2016 HCPCS Implementation

On January 1, 2016, the Texas Medicaid & Healthcare Partnership (TMHP) applied the 2016 annual Healthcare Common Procedure Coding System (HCPCS) updates that are effective for dates of service on or after January 1, 2016.

This combined Special Bulletin includes the HCPCS updates for Texas Medicaid and the Children with Special Health Care Needs (CSHCN) Services Program. This bulletin is intended to notify providers of program and coding changes related to the 2016 updates for HCPCS and Current Procedural Terminology (CPT®).

Policy updates for a specific program or provider type are discussed in designated sections of the bulletin.

Rate Hearings and Expenditure Review

New and increased benefits that are adopted by Texas Medicaid must complete the rate hearing process in order 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 2016 HCPCS procedure codes are effective for dates of service on or after January 1, 2016. The new procedure codes that are designated with asterisks (*) in the “Medicaid Allowable” and the “CSHCN Allowable” columns of the table located on page 19 of this bulletin must complete the rate hearing process, and expenditures must be approved before the rates are adopted by Texas Medicaid and the CSHCN Services Program. Providers will be notified in a future banner message or web article if a new procedure code will not be reimbursed because the expenditures were not approved.

Providers may refer to the following resources for more information about the public rate hearings:

- [www.sos.state.tx.us/texreg/index.shtml](http://www.sos.state.tx.us/texreg/index.shtml)

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### Appendix A: Diagnosis Codes for Procedure Code J1447

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<td>Procedure Code J1447 Diagnosis Codes</td>
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Claims Filing

The new 2016 HCPCS procedure codes may be billed beginning January 1, 2016, and must be submitted within the initial 95-day filing deadline. Services provided before the rate hearing is completed and expenditures are approved will be denied with an explanation of benefits (EOB) 02008, “This procedure code has been approved as a benefit pending the approval of expenditures. Providers will be notified of the effective dates of service in a future notification if expenditures are approved.”

**Note:** In the rare instance that expenditures are not approved for a particular procedure code, that procedure code will not be made a benefit effective January 1, 2016.

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

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

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

Special Process for Prior Authorizations with Specific Discontinued Procedure Codes

Effective January 1, 2016, the 2016 HCPCS deleted procedure codes are no longer reimbursed by Texas Medicaid. Except for the procedure codes listed below, providers who have received prior authorization for dates of service that occur on, after, or encompass January 1, 2016, must submit a written request on the appropriate, completed Texas Medicaid prior authorization request form in order to update the HCPCS procedure codes authorized for those services.

**Procedure codes that do not require an updated Prior Authorization form**
The following procedure codes that previously required prior authorization have been discontinued. Acceptable procedure codes are noted below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Discontinued 2015 Procedure Code(s)</th>
<th>2016 Procedure Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>D9220, D9221</td>
<td>D9223</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>G0154</td>
<td>G0299, G0300</td>
</tr>
<tr>
<td>Respiratory Equipment and Supplies (Ventilators)</td>
<td>E0450, E0460, E0461, E0463, E0464</td>
<td>E0465, E0466</td>
</tr>
</tbody>
</table>

Prior authorization requests that contain the previously-approved discontinued procedure code will not need to be updated, and will continue to be honored for dates of service on or after January 1, 2016, through the approved prior authorization period. All claims submitted that are associated with these prior authorizations must contain a valid procedure code. When the prior authorization expires, providers must include a valid procedure code on any new prior authorization or extension requests.

**Important:** Providers may refer to the section in this bulletin titled “Prior Authorization Changes” for information about prior authorizations impacted by deleted HCPCS codes.
Code Updates Web Page

Providers are encouraged to refer to the TMHP Code Updates – HCPCS web page at www.tmhp.com/Pages/CodeUpdates/HCPCS 2016.aspx for reimbursement rates, quarterly HCPCS updates, and all other notifications about HCPCS procedure codes.

MEDICAID FEE-FOR-SERVICE AND MANAGED CARE PROVIDERS

Texas Medicaid HCPCS Updates

The 2016 Healthcare Common Procedure Coding System (HCPCS) updates including prior authorization updates for Texas Medicaid are included in the HCPCS tables in the “All Code Changes” section of this bulletin beginning on page 19. The 2016 HCPCS deletions and replacements are effective January 1, 2016, for dates of service on or after January 1, 2016, for Texas Medicaid. Providers may refer to the “General Information” section for more information.

Texas Medicaid Benefit Changes

The following Texas Medicaid benefit changes have been made to support the 2016 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2016. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

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

The policy articles in this bulletin contain the following information:

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

- **Discontinued**: Discontinued procedure codes are no longer reimbursed after December 31, 2015.

- **Added**: Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS). Procedure codes noted with an asterisk (*) require a rate hearing for pricing.

- **Limitations**: Additional benefit and limitation information for the added procedure codes.

- **Replacement**: Replacement procedure codes directly replace the indicated discontinued procedure code. The discontinued procedure codes are no longer reimbursed after December 31, 2015, and the replacement procedure codes are effective for dates of service on or after January 1, 2016. Not all discontinued procedure codes have direct replacements.

