysis facility providers for services rendered in the office setting
- Hospital providers for services rendered in the outpatient hospital setting
- Independent laboratory providers for services rendered in the laboratory setting

Procedure code 87182 may be reimbursed once per day by the same provider.

Claims for procedure code 87494 may be reimbursed when they are submitted by the following providers:

- PA, NP, CNS, physician, CNM, RN, family planning clinic, nephrology (hemodialysis, renal dialysis), or renal dialysis facility providers for services rendered in the office setting
- Hospital providers for services rendered in the outpatient hospital setting
- Independent laboratory providers for services rendered in the laboratory setting

Claims for procedure code 87812 may be reimbursed when they are submitted by the following providers:

- PA, NP, CNS, physician, pharmacist, CNM, RN, or pharmacy providers for services rendered in the office setting
- Hospital providers for services rendered in the outpatient hospital setting
- Independent laboratory providers for services rendered in the laboratory setting

Refer to: *The TMPPM, Radiology and Laboratory Services Handbook,* subsection 2.2.11, "Microbiology" for additional information.

Prostate Procedures for Benign Prostatic Hyperplasia (BPH)

Added Procedure Code									
52597									

Discontinued Procedure Code									
52647									

Limitations for Added Procedure Code

Claims for procedure code 52597 may be reimbursed when they are submitted by the following providers:

- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting
- ASC providers for services rendered in the outpatient hospital setting

Transurethral resection of the prostate (TURP) is the gold standard for treating moderate to severe benign prostatic hyperplasia in patients who have not responded to medication and for whom minimally invasive procedures are contraindicated.

Claims for procedure code 52597 are restricted to male clients who are 20 years of age or older and must be submitted with diagnosis code N400 or N401.

Procedure code 52597 is limited to one procedure per day.

Refer to: *The TMPPM, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook*, subsection 9.2.63.1.3, "Types of Surgical Therapy" for additional information.

Radiology/Diagnostic Imaging

Added Procedure Code									
33882									

Discontinued Procedure Codes									
33884	75956	75957	75958	75959					

Limitations for Added Procedure Code

Claims for procedure code 33882 may be reimbursed when they are submitted by physician providers for services rendered in the inpatient hospital setting.

Refer to: *The TMPPM, Radiology and Laboratory Services Handbook*, subsection 4.2.4, "Radiology/Diagnostic Imaging Policy" for additional information.

Renal Dialysis Services

Discontinued Procedure Codes									
J1443	J1444	J1445	J1945	J3364	J3365				

Refer to: *The TMPPM, Clinics and Other Outpatient Facility Services Handbook,* subsection 7.2.2, "Renal Dialysis Facilities - Consolidated Billing" for additional information.

School Health and Related Services (SHARS)

Added Procedure Codes									
92636	92637								

Discontinued Procedure Codes									
92592	92593								

Limitations for Added Procedure Codes

Claims for procedure codes 92636 and 92637 may be reimbursed when they are submitted by SHARS providers in the office, home, or "other location" (e.g., school) setting.

Claims for procedure codes 92636 and 92637 must be submitted with one of the following modifiers:

Modifier	Description
TM	Audiology services provided to students with individualized education program (IEP)
U4	Audiology services provided to students with Section 504 plan

Refer to: *The TMPPM, School Health and Related Services (SHARS) Handbook,* subsection 2.3.1, "Audiology Services" for additional information.

Stereotactic Radiosurgery

Discontinued Procedure Code									
G6002									

Refer to: *The TMPPM, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook,* subsection 9.2.64.2, "Stereotactic Radiosurgery" for additional information.

Home Health Services Benefit Changes

Texas Medicaid has made the following Home Health services benefit changes to support the 2026 HCPCS and CPT updates. These changes are effective for dates of service on or after January 1, 2026. For more information, call the TMHP Contact Center at **800-925-9126**.

Incontinence Supplies – Home Health

Added Procedure Codes									
A4295	A4296								

Limitations for Added Procedure Codes

Claims for procedure codes A4295 and A4296 may be reimbursed when they are submitted by the following providers:

- Physician or medical supplier (DME) providers for services rendered in the office setting
- Medical supplier (DME) providers for services rendered in the home setting
- Hospital providers for services rendered in the outpatient hospital setting

Procedure codes A4295 and A4296 are included in the quantity limit of 150 per calendar month for any intermittent catheter and related supplies, any provider. Quantities that exceed 150 per calendar month may be considered with documentation of medical necessity and prior authorization.

Refer to: *The TMPPM, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook,* subsection 2.2.15.6.2, "Intermittent Catheters and Related Insertion Supplies" for additional information. ■

Texas Health Steps Dental Services Benefit Changes

Texas Medicaid has made the following Texas Health Steps dental services benefit changes to support the 2026 HCPCS and Current Dental Terminology (CDT) updates. These changes are effective for dates of service on or after January 1, 2026. For more information, call the TMHP Contact Center at **800-925-9126**.

