



Medicaid Behavioral Health and Medical Prior Authorization (PA) Code Matrix

April 1, 2026

To search this document, type in the keyword or code you are looking for by pressing press Ctrl F on your keyboard.

Please contact Molina at 1-855-322-4080 if you need more information about the Third-Party Proprietary Criteria referenced in this document or if information is needed in an alternate language.

Information that indicates certain items or services do not require authorization in this Prior Authorization (PA) Code Matrix document is only applicable for Participating Providers.

**FOR ANY PA CHANGES DUE TO REGULATORY GUIDANCE RELATED TO COVID 19 – PLEASE SEE PROVIDER NOTIFICATIONS AND MOST CURRENT INFORMATION ON THE PROVIDER PORTAL.**

Non-Participating Providers, with the exception of some facility based professional services, require prior authorization for ALL services or items in all places of service. See exceptions below.

Prior authorization exceptions for Non-Participating Offices/Providers/Facilities:

- Hospital Emergency Department Services;
- Evaluation and Management services associated with inpatient, ER visits and observation stays;
- Local Health Department (LHD) services
- Other services based on State requirements
- Radiologist, Anesthesiologist, and Pathologist professional services when billed in Place of Service Code 19, 21, 22, 23 or 24 (except dental anesthesia for STAR children)

All In-Patient admits and services require Prior Authorization, including: Acute Hospital, Neonatal Intensive Care Unit (NICU), Skilled Nursing Facilities (SNF), Rehabilitation, and Long-Term Acute Care (LTAC) Facilities.

Obstetric Admissions for Delivery: Effective 03/01/2024 no prior auth is required for three (3) days for a vaginal delivery or five (5) days for a Caesarean delivery. Additional inpatient days will require prior authorization for claims payment.

The codes in this document are for Out-Patient services only.

**Some services listed may not be covered by Medicaid. CMS, or your local State Regulatory Agency determines many of the plan benefits. The absence of a code from this list does not mean that a service is a covered benefit. Refer to the Texas Medicaid Fee Schedule and Texas Medicaid Provider Procedures Manual for the most up to date plan benefit information.**

DME Exceptional Circumstance Provision: Prior authorization for services not currently listed as a Medicaid benefit may be considered for coverage under the case-by-case exception or DME Exceptional Circumstance Provision when prior authorized and medically necessary.

Prior authorizations are not required for the following:

- Emergency Services for Participating or Non-Participating Providers.
- Office visits at Participating Providers.
- Referrals to Participating Network Specialists.

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

All services outside of the regulatory/coverage limits are subject to prior authorization review; coverage allowable and limits are outlined in the Texas Medicaid Provider Procedure Manual.

Molina covers limited gene therapy services in accordance with our medical policies. All of these requests require Prior Authorization.

For additional information please contact Molina Healthcare 1-855-322-4080.

[Healthcare Services Screening Criteria Link](#)

[Prior Authorization Code Matrix For Outpatient Drug Services](#)

[Texas Medicaid Provider Procedure Manual](#)

This document is NOT to be utilized to make benefit coverage determinations. Please review the Texas Medicaid Provider Manual and Texas Medicaid Fee Schedule.

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

The prior authorization information reflected on this document is general in nature and is not intended to be relied upon in making medical decisions. The criteria listed below is generally accurate, but may be different based on factors such as specific medical condition or type of provider requesting the service. Each patient will have unique medical conditions, submitted by his/her physician in a particularized manner, that will factor into documents required, criteria applied, and Molina's decision of whether to approve or deny a requested service. Please contact Molina or your doctor to get more information regarding prior authorization for any particular service.

| Service Category Notes | Effective Date    | Code  | Definition                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes                                                                                                                                                                                                                                                        | Date of Annual Review |
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| Anesthesia             | Prior to 9/1/2019 | 00170 | ANESTHESIA INTRAORAL WITH BIOPSY NOS | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>• Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li><li>• Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>• History of the presenting problem</li><li>• Clinical exam;</li><li>• Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>• Treatment plan and progress notes;</li><li>• Pertinent psychosocial history;</li><li>• Information and consultations with the treating practitioner;</li><li>• Pertinent evaluations from other health care practitioners and providers;</li><li>• Pertinent charts, graphs or photographic information, as appropriate;</li><li>• Rehabilitation evaluations;</li><li>• Information regarding the local delivery system; and</li><li>• Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual | Prior Auth Required for Medicaid (Star) member age 0-6 y/o. Provider to include DMO provider determination letter with PA request. Otherwise, PA is waived for all radiology, anesthesiology, and pathology services when billed in POS 19, 21, 22, 23 or 24 | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code | Definition                                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                          | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 0901 | BEHAVIORAL HEALTH TREATMENT/SVCS - Electroshock Treatment               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Please submit corresponding CPT code 90870 for prior authorization.            | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2024          | 0905 | INTENSIVE OUTPATIENT, PSYCHIATRIC                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Please submit corresponding CPT code S9480 for prior authorization.            | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2024          | 0906 | INTENSIVE OUTPATIENT, SUBSTANCE USE DISORDERS, REHABILITATION TREATMENT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Please submit corresponding HCPCS code H0004 or H0005 for prior authorization. | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 0912 | BEHAVIORAL HEALTH TREATMENT/SVCS - Partial Hosp                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Please submit corresponding HCPCS code H0035 for prior authorization.          | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 0913 | BEHAVIORAL HEALTH TREATMENT/SVCS - Partial Hosp - intensive therapy     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Please submit corresponding HCPCS code H0035 for prior authorization.          | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                  | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 1001  | Behavioral Health Accommodations - Residential -Psychiatric               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Please submit corresponding HCPCS code H0017, H0018, or H0019 for prior authorization. | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 1002  | Behavioral Health Accommodations - Residential -Chemical Dep              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Please submit corresponding HCPCS code H2035 for prior authorization.                  | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 2106  | BEHAVIORAL HEALTH TREATMENT/SVCS - Alternative Therapy Services; Hypnosis | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                                        | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2020          | 0373T | ADAPT BHV TX PRCL MODIFICAJ EA 15 MIN TECH TIME                           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                                        | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2023          | 80307 | DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | PRESUMPTIVE - PA required after 24 units used (any combination of 80305, 80306, 80307) | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                                                               | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 90867 | REPET TMS TX INITIAL W MAP MOTR THRESHLD DEL AND MNG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                                     | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 90868 | THERAP REPETITIVE TMS TX SUBSEQ DELIVERY AND MNG     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                                     | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 90869 | REPET TMS TX SUBSEQ MOTR THRESHLD W DELIV AND MNG    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                                     | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 90870 | ELECTROCONVULSIVE THERAPY (ECT)                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                                     | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2022          | 90901 | BIOFEEDBACK TRAINING ANY MODALITY                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Fax to 866-420-3639<br><br>Prior authorization is required for biofeedback services.<br>Any combination of procedure codes 90901, 90912, and 90913 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older. | 2/19/2025             |



| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Criteria Utilized                         | Notes                                                                                                                                                                                                                                                                            | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2022          | 90912 | BFB TRAING W/EMG and /MANOMETRY 1ST 15 MIN CNTCT           | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                       | Texas Medicaid Provider Procedures Manual | Fax to 866-420-3639<br><br>Prior authorization is required for biofeedback services. Any combination of procedure codes 90901, 90912, and 90913 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older. | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2022          | 90913 | 90913-BFB TRAING W/EMG and /MANOMETRY EA ADDL 15 MIN CNTCT | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                       | Texas Medicaid Provider Procedures Manual | Fax to 866-420-3639<br><br>Prior authorization is required for biofeedback services. Any combination of procedure codes 90901, 90912, and 90913 are a benefit for biofeedback sessions for urinary or fecal incontinence conditions in clients who are 4 years of age and older. | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2022          | 97151 | BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN               | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>• Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |                                                                                                                                                                                                                                                                                  | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 97153 | ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN            | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>• Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |                                                                                                                                                                                                                                                                                  | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 97154 | GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN           | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>• Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |                                                                                                                                                                                                                                                                                  | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 97155 | ADAPT BHV TX PRCL MODIFICAJ<br>PHYS QHP EA 15 MIN   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 97156 | FAMILY ADAPT BHV TX GDN PHYS<br>QHP EA 15 MIN       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 97157 | MULTIPLE FAM GROUP BHV TX GDN<br>PHYS QHP EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | 97158 | GRP ADAPT BHV PRCL MODIFICAJ<br>PHYS QHP EA 15 MIN  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2022          | 99366 | TEAM CONFERENCE FACE-TO-FACE<br>NONPHYSICIAN        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Criteria Utilized                         | Notes                                              | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2023       | G0480 | DRUG TEST DEFINITV DR ID METH P DAY 1-7 DRUG CL  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | DEFINITIVE - PA required after 12 dates of service | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2023       | G0481 | DRUG TEST DEFINITV DR ID METH P DAY 8-14 DRUG CL | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | DEFINITIVE - PA required after 12 dates of service | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2023       | G0482 | DRUG TEST DEFINITV DR ID METH P DAY 15-21 DR CL  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | DEFINITIVE - PA required after 12 dates of service | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2023       | G0483 | DRUG TST DEFINITV DR ID METH P DAY 22/MORE DR CL | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | DEFINITIVE - PA required after 12 dates of service | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2023       | G0659 | DRUG TEST DEFINITV DRUG ID METH ANY # DR CLASSES | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>History of the presenting problem</li> <li>Clinical exam;</li> <li>Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>Treatment plan and progress notes;</li> <li>Pertinent psychosocial history;</li> <li>Information and consultations with the treating practitioner;</li> <li>Pertinent evaluations from other health care practitioners and providers;</li> <li>Pertinent charts, graphs or photographic information, as appropriate;</li> <li>Rehabilitation evaluations;</li> <li>Information regarding the local delivery system; and</li> <li>Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | DEFINITIVE - PA required after 12 dates of service | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2024       | H0004 | BEHAVIORAL HEALTH CNSL AND THERAPY PER 15 MINUTES   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2024       | H0005 | ALCOHOL AND OR DRUG SERVICES; GROUP CNSL CLINICIAN  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021       | H0008 | ALCOHOL AND OR DRUG SRVC; SUB-ACUTE DTOX HOSP IP    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021       | H0009 | ALCOHOL AND OR DRUG SERVICES; ACUTE DTOX HOSP IP    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021       | H0010 | ALCOHOL and / DRUG SRVC; SUB-ACUTE DTOX RES PROG IP | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021          | H0011 | ALCOHOL and / DRUG SERVICES;<br>ACUTE DTOX RES PROG IP | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H0012 | ALCOHOL AND DRUG SRVC; SUB-<br>ACUTE DTOX RES PROG OP  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021          | H0014 | ALCOHOL AND OR DRUG SERVICES;<br>AMB DETOXIFICATION    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2020          | H0015 | ALCOHOL AND/OR DRUG SRVCS                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021          | H0016 | ALCOHOL AND OR DRUG SERVICES;<br>MEDICAL SOMATIC       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H0017 | BEHAVIORAL HEALTH; RES W O ROOM AND BOARD PER DIEM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2020          | H0018 | BHVAL HEALTH; SHORT-TERM RES W/O ROOM and BOARD-DIEM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021          | H0019 | BHVAL HEALTH; LONG-TERM RES W/O ROOM and BOARD-DIEM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H0035 | MENTAL HEALTH PARTIAL HOSP TX UNDER 24 HOURS         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2021          | H0040 | ASSERT COMM TX PROG - PER DIEM                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                        | Notes                                                                                                              | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2021          | H0046 | MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.           |                                                                                                                    | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 3/17/2024         | H0047 | ALCOHOL AND/OR OTHER DRUG ABUSE SERVICES NOS   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Uniform Managed Care Manual 16.3 "In-Lieu-of-Covered Services and Settings" Revision 2.1 |                                                                                                                    | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H2012 | BEHAVIORAL HEALTH DAY TREATMENT PER HOUR       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                         |                                                                                                                    | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H2013 | PSYCHIATRIC HEALTH FACILITY SERVICE PER DIEM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                         |                                                                                                                    | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 10/1/2025         | H2014 | SKILLS TRAINING AND DEVELOPMENT PER 15 MINUTES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                         | Prior authorization will not be required for LMHA providers. All other providers will require prior authorization. | 8/27/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                              | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H2016 | COMP COMMUNITY SUPPORT SERVICES PER DIEM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                    | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 10/1/2025         | H2017 | PSYCHOSOCIAL REHAB SERVICES PER 15 MINUTES         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | Prior authorization will not be required for LMHA providers. All other providers will require prior authorization. | 8/27/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H2018 | PSYCHOSOCIAL REHABILITATION SERVICES PER DIEM      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                    | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | H2020 | THERAPEUTIC BEHAVIORAL SERVICES PER DIEM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                    | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2024          | H2035 | ALCOHOL AND OR OTH DRUG TREATMENT PROGRAM PER HOUR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |                                                                                                                    | 2/19/2025             |