Blood Factor Products

<table>
<thead>
<tr>
<th>Added Procedure Codes</th>
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<tbody>
<tr>
<td>J7188</td>
<td>J7205</td>
</tr>
<tr>
<td>Discontinued Procedure Code</td>
<td></td>
</tr>
<tr>
<td>Q9975</td>
<td></td>
</tr>
</tbody>
</table>

Limitations for added procedure codes: Procedure codes J7188 and J7205 may be reimbursed as follows:

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


**Brachytherapy**

<table>
<thead>
<tr>
<th>Added Procedure Codes</th>
<th>10035</th>
<th>10036</th>
<th>77767</th>
<th>77768</th>
<th>77770</th>
<th>77771</th>
<th>77772</th>
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<tr>
<td>Discontinued Procedure Codes</td>
<td>77776</td>
<td>77777</td>
<td>77785</td>
<td>77786</td>
<td>77787</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Limitations for added procedure codes:** Procedure codes 10035 and 10036 may be reimbursed to physician providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure code 10036 is an add-on procedure and must be billed with the primary procedure code 10035 to be considered for reimbursement.

Procedure codes 77767, 77768, 77770, 77771, and 77772 may be reimbursed as follows:

- The total component may be reimbursed to physician and radiation treatment center providers for services rendered in the office setting. Services rendered in the outpatient hospital setting may be reimbursed to radiation treatment center and hospital providers.
- The professional component may be reimbursed to physician providers for services rendered in the office, inpatient, and outpatient hospital settings.
- The technical component may be reimbursed to radiation treatment center providers for services rendered in the office and outpatient hospital settings.

**Breast Cancer Gene 1 and 2 (BRCA) Testing**

<table>
<thead>
<tr>
<th>Added Procedure Code</th>
<th>81162</th>
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</table>

**Limitations for added procedure code:** Procedure code 81162 requires prior authorization and may be reimbursed to independent laboratory providers in the laboratory setting.

Providers may refer to the *Texas Medicaid Provider Procedures Manual Radiology and Laboratory Services Handbook* subsection 2.2.6, “Breast Cancer Gene 1 and 2 (BRCA) Testing,” for additional information.

**Colony Stimulating Factors**

<table>
<thead>
<tr>
<th>Added Procedure Code</th>
<th>J1447</th>
</tr>
</thead>
</table>

**Limitations for added procedure code:** Procedure code J1447 may be reimbursed as follows:

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

Procedure code J1447 is limited to the diagnosis codes listed in Appendix A on page 40 of this document.

**Diagnostic Endoscopies**

<table>
<thead>
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<th>Added Procedure Codes</th>
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<tbody>
<tr>
<td>31652</td>
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<table>
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<tr>
<th>Discontinued Procedure Codes</th>
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<tbody>
<tr>
<td>G6021</td>
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**Limitations for added procedure codes:** Procedure codes 31652 and 31653 may be reimbursed as follows:

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

Procedure code 31654 may be reimbursed to physician providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure codes 39401 and 39402 may be reimbursed to physician providers for services rendered in the inpatient and outpatient hospital settings.

**Drug Testing and Therapeutic Drug Assays**

<table>
<thead>
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<th>Discontinued Procedure Codes</th>
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<tr>
<td>G0431</td>
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**Gynecological and Reproductive Health Services**

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<td>J7297</td>
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<table>
<thead>
<tr>
<th>Discontinued Procedure Code</th>
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<tbody>
<tr>
<td>J7302</td>
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</table>

**Limitations for added procedure codes:** Procedure codes J7297 and J7298 may be reimbursed for female clients as follows:

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

Procedure codes J7297 and J7298 are limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis codes</th>
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<tbody>
<tr>
<td>Z30011</td>
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<tr>
<td>Z30430</td>
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</table>

Hematopoietic Injections

Discontinued Procedure Code

J0886


Home Health Skilled Nursing and Home Health Aide Services

Added Procedure Codes

G0299  G0300

Discontinued Procedure Code

G0154

Limitations for added procedure codes: Procedure codes G0299 and G0300 may be reimbursed to home health agency providers for services rendered in the home setting.

Prior authorization is required for procedure codes G0299 and G0300.

Procedure codes G0299 and G0300 must be billed in 15 minute increments. A combined total of three skilled nursing or home health aide visits may be reimbursed per date of service.

Providers may refer to the Texas Medicaid Provider Procedures Manual, Nursing and Therapy Services Handbook subsection 3.2.3, “Home Health Skilled Nursing Services,” for additional information.

Immunosuppressive Drugs

Added Procedure Code

J0202

Limitations for added procedure code: Procedure code J0202 may be reimbursed as follows:

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

• To medical supplier durable medical equipment (DME) providers for services rendered in the home setting.

• To hospital providers for services rendered in the outpatient hospital setting.

Procedure code J0202 may be indicated for, but is not limited to, treatment of relapsing forms of multiple sclerosis (MS) and should be reserved for clients who have had an inadequate response to two or more drugs indicated for the treatment of MS.