Texas Health Steps Dental Preventive Services

Discontinued Procedure Code									
D1352									

Refer to: *The TMPPM, Children's Services Handbook, subsection 3.2.3.8, "Preventive Services," and Clinics and Other Outpatient Facility Services Handbook,* subsection 4.1.2, "Services, Benefits, Limitations, and Prior Authorization," for additional information.

Texas Health Steps Therapeutic Dental Services

Added Procedure Codes									
D6049	D9224	D9225	D9244	D9245	D9246	D9247			

Discontinued Procedure Codes									
D1352	D9248								

Limitations for Added Procedure Codes

Claims for procedure code D6049 may be reimbursed when they are submitted by the following providers:

- Federally qualified health center (FQHC), Texas Health Steps dental, orthodontist, oral maxillofacial surgeon, or local health department (LHD) providers for services rendered in the office setting
- FQHC, Texas Health Steps dental, orthodontist, or oral maxillofacial surgeon providers for services rendered in the inpatient hospital or outpatient hospital setting

Claims for procedure code D6049 may be reimbursed for clients who are 16 through 20 years of age. Claims may also be reimbursed for clients who are 21 years of age or older if they reside in an intermediate care facility for individuals with intellectual disabilities (ICF-IID). Procedure code D6049 must be billed within five years after procedure code D3460, by any provider.

Claims for procedure codes D9224 and D9225 may be reimbursed when they are submitted by FQHC, Texas Health Steps dental, orthodontist, or oral maxillofacial surgeon providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.

Claims for procedure codes D9224 and D9225 may be reimbursed only for clients who are 1 through 20 years of age. Claims may also be reimbursed for clients who are 21 years of age or older if they reside in an ICF-IID. Procedure codes D9224 and D9225 are used for Level 4 sedation services. Claims for these codes require prior authorization when a dentist provides the service in conjunction with therapeutic dental services for clients who are six years of age or younger.

Providers must have a level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure codes D9224 and D9225.

Procedure code D9224 is limited to 15 minutes (one unit) per day. Procedure code D9225 is limited to 2 hours and 45 minutes (11 units) per day and must be billed with procedure code D9224 on the same day by the same provider. Dental general anesthesia may be reimbursed once per six calendar months per client, any provider.

Claims for procedure codes D9244, D9245, D9246, and D9247 may be reimbursed when they are submitted by the following providers:

- FQHC, Texas Health Steps dental, orthodontist, oral maxillofacial surgeon, or LHD providers for services rendered in the office setting
- FQHC, Texas Health Steps dental, orthodontist, or oral maxillofacial surgeon providers for services rendered in the inpatient hospital or outpatient hospital setting

Providers must have the following minimum anesthesia permit levels to receive reimbursement:

Procedure Codes	Minimum Anesthesia Permit Level
D9244	Level 1
D9245	Level 2
D9246	Level 3
D9247	Level 3

Claims for procedure codes D9244, D9245, D9246, and D9247 may be reimbursed only for clients who are 1 through 20 years of age. Claims may also be reimbursed for clients who are 21 years of age or older if they reside in an ICF-IID.

Procedure codes D9244, D9245, D9246, and D9247 are limited to two per year. Additional services may be considered with prior authorization and documentation of medical necessity.

Claims for procedure codes D9244, D9245, D9246, and D9247 are denied when billed on the same day as procedure codes D9222, D9224, D9239, D9420, or D9920.

Procedure code D9246 is limited to one unit per day. Procedure code D9247 is limited to five units per day.

Claims for procedure codes D9210, D9211, D9212, and D9230, are denied when billed on the same day, by any provider as procedure codes D9244, D9245, D9246, or D9247.

Refer to: *The TMPPM, Children's Services Handbook,* subsections 3.2.23, "Dental Anesthesia," and 3.2.29.2, "General Anesthesia for Dental Treatment," for additional information. ■

TEXAS HEALTH STEPS MEDICAL PROVIDERS

Texas Health Steps Medical Services Benefit Changes

Texas Medicaid has made the following Texas Health Steps medical services benefit changes to support the 2026 HCPCS and CPT updates. These changes are effective for dates of service on or after January 1, 2026. For more information, call the TMHP Contact Center at **800-925-9126**.

Texas Health Steps Preventive Care Medical Checkups

Added Procedure Code									
87494									

Limitations for Added Procedure Code

Texas Health Steps providers must submit specimens for laboratory testing procedure code 87494 to the Department of State Health Services (DSHS) Laboratory.

Refer to: *The TMPPM, Children's Services Handbook,* subsection 4.3.12.6, "Laboratory Test" for additional information. ■

Family Planning Program Services Benefit Changes

The Family Planning Program has made no benefit changes in response to the 2026 HCPCS and CPT updates. ■

HTW Program Services Benefit Changes

Texas Medicaid has made the following HTW benefit changes to support the 2026 HCPCS and CPT updates. These changes are effective for dates of service on or after January 1, 2026. For more information, call the TMHP Contact Center at **800-925-9126**.