| Service Category Notes                                                                                                                                                                                                                 | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2020          | H2036 | ALCOHOL AND OR OTH DRUG TREATMENT PROGRAM PER DIEM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | S0201 | PARTIAL HOSITALIZATION SERVICES UNDER 24 HR PER DIEM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | S5150 | HOME CARE TRAINING FAMILY; PER SESSION               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | Prior to 9/1/2019 | S5111 | UNSKILLED RESPITE CARE NOT HOSPICE; PER 15 MIN       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 7/1/2020          | S9480 | INTENSIVE OP PSYCHIATRY                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                 | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Criteria Utilized                         | Notes                                                                                                                                                                                                                                                                                                            | Date of Annual Review |
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| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 3/1/2025       | S9482 | FAMILY STABILIZATION SERVICES PER 15 MINUTES        | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                       | Texas Medicaid Provider Procedures Manual | <b>Par providers:</b> Prior authorization is not required for the first 104 units (26 hours) of CFP services in a rolling six-month period. If additional units are required in this six months, prior auth will be required.<br><br><b>Non-par providers:</b> Prior authorizaiton is required for all requests. | 5/21/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2022       | T1025 | INTEN MXDISCIPLIN SRVC CHILD W/CMPLX IMPAIR DIEM    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>• Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | Prescribed Pediatric Extended Care Center (PPECC) Benefit. Please fax to 866-420-3639.                                                                                                                                                                                                                           | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2022       | T1026 | INTEN MXDISCIPLIN SRVC CHILD W/CMPLX IMPAIR HR      | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>• Any documentation outlined in the Texas Medicaid Provider Procedure Manual</li> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | Prescribed Pediatric Extended Care Center (PPECC) Benefit. Please fax to 866-420-3639.                                                                                                                                                                                                                           | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 1/1/2021       | T2023 | TARGETED CASE MANAGEMENT, PER MONTH                 | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                       | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                                                                  | 2/19/2025             |
| <b>Behavioral/Mental Health, Alcohol-Chemical Dependency:</b><br>Inpatient, Residential Treatment, Partial Hospitalization, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) for tx of Autism Spectrum Disorder (ASD). | 4/1/2021       | T2048 | BHVAL HEALTH; LONG-TERM CARE RES W/ROOM and BD-DIEM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                       | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                                                                  | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                        | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15775 | PUNCH GRAFT HAIR TRANSPLANT 1-15 PUNCH GRAFTS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15776 | PUNCH GRAFT HAIR TRANSPLANT OVER 15 PUNCH GRAFTS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15780 | DERMABRASION TOTAL FACE                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15781 | DERMABRASION SEGMENTAL FACE                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15782 | DERMABRASION REGIONAL OTHER THAN FACE            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                        | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15783 | DERMABRASION SUPERFICIAL ANY SITE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15788 | CHEMICAL PEEL FACIAL EPIDERMAL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15789 | CHEMICAL PEEL FACIAL DERMAL       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15792 | CHEMICAL PEEL NONFACIAL EPIDERMAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15793 | CHEMICAL PEEL NONFACIAL DERMAL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                        | Date of Annual Review |
|-----------------------------------------------|-------------------|-------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------|-----------------------|
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15820 | BLEPHAROPLASTY LOWER EYELID                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15821 | BLEPHAROPLASTY LOWER EYELID HERNIATED FAT PAD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15822 | BLEPHAROPLASTY UPPER EYELID                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15823 | BLEPHAROPLASTY UPPER EYELID W EXCESSIVE SKIN  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15824 | RHYTIDECTOMY FOREHEAD                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                        | Date of Annual Review |
|-----------------------------------------------|-------------------|-------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------|-----------------------|
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15825 | RHYTIDECTOMY NECK W PLATYSMAL TIGHTENING      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15826 | RHYTIDECTOMY GLABELLAR FROWN LINES            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15828 | RHYTIDECTOMY CHEEK CHIN AND NECK              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15829 | RHYTIDECTOMY SMAS FLAP                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15832 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE THIGH | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                        | Date of Annual Review |
|-----------------------------------------------|-------------------|-------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------|-----------------------|
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15833 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE LEG     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15834 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE HIP     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15835 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE BUTTOCK | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15836 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE ARM     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15837 | EXC EXCESSIVE SKIN AND SUBQ TISSUE FOREARM HAND | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                        | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15838 | EXC EXCSV SKIN AND SUBQ TISSUE SUBMENTAL FAT PAD   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15839 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE OTHER AREA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15847 | EXCISION EXCESSIVE SKIN AND SUBQ TISSUE ABDOMEN    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15876 | SUCTION ASSISTED LIPECTOMY HEAD AND NECK           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15877 | SUCTION ASSISTED LIPECTOMY TRUNK                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |



| Service Category Notes                        | Effective Date    | Code  | Definition                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                             | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15878 | SUCTION ASSISTED LIPECTOMY UPPER EXTREMITY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | Prior Authorization required in any setting.                      | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 15879 | SUCTION ASSISTED LIPECTOMY LOWER EXTREMITY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | Prior Authorization required in any setting.                      | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 17380 | ELECTROLYSIS EPILATION EACH 30 MINUTES     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | Prior Authorization required in any setting.                      | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19300 | MASTECTOMY GYNECOMASTIA                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19316 | MASTOPEXY                                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                              | Notes                                                             | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19318 | REDUCTION MAMMAPLASTY                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual      | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19325 | MAMMAPLASTY AUGMENTATION W PROSTHETIC IMPLANT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual      | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19328 | REMOVAL INTACT MAMMARY IMPLANT                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Breast Implant Removal | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19330 | REMOVAL MAMMARY IMPLANT MATERIAL                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Breast Implant Removal | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19340 | IMMT INSJ BRST PROSTH FLWG MASTOPEXY MAST RCNSTJ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual      | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                             | Date of Annual Review |
|-----------------------------------------------|-------------------|-------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------|-----------------------|
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19342 | DLYD INSJ BRST PROSTH FLWG<br>MASTOPEXY MAST RCNSTJ  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19350 | NIPPLE AREOLA RECONSTRUCTION                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19355 | CORRECTION INVERTED NIPPLES                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 19396 | PREPARATION MOULAGE CUSTOM<br>BREAST IMPLANT         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior authorization required, except with breast cancer diagnoses | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30400 | RHINP PRIM LAT AND ALAR CRTLGS<br>AND ELVTN NASAL TI | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | Prior Authorization required in any setting.                      | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                        | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30410 | RHINP PRIM COMPLETE XTRNL PARTS             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30420 | RHINOPLASTY PRIMARY W MAJOR SEPTAL REPAIR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30430 | RHINOPLASTY SECONDARY MINOR REVISION        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30435 | RHINOPLASTY SECONDARY INTERMEDIATE REVISION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30450 | RHINOPLASTY SECONDARY MAJOR REVISION        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                      | Notes                                        | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30460 | RHINP DFRM W COLUM LNGTH TIP ONLY                                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria       | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 30462 | RHINP DFRM COLUM LNGTH TIP SEPTUM OSTEO                                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria       | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | 1/1/2021          | 30468 | REPAIR OF NASAL VALVE COLLAPSE WITH SUBCUTANEOUS/SUBMUCOSAL LATERAL WALL IMPLANT(S) | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria       | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 67904 | RPR BLEPHAROPTOSIS LEVATOR RESCJ ADVMNT XTRNL                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Blepharoplasty | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 67906 | RPR BLEPHAROPTOSIS SUPERIOR RECTUS FASCIAL SLING                                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Blepharoplasty | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                        | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Criteria Utilized                      | Notes                                        | Date of Annual Review |
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| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 67908 | RPR BLPOS CONJUNCTIVO-TARSO-MUSC-LEVATOR RESCJ   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.                                                                                                                                                                                                                                                                                                                                                                                                                                       | Molina Clinical Policy: Blepharoplasty | Prior Authorization required in any setting. | 2/19/2025             |
| Cosmetic, Plastic & Reconstructive Procedures | Prior to 9/1/2019 | 69300 | OTOPLASTY PROTRUDING EAR W WO SIZE RDCTJ         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.                                                                                                                                                                                                                                                                                                                                                                                                                                       | Third Party Proprietary Criteria       | Prior Authorization required in any setting. | 2/19/2025             |