Injections – Immune Globulins

**Added Procedure Code**

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<tr>
<th>Code</th>
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<tr>
<td>J1575</td>
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**Limitations for added procedure code:** Procedure code J1575 may be reimbursed as follows:

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


Neurostimulators and Neuromuscular Stimulators

**Discontinued Procedure Code**

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Otology and Audiometry Services

**Added Procedure Codes**

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<th>Code</th>
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<tbody>
<tr>
<td>92543</td>
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**Limitations for added procedure codes:** Procedure codes 92537 and 92538 may be reimbursed as follows:

- The total component may be reimbursed to physician providers for services rendered in the office, inpatient, and outpatient hospital settings and to portable x-ray supplier, radiological lab, and physiological lab providers in the office setting.
- The professional component may be reimbursed to physician providers for services rendered in the office, inpatient, and outpatient hospital settings.
- The technical component may be reimbursed to physician, audiology, radiation treatment center, portable x-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting and to radiation treatment center providers for services rendered in the outpatient hospital setting.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Vision and Hearing Services Handbook* subsection 2.2.3.2, “Vestibular Evaluations,” for additional information.

Solid Organ Transplants

**Discontinued Procedure Code**

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**Texas Health Steps (THSteps) Preventive Care Medical Checkups**

| Added Procedure Code | G0475 |

**Limitations for added procedure code:** Procedure code G0475 may be reimbursed as follows:

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

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Children's Services Handbook* subsection 5.3.11.6, “Laboratory Test,” for additional information.

**Vaccines and Toxoids**

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**ASC/HASC Code Additions**

Additions for ambulatory surgical center/hospital ambulatory surgical center (ASC/HASC) facilities are listed with appropriate group payments in the 2016 Healthcare Common Procedure Coding System (HCPCS) procedure code additions table located on page 19 and replacement procedure codes table located on page 37 of this bulletin.

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

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

**Home Health Services Benefit Changes**

The following Texas Medicaid Home Health Services benefit changes have been made to support the 2016 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2016. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.
Mobility Aids – Home Health

**Added Procedure Code**

| E1012 |

**Limitations for added procedure code:** Procedure code E1012 requires prior authorization and may be reimbursed to home health DME, medical supplier (DME), and specialized/custom wheeled mobility providers for services rendered in the home setting.

Procedure code E1012 is limited to 1 per five years.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* subsection 2.2.15, “Mobility Aids,” for additional information.

Respiratory Equipment and Supplies – Home Health

**Added Procedure Codes**

| E0465 | E0466 |

**Discontinued Procedure Codes**

| A7011 | E0450 | E0460 | E0463 | E0464 |

**Limitations for added procedure codes:** Procedure codes E0465 and E0466 require prior authorization and may be reimbursed to home health DME and medical supplier (DME) providers for services rendered in the home setting.

Procedure codes E0465 and E0466 will be limited to one rental per month.

Providers may refer to the *Texas Medicaid Provider Procedures Manual, Durable Medical Equipment Handbook* subsection 2.2.19.13, “Procedure Codes and Limitations for Respiratory Equipment and Supplies,” for additional information.

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**THSTEPS PROVIDERS**

**THSteps Dental Benefit Changes**

The following Texas Health Steps (THSteps) dental services benefit changes have been made to support the 2016 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2016. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

**Texas Health Steps (THSteps) Diagnostic Dental Services**

**Added Procedure Codes**

| D4283 | D4285 |

**Discontinued Procedure Codes**

| D0260 |

Providers may refer to the *Texas Medicaid Provider Procedures Manual Children's Services Handbook* subsection 4.2.13, “Diagnostic Services,” for additional information.
Texas Health Steps (THSteps) Therapeutic Dental Services

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<table>
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<th>Discontinued Procedure Codes</th>
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<tbody>
<tr>
<td>D2970</td>
<td>D9220</td>
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</table>

Limitations for added procedure code: Procedure codes D4283 and D4285 may be reimbursed for clients who are 13 through 20 years of age to FQHC, THSteps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure codes D4283 and D4285 are limited to three teeth per site same day same provider.

Procedure code D4283 is an add-on code and must be billed along with procedure code D4273.

Pre- and postoperative photographs are required for procedure codes D4283 and D4285.

Procedure code D4285 is an add-on code and must be billed along with procedure code D4275.

Documentation will be required when medical necessity is not evident on radiographs for procedure codes D4283 and D4285.

Procedure code D9223 requires prior authorization and may be reimbursed for clients who are 1 through 20 years of age to FQHC, THSteps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office setting.

Procedure code D9223 may be billed in 15 minute increments and are limited to three hours per day.

Procedure code D9243 may be reimbursed to FQHC, THSteps dental, orthodontist, and oral maxillofacial surgeon providers for services rendered in the office, inpatient, and outpatient hospital settings.

Procedure code D9243 may be billed in 15 minute increments and are limited to one and one-half hours per day.

Procedure codes D9223 and D9243 will be denied when billed for the same date of service as procedure code D9248.