Healthy Texas Women

Added Procedure Code									
87494									

Limitations for Added Procedure Code:

Claims for procedure code 87494 may be reimbursed when they are submitted by the following providers:

- Physician assistant, nurse practitioner, clinical nurse specialist, physician, certified nurse midwife, registered nurse, family planning clinic, nephrology (hemodialysis, renal dialysis), or renal dialysis facility providers for services rendered in the office setting
- Hospital providers for services rendered in the outpatient hospital setting
- Independent laboratory providers for services rendered in the laboratory setting

Refer to: *The TMPPM, Healthy Texas Women Program Handbook*, subsection 2.3, "Services, Benefits, Limitations, and Prior Authorization" for additional information. ■

CSHCN Services Program Updates

The 2026 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, Discontinued, Replacement, and Revised" section of this bulletin beginning on page 32. The 2026 HCPCS deletions and replacements are effective January 1, 2026, for dates of service on or after January 1, 2026, for the CSHCN Services Program. Providers may refer to the "General Information" section in this bulletin 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 "Requires rate review" in the "CSHCN Allowable" column of the "2026 HCPCS Procedure Code Additions" table on page 32 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 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, 2026, the CSHCN Services Program is no longer reimbursing claims for discontinued 2026 HCPCS procedure codes. Unless otherwise indicated in the "Prior Authorization for Discontinued Procedure Codes That Do Not Need to be Updated by the Provider" section on page 5 of this bulletin, providers that have received authorizations or prior authorizations for dates of service that occur on or after or encompass January 1, 2026, must submit a written request on the appropriate, completed CSHCN Services Program authorization or prior authorization request form to update the HCPCS procedure codes that have been 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 TMHP-CSHCN Services Program Contact Center at **800-568-2413**. ■

CSHCN Services Program Benefit Changes

The CSHCN Services Program has made the following benefit changes to support the 2026 HCPCS and CPT updates. These changes are effective for dates of service on or after January 1, 2026. For more information, call the TMHP-CSHCN Services Program Contact Center at **800-568-2413**.

The policy articles below contain information about the following:

- Discontinued procedure codes that are no longer reimbursed after December 31, 2025
- Added procedure codes, which are new procedure codes that have been added by the Centers for Medicare & Medicaid Services (CMS)
- 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 only nurse practitioner (NP) and clinical nurse specialist (CNS) providers.*

Anesthesia Services

Added Procedure Codes									
D9224	D9225								

Limitations for Added Procedure Codes

Claims for procedure codes D9224 and D9225 may be reimbursed when they are submitted by dentist, federally qualified health center (FQHC), orthodontist, or oral maxillofacial surgeon providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.

Procedure codes D9224 and D9225 are used for Level 4 sedation services. Claims for these codes require prior authorization when a dentist provides the service in conjunction with therapeutic dental services for clients who are six years of age or younger.

Claims for procedure code D9224 are limited to one unit per day. The combined maximum time allowed for services billed with procedure codes D9224 and D9225 is three hours per day.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 14.2.6.10, "Dental Anesthesia," for additional information.

Biopsy of the Prostate

Added Procedure Codes									
55707	55708	55709	55710	55711	55712	55713	55714	55715	

Limitations for Added Procedure Codes

Claims for the added prostate biopsy procedure codes are restricted to male clients who are 20 years of age or older.

Claims for procedure codes 55707, 55708, 55709, 55710, 55711, 55712, and 55714 may be reimbursed when they are submitted by the following providers:

- APRN or physician providers for services rendered in the office setting
- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting
- Ambulatory surgical center (ASC) providers for services rendered in the outpatient hospital setting

Claims for procedure code 55713 may be reimbursed when they are submitted by the following providers:

- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting
- ASC providers for services rendered in the outpatient hospital setting

Claims for procedure code 55715 may be reimbursed when they are submitted by the following providers:

- APRN or physician providers for services rendered in the office setting
- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting

Computed Tomography

Added Procedure Code									
70471									

Limitations for Added Procedure Code

Claims for the total component of procedure code 70471 may be reimbursed when they are submitted by the following providers:

- Physician, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the office setting
- Hospital providers for services rendered in the outpatient hospital setting

Claims for the professional component of procedure code 70471 may be reimbursed when they are submitted by physician providers for services rendered in the office, inpatient hospital, or outpatient hospital setting.

Claims for the technical component of procedure code 70471 may be reimbursed when they are submitted by physician, portable X-ray supplier, radiological lab, or physiological lab providers for services rendered in the office setting.

Computed tomography (CT) imaging is limited to four procedures per rolling year. Additional scans may be approved with prior authorization if documentation confirms a severe or life-threatening medical condition that requires close monitoring through CT imaging to determine appropriate treatment, without which the condition could progress to severe disability or death.

Refer to: *The CSHCN Services Program Provider Manual*, subsection 16.2.4, "Computed Tomography (CT) Scan," for additional information.

Dental - Preventive Services

Discontinued Procedure Code									
D1352									

Refer to: *The CSHCN Services Program Provider Manual*, subsection 14.2.5.4, "Dental Sealants," for additional information.