| Durable Medical Equipment (DME)               | 1/1/2022          | 0705T | REM TX AMBLYOPIA TCH SPRT MIN 18 TRAING HR EA 30 | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Third Party Proprietary Criteria       |                                              | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes                           | Date of Annual Review |
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| Durable Medical Equipment (DME) | 7/1/2023       | B4105 | IN-LINE CART CTG DIG ENZYME ENTERAL FEEDING EA        | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |                                 | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2020       | B4187 | OMEGAVEN 10 G LIPIDS                                  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual | In any setting (Add on for TPN) | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2025       | B4199 | PARNTRAL NUT SOL; AMINO ACID and CARB GT 100 GMS PPAR | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |                                 | 5/21/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | B9000 | ENTERAL NUT INFUS PUMP - W O ALARM               | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2020          | C1734 | ORTHOPEDIC/DEVC/DX MATRIX OPP BTB/SFT TISS-TO BN | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2020          | C1982 | CATHETER PRES GENERAT 1-WAY VALV INTERMIT OCCL   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Third Party Proprietary Criteria          |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 9/1/2019          | C2624 | IMPL WIRELESS PULM ARTERY PRESS SENSOR DEL CATH  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0194 | AIR FLUIDIZED BED                                | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0255 | HOS BED VARIBL HT W ANY TYPE SIDE RAIL W MATTRSS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0260 | HOS BED SEMI-ELEC W ANY TYPE SIDE RAIL W MATTRSS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0261 | HOS BED SEMI-ELEC ANY TYPE SIDE RAIL W O MATTRSS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0265 | HOSP BED TOT ELEC W ANY TYPE SIDE RAIL W MATTRSS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0266 | HOS BED TOT ELEC ANY TYPE SIDE RAIL W O MATTRSS  | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0277 | POWERED PRESSURE-REDUCING AIR MATTRESS           | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0292 | HOSP BED VARIBL HT HI-LO W O SIDE RAIL W MATTRSS | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0293 | HOS BED VARIBL HT HI-LO W O SIDE RAIL NO MATTRSS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0294 | HOSPITAL BED SEMI-ELEC W O SIDE RAILS W MATTRSS  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0295 | HOSP BED SEMI-ELEC W O SIDE RAILS W O MATTRSS    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0296 | HOSPITAL BED TOTAL ELEC W O SIDE RAILS W MATTRESS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0297 | HOSP BED TOTAL ELEC W O SIDE RAILS W O MATTRESS   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0300 | PED CRIB HOS GRADE FULLY ENC W WO TOP ENC         | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0301 | HOS BED HEVY DUTY XTRA WIDE W<br>WT CAPACTY OVER 350 PDS   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0302 | HOS BED XTRA HEVY DUTY WT CAP<br>OVER 600 PDS W O MITTRSS  | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0303 | HOS BED HEVY DUTY W WT CAP<br>OVER 350 PDS UNDER EQ TO 600 | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0304 | HOS BED EXTRA HEAVY DUTY WT<br>CAP OVER 600 PDS MATTRSS | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2024          | E0316 | SFTY ENCLOS FRME/CANOPY USE<br>W/HOSP BED ANY TYPE      | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0328 | HOSPITAL BED PEDIATRIC MANUAL<br>INCLUDES MATTRESS      | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0329 | HOSPITAL BED PEDIATRIC ELECTRIC<br>INCLUDE MATTRESS     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0371 | NONPWR ADV PRSS RDUC OVRLAY<br>MATTRSS STD LEN AND WDTN | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0372 | PWR AIR OVRLAY MATTRSS STD<br>MATTRSS LENGTH AND WIDTH  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0373 | NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0462 | ROCKING BED WITH OR WITHOUT SIDE RAILS         | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023          | E0465 | HOME VENTILATOR ANY TYPE USED W/INVASIVE INTF  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 7/1/2023       | E0466 | HOME VENTILATOR ANY TYPE USED W/NON-INVASV INTF  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023       | E0467 | HOME VENTILATOR MULTI-FUNCTION RESPIRATORY DEVC  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2024       | E0468 | HOME VENT DF RESP DVC PER ADD FUNC OF COUGH STIM | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 7/1/2023       | E0470 | RESP ASST DEVC BI-LEVL PRSS<br>CAPABILITY W/O BACKU | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023       | E0471 | RESP ASST DEVC BI-LEVL PRSS<br>CAPABILITY W/O BACKU | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023       | E0472 | RESP ASST DEVC BI-LEVL PRSS<br>CAPABILITY W/O BACKU | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0481 | INTRAPULM PERCUSSIVE VENT SYSTEM AND REL ACCSORIES | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0483 | HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM EA    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 10/1/2023         | E0486 | ORL DEVC/APPL RDUC UP AIRWAY COLLAPSIBILITY CSTM   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 1/1/2024       | E0492 | POWER SRC and CTRL ELEC ORAL DVC NEUMUSC ELC STM TNG | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 1/1/2024       | E0493 | ORAL DVC NM ELC STIM TONGUE MUSC PWR S and C ELC 90D | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2023       | E0637 | COMB SIT STAND FRAME/TABLE SYS SEATLIFT FEATURE      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 4/1/2023       | E0638 | STANDING FRAME/TABLE SYS ONE POSITION ANY SZ    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2024       | E0640 | PATIENT LIFT FIX SYS INCLUDES ALL CMPNTS/ACCESS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2023       | E0641 | STANDING FRAME/TABLE SYS MULTI-POSITION ANY SZ  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 4/1/2023       | E0642 | STANDING FRAME/TABLE SYS<br>MOBILE DYNAMIC ANY SZ                                  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 10/1/2019      | E0652 | PNEUMATIC COMPRESSOR,<br>SEGMENTAL HOME MODEL WITH<br>CALIBRATED GRADIENT PRESSURE | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 10/1/2020      | E0656 | SEG PNEUMAT APPLIANCE USE W<br>PNEUMAT COMPRS