DSHS EPHC PROVIDERS

DSHS EPHC Services Benefit Changes

The 2016 HCPCS updates include added procedure codes for the Department of State Health Services (DSHS) Expanded Primary Health Care (EPHC) program. Updates for the EPHC program are included in the HCPCS tables in the “All Code Changes” section of this bulletin beginning on page 19.
DSHS FAMILY PLANNING PROVIDERS

DSHS Family Planning Services Benefit Changes

The 2016 HCPCS updates include added procedure codes for the Department of State Health Services (DSHS) Family Planning (FP) program. Updates for the FP program are included in the HCPCS tables in the “All Code Changes” section of this bulletin beginning on page 19.

TEXAS WOMEN’S HEALTH PROGRAM (TWHP) PROVIDERS

TWHP Providers Benefit Changes

The following Texas Women’s Health Program (TWHP) benefit changes have been made to support the 2016 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2016. For more information, call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

Texas Women’s Health Program (TWHP)

<table>
<thead>
<tr>
<th>Added Procedure Codes</th>
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<tbody>
<tr>
<td>J7297</td>
<td>J7298</td>
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<table>
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<tr>
<th>Discontinued Procedure Codes</th>
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<tbody>
<tr>
<td>J7302</td>
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</table>

Limitations for added procedure code: Procedure codes J7297 and J7298 may be reimbursed for female clients as follows:

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

Procedure codes J7297 and J7298 are limited to the following diagnosis codes:

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<tr>
<th>Diagnosis Codes</th>
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CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM PROVIDERS

CSHCN Services Program Updates

The 2016 HCPCS updates including authorization and prior authorization updates for the CSHCN Services Program are included in the Healthcare Common Procedure Coding System (HCPCS) tables in the “All Code Changes” section of this bulletin beginning on page 19. The 2016 HCPCS deletions and replacements are effective January 1, 2016, for dates of service on or after January 1, 2016, for the CSHCN Services Program. Providers may refer to the “General Information” section for more information.

Authorization and Prior Authorization Update Reminder

Effective January 1, 2016, the 2016 HCPCS deleted procedure codes are no longer reimbursed by the CSHCN Services Program. Unless otherwise indicated on page 39 of this bulletin, providers who have received authorizations or prior authorizations for dates of service that occur on, after, or encompass January 1, 2016, must submit a written request on the appropriate, completed CSHCN Services Program authorization or prior authorization request form in order to update the HCPCS procedure codes authorized for those services.

Providers may refer to the section of this bulletin titled, “Prior Authorization Changes,” for information about obtaining authorization or prior authorization.

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

CSHCN Services Program Benefit Changes

The following CSHCN Services Program benefit changes have been made to support the 2016 HCPCS and Current Procedural Terminology (CPT) updates and are effective for dates of service on or after January 1, 2016. For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-925-9126.

The policy articles below contain the following information:

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

• **Discontinued:** Discontinued procedure codes are no longer reimbursed after December 31, 2015.

• **Added:** Added procedure codes are new procedure codes added by the Centers for Medicare & Medicaid Services (CMS). Procedure codes noted with an asterisk (*) require a rate hearing for pricing.

• **Limitations:** Additional benefit and limitation information for the added procedure codes.

• **Replacement:** Replacement procedure codes directly replace the indicated discontinued procedure code. The discontinued procedure codes are no longer reimbursed after December 31, 2015, and the replacement procedure codes are effective for dates of service on or after January 1, 2016. Not all discontinued procedure codes have direct replacements.

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

Added Procedure Codes

| J7188 | J7205 |

Discontinued Procedure Code

| Q9975 |

Limitations for added procedure code: Procedure code J7188 may be reimbursed as follows:

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

Procedure code J7188 is limited to the following diagnosis codes:

| D66  | D67  | D681 | D682 | D683311 | D688 | D689 |

Procedure code J7205 may be reimbursed as follows:

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

Procedure code J7205 is limited to the following diagnosis codes:

| D66  | D682 | D688 | D689 |

Providers may refer to the CSHCN Services Program Provider Manual subsection 24.4.1.1, “Blood Factor Products,” for additional information.

Dental – Diagnostic Services

Added Procedure Codes

| D4283 | D4285 |

Discontinued Procedure Codes

| D0260 |

Providers may refer to the CSHCN Services Program Provider Manual subsection 14.2.5.5, “Periodontics,” for additional information.
Dental – Therapeutic Services

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<td>D2970</td>
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**Limitations for added procedure codes:** Procedure codes D4283 and D4285 may be reimbursed to dentists, orthodontists, and oral maxillofacial surgeon providers for services rendered in the office, inpatient, and outpatient hospital settings.

D9223 may be reimbursed to dentists, orthodontists, and oral maxillofacial surgeon providers for services rendered in the office setting.

Procedure code D9243 may be reimbursed to dentists, orthodontists, and oral maxillofacial surgeon providers for services rendered in the office and inpatient hospital settings; and may be reimbursed to dentists and orthodontist providers for services rendered in the outpatient hospital setting.

Procedure codes D4283 and D4285 may be reimbursed to clients who are 13 years of age and older and are limited to three teeth per site same day same provider.

Pre- and post-operative photographs are required for procedure codes D4283 and D4285.

Documentation will be required when medical necessity is not evident on radiographs for procedure codes D4283 and D4285.

Procedure code D4283 is an add-on code and must be billed with the primary procedure code D4273 to be considered for reimbursement.