Dental – Therapeutic Services

Added Procedure Codes									
D6049	D9224	D9225	D9244	D9245	D9246	D9247			

Discontinued Procedure Codes									
D1352	D9248								

Limitations for Added Procedure Codes

Claims for procedure code D6049 may be reimbursed when they are submitted by dentist, orthodontist, or oral maxillofacial surgeon providers for services rendered in the office, inpatient hospital, or outpatient hospital settings.

Claims for procedure code D6049 may be reimbursed for clients who are 16 years of age or older. Procedure code D6049 must be billed within five years after procedure code D3460, by any provider.

Claims for procedure codes D9224 and D9225 may be reimbursed when they are submitted by dentist or FQHC providers for services rendered in the office, inpatient hospital, or outpatient hospital settings.

Procedure codes D9224 and D9225 are used for Level 4 sedation services. Claims for these codes require prior authorization when a dentist provides the service in conjunction with therapeutic dental services for clients who are six years of age or younger. Providers must have a level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to bill the enhanced rate for procedure codes D9224 and D9225.

Procedure code D9224 is limited to 15 minutes (1 unit) per day. Procedure code D9225 is limited to 2 hours and 45 minutes (11 units) per day and must be billed with procedure code D9224 on the same day by the same provider.

Claims for procedure code D9239 are denied when billed on the same day, by any provider as procedure code D9224 or D9225.

Procedure code D9920 is denied when billed on the same day as procedure code D9224 or D9225.

Claims for procedure codes D9244, D9245, D9246, and D9247 may be reimbursed when they are submitted by dentist, FQHC, orthodontist, or oral maxillofacial surgeon providers for services rendered in the office setting. Providers must have the following minimum anesthesia permit levels to receive reimbursement:

Procedure Codes	Minimum Anesthesia Permit Level
D9244	Level 1
D9245	Level 2
D9246	Level 3
D9247	Level 3

Reimbursement for non-intravenous (IV) sedation (procedure codes D9244, D9245, D9246, or D9247) is limited to one non-IV sedation service per client, per day, for a total of two per year. Prior authorization is required if more than two IV sedation services are required by any provider in a 12-month period.

Procedure codes D9244, D9245, D9246, and D9247 are denied when billed on the same day as procedure codes D9222, D9224, D9225, or D9239, any provider.

Procedure code D9246 is limited to 15 minutes (1 unit) per day. Procedure code D9247 is limited to 1 hour and 15 minutes (5 units) per day and must be billed with procedure code D9246 on the same day by the same provider.

Claims for procedure codes D9210, D9211, D9212, and D9230 are denied when billed on the same day, by any provider as procedure code D9244, D9245, D9246, or D9247.

Non-IV sedation (procedure code D9244, D9245, D9246, or D9247) and dental behavior management (procedure code D9920) are not reimbursed when provided on the same day. Only one procedure, either non-IV sedation or dental behavior management, may be reimbursed.

Dental general anesthesia may be reimbursed once every 6 months per client, any provider.

Refer to: *The CSHCN Services Program Provider Manual,* subsections 14.2.6.2, “Anesthesia Requirements for Clients who are Six Years of Age or Younger,” 14.2.6.6, “Periodontics,” and 14.2.6.10, “Dental Anesthesia,” for additional information.

Expendable Medical Supplies

Added Procedure Codes									
A4295	A4296								

Limitations for Added Procedure Codes

Claims for procedure codes A4295 and A4296 may be reimbursed when they are submitted by custom durable medical equipment (DME) or medical supplier (DME) providers for services rendered in the home setting.

Procedure codes A4295 and A4296 are included in the quantity limit of 150 per calendar month for any catheter, any provider. Quantities that exceed 150 per calendar month require prior authorization.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 18.2, "Benefits, Limitations, and Authorization Requirements," for additional information.

Hearing Services

Added Procedure Codes									
92628	92629	92631	92632	92634	92635	92636	92637	92638	92639
92641									

Discontinued Procedure Codes									
92590	92591	92592	92593	92594	92595				

Limitations for Added Procedure Codes

Claims for procedure codes 92628, 92631, 92634, and 92636 must be submitted with modifier LT or RT to indicate which ear the service was performed for. If the service was performed for both ears, both modifiers must be submitted.

Claims for procedure codes 92628, 92629, 92631, and 92632 may be reimbursed when they are submitted by physician or audiologist providers for services rendered in the office setting.

Claims for procedure codes 92634, 92635, 92636, and 92637 may be reimbursed when they are submitted by audiologist or hearing aid providers for services rendered in the office setting.

A hearing aid fitting visit (procedure code 92634) is limited to one per hearing aid every five rolling years. A fitting follow-up check should be performed within five weeks after the initial hearing aid fitting visit. This evaluation is considered part of the hearing aid fitting visit and is not reimbursed separately.

Procedure code 92636 is limited to two per calendar year when billed by any provider. Additional hearing aid checks may be reimbursed with prior authorization and documentation of medical necessity.