TRUNK                                | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Criteria Utilized                | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 10/1/2020      | E0667 | SEG PNEUMAT APPLINC W PNEUMAT COMPRS FULL LEG    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 10/1/2020      | E0668 | SEG PNEUMAT APPLINC W PNEUMAT COMPRS FULL ARM    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 10/1/2020      | E0671 | SEGMENTAL GRADENT PRESS PNEUMAT APPLINC FULL LEG | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes          | Effective Date | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 10/1/2020      | E0675 | PNEUMAT COMPRS DEVC HI PRSS<br>RAPID INFLATION DEFL   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 10/1/2020      | E0676 | INTERMITTENT LIMB COMPRESSION<br>DEVICE NOS           | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023       | E0677 | Nonpneumatic sequential<br>compression garment, trunk | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                                                                    | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0691 | UV LIGHT TX SYS BULB LAMP TIMER;<br>TX 2 SQ FT LESS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Molina Clinical Policy: Phototherapy and Laser Therapy for Dermatological Conditions |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0694 | UV MX DIR LT TX SYS 6 FT CABINET<br>W BULB LAMP TMR | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Molina Clinical Policy: Phototherapy and Laser Therapy for Dermatological Conditions |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0747 | OSTOGNS STIM ELEC NONINVASV<br>OTH THAN SP APPLIC   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual                                            |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0748 | OSTOGNS STIMULATOR ELEC<br>NONINVASV SPINAL APPLIC | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0749 | OSTEOGENESIS STIMULATOR ELEC<br>SURGICALLY IMPL    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0760 | OSTOGNS STIM LOW INTENS<br>ULTRASOUND NON-INVASV   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0764 | FUNC NEUROMUSC STIM MUSC<br>AMBUL CMPT CNTRL SC INJ | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0766 | ELEC STIM DVC U CANCER TX INCL<br>ALL ACC ANY TYPE  | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0782 | INFUSION PUMP IMPLANTABLE NON-<br>PROGRAMMABLE      | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0783 | INFUSION PUMP SYSTEM<br>IMPLANTABLE PROGRAMMABLE | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0784 | EXTERNAL AMBULATORY INFUSION<br>PUMP INSULIN     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2020          | E0787 | EXTERNAL AMB INFUS PUMP<br>INSULIN DOS RATE ADJ  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0983 | MNL WC ACSS PWR ADD-ON<br>CONVRT MNL WC MOTRIZD WC | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0984 | MNL WC ACSS PWR ADD-ON<br>CONVRT MNL WC MOTRIZD WC | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0986 | MNL WHEELCHAIR ACSS PUSH-RIM<br>ACT PWR ASSIST SYS | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E0988 | MANUAL WC ACCESSORY LEVR-ACTIVATD WHL DRIVE PAIR | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1002 | WHEELCHAIR ACCESS POWER SEATING SYSTEM TILT ONLY | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1003 | WC ACSS PWR SEAT SYS RECLINE W O SHEAR RDUC      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered–the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1004 | WC ACSS PWR SEAT SYS RECLINE W MECH SHEAR RDUC      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1005 | WC ACSS PWR SEAT SYS RECLINE W PWR SHEAR RDUC       | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1006 | WC ACSS PWR SEAT SYS TILT AND RECLINE NO SHEAR RDUC | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1007 | WC ACSS PWR SEAT TILT AND RECLINE MECH SHEAR RDUC  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1008 | WC ACSS PWR SEAT TILT AND RECLINE W PWR SHEAR RDUC | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1010 | WC ACCSS ADD PWR SEAT SYS PWR LEG ELEV SYS PAIR    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1012 | WC ACCSS PWR SEAT SYS CNTR MNT<br>PWR ELEV LEG EA   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1030 | WHEELCHAIR ACCESSORY<br>VENTILATOR TRAY GIMBALED    | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1161 | MANUAL ADULT SIZE WHEELCHAIR<br>INCLUDES TILT SPACE | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 7/1/2024          | E1229 | SPECIAL BACK HEIGHT FOR WHEELCHAIR                | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1230 | PWR OPERATED VEH SPEC BRAND NAME AND MODEL NUMBER | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1232 | WC PED SZ TILT-IN-SPACE FOLD ADJUSTBL W SEAT SYS  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1233 | WC PED SZ TILT-IN-SPACE RIGD ADJUSTBL W O SEAT   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1234 | WC PED SZ TILT-IN-SPACE FOLD ADJUSTBL W O SEAT   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1235 | WHLCHAIR PED SIZE RIGD ADJUSTBL W SEATING SYSTEM | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1236 | WHLCHAIR PED SIZE FOLD ADJUSTBL W SEATING SYSTEM | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1237 | WHLCHAIR PED SZ RIGD ADJUSTBL W O SEATING SYSTEM | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1238 | WHLCHAIR PED SZ FOLD ADJUSTBL W O SEATING SYSTEM | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes                                                                                                                                                                                                                            | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E1310 | WHIRLPOOL NONPORTABLE                   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |                                                                                                                                                                                                                                  | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2025          | E2102 | ADJUNCTIVE NONIMPLANTED CGM/RECEIVER    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual | <p>Prior authorization is not required for par providers when the member has a diagnosis of insulin dependent or gestational diabetes.</p> <p>Units over TMPPM allowable will require prior authorization for all providers.</p> | 5/21/2025             |