Procedure code D4285 is an add-on code and must be billed with the primary procedure code D4275 to be considered for reimbursement.

Procedure code D9223 requires prior authorization and is limited to three hours per day.

Procedure codes D9223 and D9243 will be denied when billed for the same date of service as procedure code D9248.

Procedure code D9920 will be denied when billed on the same day as procedure codes D9223 and D9243.

Providers may refer to the CSHCN Services Program Provider Manual subsections 14.2.5.5, “Periodontics,” and 14.2.5.8, Adjunctive General Services for additional information.

**Durable Medical Equipment (DME)**

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**Limitations for added procedure code:** Procedure code E1012 requires prior authorization and may be reimbursed as a purchase to home health DME, medical supplier (DME), and custom DME providers for services rendered in the home setting.
Purchase is limited to one per five years for procedure code E1012.

Providers may refer to the CSHCN Services Program Provider Manual subsection 17.3, “Benefits, Limitations, and Authorization Requirements,” for additional information.

**Genetic Testing for Hereditary Breast and Ovarian Cancers**

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*Limitations for added procedure code:* Procedure code 81162 requires prior authorization and may be reimbursed for clients who are 18 years of age and older to independent laboratory providers for services rendered in the laboratory setting.

Providers may refer to the CSHCN Services Program Provider Manual subsection 25.2.5.3, “Genetic Testing for Hereditary Breast and Ovarian Cancers,” for additional information.

**Hearing Services**

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<td>92543</td>
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*Limitations for added procedure code:* Procedure codes 92537 and 92538 may be reimbursed as follows:

- The total component may be reimbursed to physician providers for services rendered in the office and outpatient hospital settings.

- The professional component may be reimbursed to physician providers for services rendered in the office, inpatient, and outpatient hospital settings.

- The technical component may be reimbursed to physician, audiologist, radiation treatment center, portable x-ray supplier, radiological lab, and physiological lab providers for services rendered in the office setting and to radiation treatment center providers for services rendered in the outpatient hospital setting.

Providers may refer to the CSHCN Services Program Provider Manual subsection 20.2.3.3, “Vestibular Evaluations,” for additional information.

**Home Health Services**

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*Limitations for added procedure code:* Procedure codes G0299 and G0300 require prior authorization and may be reimbursed to home health agency providers for services rendered in the home setting.

Providers must bill procedure codes G0299 and G0300 for conditions which are expected to resolve in 60 calendar days or less. All claims for reimbursement of procedure codes G0299 and G0300 are based on the actual amount
of billable time associated with the service. For those services in which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour. Procedure codes G0299 and G0300 will be limited to 30 units per day, for any procedure, any provider.

Procedure codes G0299 and G0300 will be denied if billed by any provider on the same date of service as procedure code S9123 or S9124.

Providers may refer to the CSHCN Services Program Provider Manual Chapter 21, “Home Health Services,” for additional information.

**Immune Globulins**

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<td>J1575</td>
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**Limitations for added procedure code:** Procedure code J1575 may be reimbursed as follows:

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

Providers may refer to the CSHCN Services Program Provider Manual subsection 31.2.25.12, “Immune Globulins,” for additional information.

**Neurostimulators and Neuromuscular Stimulators**

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Providers may refer to the CSHCN Services Program Provider Manual Section 27, “Neurostimulators and Neuromuscular Stimulators,” for additional information.

**Radiation Therapy Services**

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<th>Added Procedure Codes</th>
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<td>77776 77777 77785 77786 77787</td>
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**Limitations for added procedure codes:** Procedure codes 10035 and 10036 may be reimbursed for the surgical component to physician providers in the office, inpatient hospital, and outpatient hospital settings.

Procedure code 10036 is an add-on procedure code, and must be billed with the primary procedure code 10035 to be considered for payment.

Procedure codes 77767, 77768, 77770, 77771, and 77772 may be reimbursed as follows:

- The total component may be reimbursed to physician and radiation treatment center providers for services rendered in the office setting and to radiation treatment center and hospital providers for services rendered in the outpatient hospital setting.
• The professional component may be reimbursed to physician providers for services rendered in the office, inpatient hospital, and outpatient hospital settings.

• The technical component may be reimbursed to physician and radiation treatment center providers for services rendered in the office setting and to radiation treatment center providers for services rendered in the outpatient hospital setting.

Providers may refer to the *CSHCN Services Program Provider Manual* subsection 33, “Radiation Therapy Services,” for additional information.

**Radiology – X-Ray and Ultrasound**

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**Limitations for added procedure code:** Procedure code Q9950 may be reimbursed as follows:

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

Procedure code Q9950 is an add-on procedure and must be billed with the primary procedure code 93306 to be considered for reimbursement.

Providers may refer to the *CSHCN Services Program Provider Manual* subsection 16.2.10.1, “Diagnostic Imaging,” for additional information.

**Respiratory Equipment and Supplies**

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<tr>
<td>A7011 E0450 E0460 E0463 E0464</td>
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</table>

**Limitations for added procedure code:** The rental component for procedure codes E0465 and E0466 may be reimbursed to home health DME, medical supplier (DME), and custom DME providers for services rendered in the home setting.