Claims for procedure codes 92638, 92639, and 92641 may be reimbursed when they are submitted by physician, audiologist, or hearing aid providers for services rendered in the office setting.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 20.2, "Benefits, Limitations, and Authorization Requirements – Non-Implantable Devices and Services," for additional information.

Injections - Limitations for Other Procedure Codes

Claims for procedure code J0654 may be reimbursed for clients who are 18 years of age or older.

Claims for procedure codes J1837 and J2711 may be reimbursed for clients who are two years of age or older.

Neurostimulators and Neuromuscular Stimulators

Added Procedure Code									
C1607									

Limitations for Added Procedure Code

Claims for procedure code C1607 may be reimbursed when they are submitted by the following providers:

- Medical supplier (DME) providers for services rendered in the home setting
- ASC providers for services rendered in the outpatient hospital setting

Procedure code C1607 requires prior authorization.

Only one similar implantable neurostimulator device may be reimbursed per date of service for any provider.

Procedure code C1607 must be billed on the same date of service as procedure code 61885, 61886, 64553, 64568, or 64590, by any provider.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 27.2, "Benefits, Limitations, and Authorization Requirements," for additional information.

Pathology and Laboratory Services - Microbiology

Added Procedure Codes									
87182	87494	87627	87812						

Limitations for Added Procedure Codes

Claims for procedure codes 87182, 87494, and 87627 may be reimbursed when they are submitted by the following providers:

- Physician providers for services rendered in the office setting
- Hospital providers for services rendered in the outpatient hospital setting
- Independent laboratory providers for services rendered in the laboratory setting

Procedure code 87182 may be reimbursed once per day by the same provider.

Claims for procedure code 87812 may be reimbursed when they are submitted by the following providers:

- APRN or physician providers for services rendered in the office setting
- Hospital providers for services rendered in the outpatient hospital setting
- Independent laboratory providers for services rendered in the laboratory setting

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

Radiation Therapy Services

Added Procedure Codes									
77436	77437	77438	77439						

Discontinued Procedure Codes									
77385	77386	77401	G6002	G6003	G6004	G6005	G6006	G6007	G6008
G6009	G6010	G6011	G6012	G6013	G6014	G6015	G6016	G6017	

Limitations for Added Procedure Codes

Claims for the total and technical components of procedure code 77436 may be reimbursed when they are submitted by the following providers:

- Physician or radiation therapy center providers for services rendered in the office setting
- Radiation therapy center or hospital providers for services rendered in the outpatient hospital setting

Claims for the professional component of procedure code 77436 may be reimbursed when they are submitted by physician providers for services rendered in the office or inpatient hospital setting.

Claims for procedure codes 77437 and 77438 may be reimbursed when they are submitted by the following providers:

- Physician or radiation therapy center providers for services rendered in the office setting
- Radiation therapy center or hospital providers for services rendered in the outpatient hospital setting

Claims for the total component of procedure code 77439 may be reimbursed when they are submitted by the following providers:

- Physician or radiation therapy center providers for services rendered in the office setting
- Radiation therapy center or hospital providers for services rendered in the outpatient hospital setting

Claims for the professional component of procedure code 77439 may be reimbursed when they are submitted by physician providers for services rendered in the office or inpatient hospital setting.

Procedure codes 77436, 77437, 77438, and 77439 may be submitted with an evaluation and management (E/M) procedure code if the E/M is for a separate, distinct service.

Refer to: *The CSHCN Services Program Provider Manual,* subsection 34.2.7, "Radiation Treatment Management and Delivery," for additional information.

Radiology – X-Ray and Ultrasound

Discontinued Procedure Codes									
75956	75957	75958	75959						

Refer to: *The CSHCN Services Program Provider Manual,* subsection 16.2.10.2, "Interventional Radiological Procedures," for additional information.

Renal Dialysis Services

Discontinued Procedure Codes									
J1443	J1444	J1445	J1945	J3364	J3365				

Refer to: *The CSHCN Services Program Provider Manual,* subsection 35.3.1.1.3, "Maintenance CAPD and CCPD," for additional information.

Resection of Prostate

Added Procedure Code									
52597									

Limitations for Added Procedure Code

Claims for procedure code 52597 may be reimbursed when they are submitted by the following providers:

- Physician providers for services rendered in the inpatient hospital or outpatient hospital setting
- ASC providers for services rendered in the outpatient hospital setting

Claims for procedure code 52597 are restricted to male clients who are 20 years of age or older and must be submitted with diagnosis code N400 or N401. ■

2026 HCPCS Procedure Code Additions

The table below lists the new HCPCS procedure codes. If a program name (e.g., Medicaid, CSHCN, HTW) appears in the Benefit Changes column, see that program's section of this bulletin for more information.