Procedure codes E0465 and E0466 require prior authorization and are limited to one per month.

Providers may refer to the *CSHCN Services Program Provider Manual* subsection 35.2, “Benefits, Limitations, and Authorization Requirements,” for additional information.

**Vaccines/Toxoids**

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Providers may refer to the *CSHCN Services Program Provider Manual* subsection 31.2.24.9, “Vaccine and Toxoid Procedure Codes,” for additional information.
**ALL CODE CHANGES: ADDED, REVISED, REPLACEMENT, AND DISCONTINUED**

### 2016 HCPCS Procedure Code Additions

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

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<tr>
<th>TOS</th>
<th>Procedure Code</th>
<th>Medicaid Allowable</th>
<th>CSHCN Allowable</th>
<th>Other Allowable</th>
<th>Authorization Requirements</th>
<th>Benefit Changes</th>
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</table>

* = Texas Medicaid rate hearing required, ** = Expenditures for procedure codes J7297 and J7298 have been approved for reimbursement for claims submitted with dates of service on or after January 1, 2016. No additional rate hearing is required, *** = Rate hearing required; providers will be notified in a future notification of the effective date for these procedure codes, NC = Procedure code not a benefit, EPHC = Procedure code a benefit of the EPHC program, FP = Procedure code a benefit of the DSHS FP program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required. MC in the Authorization Requirements column indicates that a Medicaid managed care prior authorization is required. None in the Authorization Requirements column indicates that authorization or prior authorization is not required. MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.
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<td>*</td>
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<td>EPHC</td>
</tr>
</tbody>
</table>

* = Texas Medicaid rate hearing required, ** = Expenditures for procedure codes J7297 and J7298 have been approved for reimbursement for claims submitted with dates of service on or after January 1, 2016. No additional rate hearing is required, *** = Rate hearing required; providers will be notified in a future notification of the effective date for these procedure codes, NC = Procedure code not a benefit, EPHC = Procedure code a benefit of the EPHC program, FP = Procedure code a benefit of the DSHS FP program, MD in the Authorization Requirements column indicates that a Medicaid prior authorization is required. CSHCN in the Authorization Requirements column indicates that a CSHCN Services Program authorization or prior authorization is required.

MC in the Authorization Requirements column indicates that a Medicaid managed care prior authorization is required. None in the Authorization Requirements column indicates that authorization or prior authorization is not required.

MD in the Benefit Changes column indicates that additional information is available in the Medicaid program benefit changes section at the beginning of this bulletin. CSHCN in the Benefit Changes column indicates that additional information is available in the CSHCN Services Program benefit changes section at the beginning of this bulletin. If the Benefit Changes column is blank, no additional program information is available for the procedure code.
Note: All new, revised, and discontinued 2016 HCPCS procedure codes are effective for dates of service on or after January 1, 2016. The new procedure codes that are indicated with an asterisk (*) in the above table are pending a rate hearing and approval of expenditures. Providers will be notified in a future notification if a new procedure code is not approved for reimbursement. Providers can refer to the section in this bulletin titled “Rate Hearings and Expenditure Review” for more information about benefits that are pending approval of expenditures.

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Procedures</strong></td>
</tr>
<tr>
<td>0403T 0405T</td>
</tr>
<tr>
<td><strong>Surgical Procedures</strong></td>
</tr>
<tr>
<td>0396T 0397T 0398T 0402T 0404T 0406T 0407T 0408T 0409T 0410T</td>
</tr>
<tr>
<td>0411T 0412T 0413T 0416T 0417T 0418T 0419T 0420T 0421T 0424T</td>
</tr>
<tr>
<td>0425T 0426T 0427T 0428T 0429T 0432T 0433T 0434T 0435T 0436T</td>
</tr>
<tr>
<td><strong>Radiological Procedures</strong></td>
</tr>
<tr>
<td>0399T</td>
</tr>
<tr>
<td><strong>Laboratory Procedures</strong></td>
</tr>
<tr>
<td>0009M 0010M</td>
</tr>
<tr>
<td><strong>Radiation Therapy Procedures</strong></td>
</tr>
<tr>
<td>0394T 0395T</td>
</tr>
</tbody>
</table>