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	27458	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
8	27458	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	27458	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	27713	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
8	27713	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	27713	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	33882	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid
8	33882	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid
2	35602	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
8	35602	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37254	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37254	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37255	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37256	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37256	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37257	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37258	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37258	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37259	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37260	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
F	37260	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37261	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37262	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37263	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37263	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37264	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37265	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37265	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37266	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37267	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37267	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	37268	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37269	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37269	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37270	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37271	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37271	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37272	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37273	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37273	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37274	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37275	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
F	37275	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37276	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37277	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37277	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37278	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37279	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37280	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37280	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37281	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37282	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37282	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	37283	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37284	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37284	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37285	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37286	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37286	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37287	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37288	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37288	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37289	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37290	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
F	37290	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37291	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37292	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37292	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37293	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37294	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37294	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37295	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37296	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37296	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37297	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	37298	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	37298	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	37299	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	43889	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	43889	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	47384	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	47384	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	52443	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	52443	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	52597	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	52597	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55707	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	55707	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55708	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
F	55708	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55709	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	55709	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55710	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	55710	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55711	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	55711	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55712	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	55712	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55713	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	55713	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	55714	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
F	55714	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55715	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
2	55868	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
8	55868	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	55868	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	55869	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
8	55869	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	55869	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	55877	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	55877	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	62330	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
8	62330	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	62330	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	62331	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
8	62331	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	63032	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
8	63032	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
2	64567	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	64567	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	64654	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	64654	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	64655	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	64655	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	64656	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	64656	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	64657	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	64657	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	64658	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	64658	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	64659	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
F	64659	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	64728	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	64728	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
4	70471	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid, CSHCN
I	70471	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid, CSHCN
T	70471	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid, CSHCN
4	70472	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
I	70472	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
T	70472	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
4	70473	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
I	70473	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
T	70473	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
4	75577	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
I	75577	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
T	75577	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
6	77436	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
I	77436	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
T	77436	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
6	77437	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
6	77438	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
6	77439	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
I	77439	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
5	81354	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	81524	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
5	87182	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	87183	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
5	87494	Requires rate hearing	Requires rate review	Requires rate hearing	Requires rate hearing	Not a benefit		Medicaid, CSHCN, HTW
5	87627	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
5	87812	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	90481	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	90482	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	90483	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	90484	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	90631	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	91124	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	91125	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	92288	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	92628	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92629	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92631	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	92632	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92634	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92635	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92636	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92637	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92638	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92639	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92641	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	92642	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	92930	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	92930	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
2	92945	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
F	92945	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	93145	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	93146	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	97007	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	97008	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	97009	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	98979	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	98984	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	98985	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	98986	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	99445	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	99470	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	A4295	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
9	A4296	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
9	A4297	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
J	C1607	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit	Medicaid, CSHCN	Medicaid, CSHCN
9	C1608	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C7566	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C7567	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	C7568	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
2	C7569	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
2	C7570	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
2	C7571	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
9	C9176	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	C9307	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		Medicaid
1	C9308	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C9810	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C9811	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C9812	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
9	C9813	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C9814	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C9815	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C9816	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
9	C9817	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0426	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D0461	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D1720	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5877	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5878	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5909	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5930	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5938	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5939	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5940	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5941	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5942	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5943	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5944	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
W	D5945	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5946	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5947	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5948	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D5949	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D6049	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
W	D6196	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D6280	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D9128	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D9129	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
W	D9224	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
W	D9225	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
W	D9244	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
W	D9245	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
W	D9246	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
W	D9247	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
W	D9936	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0568	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0569	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0570	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
2	G0571	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0660	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0661	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0662	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0663	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0664	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0665	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0666	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0667	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G0668	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	G9871	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J0013	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	J0162	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid
1	J0654	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
1	J1073	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
1	J1736	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J1737	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J1837	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		CSHCN
1	J2516	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	J2596	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	J2711	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		Medicaid, CSHCN
1	J3291	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	J3376	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		
1	J3379	Requires rate hearing	Requires rate review	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	J3387	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Medicaid	Medicaid
1	J3389	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J7299	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J7528	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J9184	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	J9256	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		Medicaid
1	J9282	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		Medicaid
1	J9326	Requires rate hearing	Not a benefit	Not a benefit	Not a benefit	Not a benefit		Medicaid
1	M1426	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1427	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1428	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1429	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	M1430	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1431	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1432	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1433	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1434	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1435	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1436	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1437	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1438	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1439	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1440	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	M1441	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1442	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1443	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1444	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1445	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1446	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1447	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1448	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1449	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1450	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1451	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	M1452	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1453	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1454	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1455	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1456	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1457	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1458	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1459	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1460	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1461	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1462	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	M1463	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1464	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1465	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1466	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1467	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1468	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1469	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1470	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1471	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1472	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1473	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	M1474	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1475	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1476	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1477	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1478	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1479	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1480	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1481	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1482	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1483	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1484	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	M1485	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1486	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1487	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1488	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1489	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1490	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1491	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1492	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1493	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1494	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1495	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	M1496	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1497	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1498	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1499	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1500	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1501	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1502	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	M1503	Informational only	Informational only	Not a benefit	Not a benefit	Not a benefit		
1	Q4398	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4399	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4400	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4401	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4402	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4403	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	Q4404	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4405	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4406	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4407	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4408	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4409	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4410	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4411	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4412	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4413	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4414	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4415	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4416	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4417	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4420	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4431	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4432	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		
1	Q4433	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Type of Service	Procedure Code	Medicaid Allowable	CSHCN Allowable	HTW Allowable	HTW+ Allowable	FPP Allowable	Authorization Requirement	Benefit Changes
1	Q5160	Not a benefit	Not a benefit	Not a benefit	Not a benefit	Not a benefit		