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

### Discontinued Procedure Codes

The 2016 HCPCS discontinued procedure codes are no longer reimbursed after December 31, 2015. The following is a list of procedure codes that have been discontinued:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>21805 31620 37202 37250 37251 39400 47136 47500 47505 47510</td>
</tr>
<tr>
<td>47511 47525 47530 47560 47561 47630 50392 50393 50394 50398</td>
</tr>
<tr>
<td>64412 67112 70373 72010 72069 72090 73500 73510 73520 73530</td>
</tr>
<tr>
<td>73540 73550 74305 74320 74327 74475 74480 75896 75945 75946</td>
</tr>
<tr>
<td>75980 75982 77776 77777 77785 77786 77787 82486 82487 82488</td>
</tr>
<tr>
<td>82489 82491 82492 82541 82543 82544 83788 83847 90645 90646</td>
</tr>
<tr>
<td>90669 90692 90693 90703 90704 90705 90706 90708 90712 90719</td>
</tr>
<tr>
<td>90720 90721 90725 90727 90735 92543 95973 A7011 C9025* C9026*</td>
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<tr>
<td>C9027* C9136 C9442* C9443* C9444* C9445* C9446* C9448 C9449* C9450*</td>
</tr>
<tr>
<td>C9451* C9452* C9453* C9454* C9455* C9456* C9457* C9724* C9737 D0260</td>
</tr>
<tr>
<td>D0421 D2970 D9220 D9221 D9241 D9242 D9931 E0450 E0460 E0461</td>
</tr>
<tr>
<td>E0463 E0464 G0154 G0431 G0434 G6018 G6019 G6020 G6021 G6022</td>
</tr>
</tbody>
</table>
The procedure codes indicated with an asterisk (*) have been replaced. Replacement procedure codes are available for the Texas Medicaid Program, the CSHCN Services Program, or both. Providers may refer to the “Replacement Procedure Codes” section on page 37 of this bulletin for details.

The following informational reporting procedure codes have been discontinued:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0099T 0103T 0123T 0182T 0223T 0224T 0225T 0240T 0241T 0243T 0244T 0262T 0311T</td>
</tr>
</tbody>
</table>

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

### Replacement Procedure Codes

Effective for dates of service on or after January 1, 2016, the following discontinued procedure codes will be replaced by the corresponding replacement procedure codes:

<table>
<thead>
<tr>
<th>Replacement Codes</th>
<th>Discontinued Codes</th>
<th>Medicaid Rate</th>
<th>CSHCN Rate</th>
<th>Authorization Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>43210</td>
<td>C9724</td>
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<tr>
<td>J0202</td>
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<td>J0202</td>
<td>Q9979</td>
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<td>J0596</td>
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<td>J2547</td>
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<td>J3090</td>
<td>C9446</td>
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</table>
### Replacement Codes

<table>
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<th>New Code</th>
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<th>CSHCN Rate</th>
<th>Authorization Requirement</th>
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<td>C9449</td>
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<td>Q9950</td>
<td>C9457</td>
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<td>None</td>
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</tbody>
</table>

* = Texas Medicaid rate hearing required, NC = Procedure code not a benefit

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

### Procedure Code Description Changes

Effective for dates of service on or after January 1, 2016, the following procedure code descriptions have changed:

| Procedure Codes |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| 37184           | 37185           | 37186           | 50387           | 65855           | 67107           | 67108           | 67113           | 67227           | 67228           |
| 72080           | 77057           | 77417           | 77778           | 77789           | 78264           | 81210           | 81275           | 81435           | 81436           |
| 82542           | 83789           | 86708           | 87301           | 87305           | 87320           | 87324           | 87327           | 87328           | 87329           |
| 87332           | 87335           | 87336           | 87337           | 87338           | 87339           | 87340           | 87341           | 87350           | 87380           |
| 87385           | 87389           | 87390           | 87391           | 87400           | 87420           | 87425           | 87427           | 87430           | 87449           |
| 87450           | 87451           | 87502           | 87503           | 88341           | 88342           | 88346           | 88381           | 89055           | 90632           |
| 90633           | 90634           | 90644           | 90647           | 90648           | 90649           | 90650           | 90651           | 90653           | 90655           |
| 90656           | 90657           | 90658           | 90660           | 90661           | 90662           | 90667           | 90668           | 90670           | 90672           |
| 90673           | 90680           | 90681           | 90685           | 90686           | 90687           | 90688           | 90696           | 90698           | 90702           |
| 90714           | 90716           | 90732           | 90733           | 90734           | 90736           | 90739           | 90740           | 90743           | 90744           |
| 90746           | 90747           | 90748           | 94640           | 95972           | 99354           | 99355           | B5000           | B5100           | B5200           |
| C1820           | C9349           | D0250           | D0340           | D4273           | D4275           | D4277           | D4278           | D5630           | D5660           |
| D5993           | D6103           | D6600           | D6601           | D6602           | D6603           | D6604           | D6605           | D6606           | D6607           |
| D6608           | D6609           | D6610           | D6611           | D6612           | D6613           | D6614           | D6615           | D6624           | D6634           |
| D6710           | D6720           | D6721           | D6722           | D6740           | D6750           | D6751           | D6752           | D6780           | D6781           |
| D6782           | D6783           | D6790           | D6791           | D6792           | D6794           | D9248           | G8399           | G8400           | G8401           |
| G8458           | G8465           | G8784           | G8924           | G8925           | G8928           | G8929           | G8955           | G9196           | G9226           |
| G9277           | G9286           | G9287           | G9298           | G9354           | G9384           | G9385           | G9389           | G9390           | G9419           |
| G9429           | G9460           | G9467           | J0571           | J0572           | J0573           | J0574           | J0575           | J1442           | J2791           |
| J7180           | J7508           | K0017           | K0018           | L1902           | L1904           | L8621           | Q4153           |
The description of the following informational reporting procedure code has changed:

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<thead>
<tr>
<th>Reporting Procedure Code - Informational</th>
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<tbody>
<tr>
<td>0295T</td>
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</tbody>
</table>

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

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

Modifiers

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

<table>
<thead>
<tr>
<th>New Modifiers</th>
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</thead>
<tbody>
<tr>
<td>CP</td>
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</tbody>
</table>

New modifiers are effective for dates of service on or after January 1, 2016. Providers may contact the appropriate copyright holder to obtain modifier descriptions.

PRIOR AUTHORIZATION CHANGES

Authorization or Prior Authorization

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

- Current Texas Medicaid Provider Procedures Manual
- Current CSHCN Services Program Provider Manual
- Articles published on the Texas Medicaid & Healthcare Partnership (TMHP) web page at www.tmhp.com

Providers must obtain a timely authorization or prior authorization for the service that they provide. Services that are submitted without the proper authorization will be denied.

Providers are responsible for meeting all filing deadlines and for ensuring that the authorization or prior authorization number appears on the claim or that the appropriate documentation is submitted with the claim. Retroactive authorization requests for certain services will not be granted, unless otherwise indicated in the applicable authorization requirements sections of the current Texas Medicaid Provider Procedures Manual or the current CSHCN Services Program Provider Manual.

The procedure codes that require authorization or prior authorization are indicated in the Authorization Requirements column of the 2016 HCPCS Procedure Code Additions table that begins on page 19 of this bulletin.

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

Prior Authorization Update

Providers who have received prior authorization for any of the following 2016 Healthcare Common Procedure Coding System (HCPCS) procedure codes that are being discontinued on January 1, 2016, for dates of service that
occur on, after, or encompass January 1, 2016, must contact the TMHP Prior Authorization Department to update the procedure codes in the following table:

<table>
<thead>
<tr>
<th>TOS</th>
<th>Discontinued Procedure Code</th>
<th>Prior Authorization Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>47136</td>
<td>MD</td>
</tr>
<tr>
<td>8</td>
<td>47136, CSHCN</td>
<td>MD, CSHCN</td>
</tr>
<tr>
<td>2</td>
<td>G6021</td>
<td>MD, CSHCN</td>
</tr>
</tbody>
</table>

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

For a list of Prior Authorization Department telephone numbers, providers may refer to the “TMHP Telephone and Fax Communication” in the current Texas Medicaid Provider Procedures Manual, Appendix A: State, Federal, and TMHP Contact Information, and TMHP-CSHCN Services Program Contact Information” in the current CSHCN Services Program Provider Manual, on page 1-2.

APPENDIX A: DIAGNOSIS CODES FOR PROCEDURE CODE J1447

Procedure Code J1447 Diagnosis Codes

Procedure code J1447 is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>C000 C001 C002 C003 C004 C005 C006 C008 C01 C020</td>
</tr>
<tr>
<td>C021 C022 C023 C024 C028 C029 C030 C031 C039 C040</td>
</tr>
<tr>
<td>C041 C048 C049 C050 C051 C052 C059 C060 C061 C062</td>
</tr>
<tr>
<td>C0689 C069 C07 C080 C081 C089 C090 C091 C099 C100</td>
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<tr>
<td>C101 C102 C103 C104 C108 C109 C110 C111 C112 C113</td>
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<td>C118 C119 C12 C130 C131 C132 C138 C139 C140 C142</td>
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<tr>
<td>C148 C153 C154 C155 C158 C159 C160 C161 C162 C163</td>
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<td>C164 C165 C166 C168 C169 C170 C171 C172 C173 C178</td>
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<tr>
<td>C179 C180 C181 C182 C183 C184 C185 C186 C187 C188</td>
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<td>C189 C19 C20 C210 C211 C218 C220 C221 C222 C223</td>
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<td>C227 C228 C229 C23 C240 C241 C248 C249 C250 C251</td>
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<tr>
<td>C252 C253 C254 C257 C258 C259 C260 C261 C269 C300</td>
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<tr>
<td>C301 C310 C311 C312 C313 C318 C319 C320 C321 C322</td>
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<tr>
<td>C323 C328 C329 C33 C3401 C3402 C3411 C3412 C342 C3431</td>
</tr>
<tr>
<td>C3432 C3481 C3482 C3491 C3492 C37 C380 C381 C382 C383</td>
</tr>
<tr>
<td>C384 C388 C390 C399 C4001 C4002 C4011 C4012 C4021 C4022</td>
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<tr>
<td>C4031 C4032 C4081 C4082 C410 C411 C412 C413 C414 C430</td>
</tr>
<tr>
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<td>C4361 C4362 C4371 C4372 C438 C439 C460 C461 C462 C463</td>
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<tr>
<td>C464 C4651 C4652 C467 C469 C478 C480 C481 C482 C488</td>
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<tr>
<td>C490 C4911 C4912 C4921 C4922 C493 C494 C495 C496 C498</td>
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<tr>
<td>C499 C4A0 C4A11 C4A12 C4A21 C4A22 C4A31 C4A39 C4A4 C4A51</td>
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<td>C4A52 C4A59 C4A61 C4A62 C4A71 C4A72 C4A8 C50011 C50012 C50021</td>
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<td>Diagnosis Codes</td>
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<td>Diagnosis Codes</td>
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