Note: *All new, revised, and discontinued 2026 HCPCS procedure codes are effective for dates of service on or after January 1, 2026. The new procedure codes that are indicated with "Requires rate hearing" or "Requires rate review" in the above table are pending a rate hearing and approval of expenditures. Providers will be notified in a future article 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 procedure codes are Medicaid-only benefits and are not covered by Medicare.

Procedure Codes									
92628	92629	92631	92632	92634	92635	92636	92637	92638	92639
92641	J0013	J3291							

The following procedure codes are not benefits because they are considered part of another service:

Procedure Codes									
Q4398	Q4399	Q4400	Q4401	Q4402	Q4403	Q4404	Q4405	Q4406	Q4407
Q4408	Q4409	Q4410	Q4411	Q4412	Q4413	Q4414	Q4415	Q4416	Q4417
Q4420	Q4431	Q4432	Q4433	C9812	C9813	C9814	C9815	C9816	D0461

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

Medical Procedure Codes									
0990T	0992T	0993T	0994T	0995T	0997T	0998T	1002T	1004T	1005T
1006T	1007T	1008T	1009T	1010T	1011T	1016T	1017T	1018T	1020T
1021T	1022T	1023T	1024T						

Surgical Procedure Codes									
0988T	0989T	0991T	0996T	0999T	1000T	1001T	1003T	1012T	1013T
1014T	1015T	1019T							

Radiological Procedure Code									
1025T									

Laboratory Procedure Codes									
0600U	0601U	0602U	0603U	0604U	0605U	0606U	0607U	0608U	0609U
0610U	0611U	0612U	0613U						

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

Discontinued Procedure Codes

Texas Medicaid and the CSHCN Services Program are no longer reimbursing claims for the following list of discontinued 2026 HCPCS procedure codes after December 31, 2025:

Procedure Codes									
27445	27468	33884	33889	33891	37220	37221	37222	37223	37224
37225	37226	37227	37228	37229	37230	37231	37232	37233	37234
37235	37500	52647	55700	75842	75956	75957	75958	75959	77014
77385	77386	77401	91120	91122	92590	92591	92592	92593	92594
92595	92921	92925	92929	92934	92938	92944	92975	92977	94662
C5271	C5272	C5273	C5274	C5275	C5276	C5277	C5278	C9089	C9305
C9306	C9751	C9784	D1352	D1705	D1706	D1707	D1712	D9248	G0071
G0511	G0512	G6001	G6002	G6003	G6004	G6005	G6006	G6007	G6008
G6009	G6010	G6011	G6012	G6013	G6014	G6015	G6016	G6017	G9604
J0172	J0190	J0200	J0205	J0215	J0288	J0350	J0365	J0380	J0395
J0710	J0715	J0795	J0889	J1267	J1330	J1443	J1444	J1445	J1452
J1457	J1562	J1620	J1655	J1710	J1945	J2504	J2513	J2910	J2940
J2995	J3280	J3305	J3310	J3320	J3355	J3364	J3365	J3400	J7309
J7310	J7505	J7513	J8562	J8650	J9019	J9020	J9098	J9151	J9165
J9212	J9270	Q0174	Q2017	Q4100	Q4106	Q5109	Q9969	S0013	S0080
S0189									

The following informational reporting procedure codes have been discontinued:

Procedure Codes									
0033U	0042T	0131U	0132U	0135U	0240U	0241U	0266T	0267T	0268T
0269T	0270T	0271T	0272T	0273T	0275T	0346U	0361U	0369U	0370U
0373U	0374U	0380U	0394T	0421T	0428U	0448U	0450U	0451U	0456U
0508U	0509U	0544U	0550U	0551U	0619T	0623T	0624T	0625T	0626T
0631T	0662T	0663T	0720T						

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

Replacement Procedure Codes

Effective for dates of service on or after January 1, 2026, Texas Medicaid and the CSHCN Services Program will replace the following discontinued procedure codes with the corresponding replacement procedure codes:

Type of Service	Discontinued Codes	Replacement Codes	Medicaid Rate	CSHCN Rate
1	91120	91124	Requires rate hearing	Requires rate review
1	91122	91125	Requires rate hearing	Requires rate review
1	S0013	J0013	Requires rate hearing	Not a benefit
1	S0080	J2516	Requires rate hearing	Requires rate review
1	C9305	J9256	Requires rate hearing	Not a benefit
1	C9306	J9326	Requires rate hearing	Not a benefit

Procedure Code Description Changes

Providers may refer to the following CMS web page to identify procedure code description changes that are effective for dates of service on or after January 1, 2026:

https://cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcs-quarterly-update

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

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

Updates for Procedure Codes From a Previous Quarter

The following procedure codes will be added as benefits pending the required rate hearing and approval of expenditures:

Procedure Codes	Applicable Programs
91323	Texas Medicaid, HTW, CSHCN
C1742	Texas Medicaid, CSHCN
J0462	Texas Medicaid, CSHCN
J9361	Texas Medicaid

Procedure Codes	Applicable Programs
Q5098	Texas Medicaid, CSHCN
Q5156	Texas Medicaid, CSHCN
Q5157	Texas Medicaid, CSHCN
Q5158	Texas Medicaid, CSHCN

Limitations for Added Procedure Codes

Age limitations will apply to the following procedure codes for all applicable programs:

Procedure Codes	Client Age Limitation
91323	12 years of age or older
J9361	18 years of age or older
Q5098	6 years of age or older
Q5156	2 years of age or older

Procedure Code C1742

Texas Medicaid will limit procedure code C1742 to clients who are birth through 20 years of age.

Procedure Codes Q5157 and Q5158

The CSHCN Services Program will limit procedure codes Q5157 and Q5158 to clients who are 12 years of age or older.

Procedure Code Q5098

Claims for procedure code Q5098 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
K5000	K50011	K50012	K50013	K50014	K50018	K50019	K5010
K50111	K50112	K50113	K50114	K50118	K50119	K5080	K50811
K50812	K50813	K50814	K50818	K50819	K5090	K50911	K50912
K50913	K50914	K50918	K50919	K5100	K51011	K51012	K51013
K51014	K51018	K51019	K5120	K51211	K51212	K51213	K51214
K51218	K51219	K5130	K51311	K51312	K51313	K51314	K51318
K51319	K5180	K51811	K51812	K51813	K51814	K51818	K51819

Diagnosis Codes							
K5190	K51911	K51912	K51913	K51914	K51918	K51919	L400
L401	L402	L403	L404	L405	L4050	L4051	L4052
L4053	L4054	L4059	L408	L409			

Procedure Code Q5156

Claims for procedure code Q5156 must be submitted with one of the following diagnosis codes:

Diagnosis Codes							
M0500	M05011	M05012	M05019	M05021	M05022	M05029	M05031
M05032	M05039	M05041	M05042	M05049	M05050	M05052	M05059
M05061	M05062	M05069	M05071	M05072	M05079	M0509	M0510
M05111	M05112	M05119	M05121	M05122	M05129	M05131	M05132
M05139	M05141	M05142	M05149	M05151	M05152	M05159	M05161
M05162	M05169	M05171	M05172	M05179	M0519	M0520	M05211
M05212	M05219	M05221	M05222	M05229	M05231	M05232	M05239
M05241	M05242	M05249	M05251	M05252	M05259	M05261	M05262
M05269	M05271	M05272	M05279	M0529	M0530	M05311	M05312
M05319	M05321	M05322	M05329	M05331	M05332	M05339	M05341
M05342	M05349	M05351	M05352	M05359	M05361	M05362	M05369
M05371	M05372	M05379	M0539	M0540	M05411	M05412	M05419
M05421	M05422	M05429	M05431	M05432	M05439	M05441	M05442
M05449	M05451	M05452	M05459	M05461	M05462	M05469	M05471
M05472	M05479	M0549	M0550	M05511	M05512	M05519	M05521
M05522	M05529	M05531	M05532	M05539	M05541	M05542	M05549
M05551	M05552	M05559	M05561	M05562	M05569	M05571	M05572
M05579	M0559	M0560	M05611	M05612	M05619	M05621	M05622
M05629	M05631	M05632	M05639	M05641	M05642	M05649	M05651
M05652	M05659	M05661	M05662	M05669	M05671	M05672	M05679

Diagnosis Codes							
M0569	M0570	M05711	M05712	M05719	M05721	M05722	M05729
M05731	M05732	M05739	M05741	M05742	M05749	M05751	M05752
M05759	M05761	M05762	M05769	M05771	M05772	M05779	M0579
M057A	M0580	M05811	M05812	M05819	M05821	M05822	M05829
M05831	M05832	M05839	M05841	M05842	M05849	M05851	M05852
M05859	M05861	M05862	M05869	M05871	M05872	M05879	M0589
M058A	M059	M0600	M06011	M06012	M06019	M06021	M06022
M06029	M06031	M06032	M06039	M06041	M06042	M06049	M06051
M06052	M06059	M06061	M06062	M06069	M06071	M06072	M06079
M0609	M060A	M0680	M06811	M06812	M06819	M06821	M06822
M06829	M06831	M06832	M06839	M06841	M06842	M06849	M06851
M06852	M06859	M06861	M06862	M06869	M06871	M06872	M06879
M0689	M068A	M069	M0820	M08211	M08212	M08219	M08221
M08222	M08229	M08231	M08232	M08239	M08241	M08242	M08249
M08251	M08252	M08259	M08261	M08262	M08269	M08271	M08272
M08279	M0829	M082A	M083	M315	M316		