| Durable Medical Equipment (DME) | 4/1/2025          | E2103 | NONADJUNCTIVE NONIMPLANTED CGM/RECEIVER | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual | <p>Prior authorization is not required for par providers when the member has a diagnosis of insulin dependent or gestational diabetes.</p> <p>Units over TMPPM allowable will require prior authorization for all providers.</p> | 5/21/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2295 | MNL WC ACCESS PED SIZE WC DYNAMIC SEATING FRAME  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2024          | E2298 | COMPLEX REHAB PWR WC ACC PWR SEAT EL SYS ANY TYP | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2023          | E2301 | WHEELCHAIR ACCESSORY POWER STANDING SYS ANY TYPE | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"><li>1. Beneficiary's name</li><li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li><li>3. Quantity</li><li>4. Signature of the prescribing physician/practitioner</li><li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li><li>6. The date of the order</li></ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2310 | PWR WC ACSS ELEC CNCT BETWN WC CNTRLER AND ONE PWR  | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2311 | PWR WC ACSS ELEC CNCT BETWN WC CNTRLER AND TWO MORE | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2312 | POWER WC ACCESS HAND OR CHIN CONTROL INTERFACE      | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2313 | POWER WC ACCESS HARNESS<br>UPGRADE EXP CONTROLLR EA | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2321 | PWR WC ACSS HND CNTRL REMOT<br>JOYSTCK NO PRPRTNL   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2322 | PWR WC ACSS HND CNTRL MX MECH<br>SWTCH NO PRPRTNL   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2325 | PWR WC ACSS SIP AND PUFF<br>INTERFCE NONPROPRTNAL | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2327 | PWR WC ACSS HEAD CNTRL<br>INTERFCE MECH PROPRTNAL | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2328 | PWR WC ACSS HEAD CNTRL EXT<br>CNTRL ELEC PRPRTNL  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2329 | PWR WC ACSS HEAD CNTRL CNTC<br>SWTCH MECH NOPRPRTNL | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2330 | PWR WC ACCSS HEAD PROX SWITCH<br>MECH NONPRPRTNL    | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2340 | POWER WC ACCESS NONSTAND SEAT<br>FRAME WD 20-23 IN  | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2341 | PWR WC ACSS NONSTD SEAT FRME WIDTH 24-27 IN | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2342 | PWR WC ACSS NONSTD SEAT FRME DEPTH 20 21 IN | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2343 | PWR WC ACSS NONSTD SEAT FRME DEPTH 22-25 IN | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2351 | PWR WC ACSS ELEC INTERFACE<br>OPERATE SPCH GEN DEVC     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2369 | POWER WC CMPNNT DRIVE WHEEL<br>GEAR BOX REPL ONLY       | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2370 | PWR WC COMP INT DR WHL MTR<br>AND GR BOX COMB REPL ONLY | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2373 | PWR WC MINI-PROPORTIONAL<br>COMPACT REMOTE JOYSTICK | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2375 | PWR WC NONEXPNDABLE<br>CONTROLLER REPLACEMENT ONLY  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2376 | PWR WC EXPANDABLE CONTROLLER<br>REPLACEMENT ONLY    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2377 | PWR WC EXPANDABLE CONTROLLER UPGRADE INIT ISSUE  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2020          | E2398 | WHEELCHAIR ACCESSORY DYNAMIC POS HARDWARE BACK   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023          | E2402 | NEG PRESS WOUND THERAPY ELEC PUMP STATION/PRTBLE | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2500 | SPEECH GEN DEVC DIGITIZED UNDER EQ 8 MINS REC TIME        | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2502 | SPCH GEN DEVC DIGTIZD OVER 8 MINS LESS THN EQ 20 MINS REC | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2504 | SPCH GEN DEVC DIGTIZD OVER 20 MINS UNDER EQ 40 MINS REC   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2506 | SPEECH GEN DEVICE DIGITIZED OVER 40 MINS REC TIME    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2508 | SPCH GEN DEVC SYNTHSIZD REQ MESS SPELL AND CNTCT     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2510 | SPCH GEN DEVC SYNTHESIZD MX METH MESS AND DEVC ACCSS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2511 | SPEECH GEN SOFTWARE PROG PC<br>PERS DIGITAL ASSIST | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2024          | E2512 | ACCESS SPEECH GENERATING DEVICE<br>MOUNTING SYSTEM | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2024          | E2599 | ACCESSORY FOR SPEECH<br>GENERATING DEVICE NOC      | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2609 | CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION SIZE   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2617 | CSTM FAB WC BACK CUSHN ANY SZ ANY MOUNT HARDWARE | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2626 | WC ACCESS SHLDR ELB MOBIL ARM SUPP WC ADJUSTBLE  | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2628 | WC ACCESS SHLDR ELB MOBIL ARM SUPP WC RECLINING  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | E2629 | WC ACCESS SHLDR ELB M ARM SUPP FRICTION ARM SUPP | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023          | K0005 | Ultralightweight wheelchair                      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0008 | CUSTOM MANUAL WHEELCHAIR BASE                    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0009 | OTHER MANUAL WHEELCHAIR BASE                     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0010 | STANDARD-WEIGHT FRAME MOTORIZED POWER WHEELCHAIR | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1.Beneficiary's name</li> <li>2.Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3.Equipment Recommended</li> <li>4.Diagnosis or conditions related to the need for the power mobility device</li> <li>5.Length of need</li> <li>6.Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only -- no stamps.</p> <ol style="list-style-type: none"> <li>7.Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0011 | STD-WT FRME MOTRIZD PWR WHLCHAIR W PROG CNTRL   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0012 | LIGHTWEIGHT PORTABLE MOTORIZED POWER WHEELCHAIR | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 10/1/2022         | K0013 | CUSTOM MOTORIZED POWER WHEELCHAIR BASE | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1.Beneficiary's name</li> <li>2.Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3.Equipment Recommended</li> <li>4.Diagnosis or conditions related to the need for the power mobility device</li> <li>5.Length of need</li> <li>6.Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <ol style="list-style-type: none"> <li>7.Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0014 | OTHER MOTORIZED POWER WHEELCHAIR BASE  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1.Beneficiary's name</li> <li>2.Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3.Equipment Recommended</li> <li>4.Diagnosis or conditions related to the need for the power mobility device</li> <li>5.Length of need</li> <li>6.Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <ol style="list-style-type: none"> <li>7.Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0108 | OTHER ACCESSORIES                                  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0606 | AUTO EXT DEFIB W INTGR ECG ANALY GARMENT TYPE      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0800 | PWR OP VEH GRP 1 STD PT WT CAP TO AND INCL 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety. Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3. Equipment Recommended</li> <li>4. Diagnosis or conditions related to the need for the power mobility device</li> <li>5. Length of need</li> <li>6. Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only -- no stamps.</p> <ol style="list-style-type: none"> <li>7. Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0801 | PWR OP VEH GRP 1 HEAVY DUTY PT 301 TO 450 LBS   | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0802 | PWR OP VEH GRP 1 VERY HEAVY DUTY PT 451-600 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0806 | PWR OP VEH GRP 2 STD PT WT CAP TO AND INCL 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0807 | PWR OP VEH GRP 2 HEAVY DUTY PT 301 TO 450 LBS      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0808 | PWR OP VEH GRP 2 VERY HEAVY DUTY PT 451-600 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0813 | PWR WC GRP 1 STD PORT SLING SEAT PT TO 300 LBS  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0814 | PWR WC GRP 1 STD PORT CAPT CHAIR PT TO 300 LBS      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0815 | PWR WC GRP 1 STD SLING SEAT PT UP TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0816 | PWR WC GRP 1 STD CAPTAINS CHAIR<br>PT TO AND EQ 300 LBS  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1.Beneficiary's name</li> <li>2.Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3.Equipment Recommended</li> <li>4.Diagnosis or conditions related to the need for the power mobility device</li> <li>5.Length of need</li> <li>6.Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <ol style="list-style-type: none"> <li>7.Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0820 | PWR WC GRP 2 STD PORT SLING<br>SEAT PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1.Beneficiary's name</li> <li>2.Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3.Equipment Recommended</li> <li>4.Diagnosis or conditions related to the need for the power mobility device</li> <li>5.Length of need</li> <li>6.Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <ol style="list-style-type: none"> <li>7.Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0821 | PWR WC GRP 2 STD PORT CAPT CHAIR PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0822 | PWR WC GRP 2 STD SLING SEAT PT TO AND EQ 300 LBS      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0823 | PWR WC GRP 2 STD CAPTAINS CHAIR<br>PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0824 | PWR WC GRP 2 HEVY DUTY SLING<br>SEAT PT 301-450 LBS     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0825 | PWR WC GRP 2 HEVY DUTY CAPT CHAIR PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0826 | PWR WC GRP 2 VRY HVY DTY SLNG SEAT PT 451-600 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0827 | PWR WC GRP 2 VRY HVY DTY CAPT CHR PT 451-600 LBS     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0828 | PWR WC GRP 2 XTRA HVY DTY SLING SEAT PT 601LB OR GRT | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0829 | PWR WC GRP 2 XTRA HVY DUTY CHAIR PT 601 LBS OR GRT    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0830 | PWR WC GRP 2 STD SEAT ELEV SLING PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0831 | PWR WC GRP 2 STD SEAT ELEV CAP<br>CHR PT TO 300 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0835 | PWR WC GRP 2 STD 1 PWR SLING<br>SEAT PT TO 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0836 | PWR WC GRP 2 STD 1 PWR CAPT CHAIR PT TO 300 LBS  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0837 | PWR WC GRP 2 HVY 1 PWR SLING SEAT PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0838 | PWR WC GRP 2 HVY 1 PWR CAPT CHAIR PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0839 | PWR WC GRP 2 VRY HVY 1 PWR SLING PT 451-600 LBS  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0840 | PWR WC GRP 2 XTRA HVY 1 PWR SLING PT 601 LBS OR GRT | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0841 | PWR WC GRP 2 MX PWR SLING SEAT PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0842 | PWR WC GRP 2 STD MX PWR CAPT<br>CHR PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0843 | PWR WC GRP 2 HVY MX PWR SLNG<br>SEAT PT 301-450 LBS      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0848 | PWR WC GRP 3 STD SLING SEAT PT TO AND EQ 300 LBS    | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0849 | PWR WC GRP 3 STD CAPTAIN CHAIR PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0850 | PWR WC GRP 3 HVY DUTY SLING SEAT PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1.Beneficiary's name</li> <li>2.Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3.Equipment Recommended</li> <li>4.Diagnosis or conditions related to the need for the power mobility device</li> <li>5.Length of need</li> <li>6.Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <ol style="list-style-type: none"> <li>7.Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0851 | PWR WC GRP 3 HVY DUTY CAPT CHAIR PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <ol style="list-style-type: none"> <li>1.Beneficiary's name</li> <li>2.Face to Face Completion Date</li> </ol> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <ol style="list-style-type: none"> <li>3.Equipment Recommended</li> <li>4.Diagnosis or conditions related to the need for the power mobility device</li> <li>5.Length of need</li> <li>6.Physician's signature</li> </ol> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <ol style="list-style-type: none"> <li>7.Date the physician signed the PMD order</li> </ol> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0852 | PWR WC GRP 3 V HVY DUTY SLING SEAT PT 451-600 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0853 | PWR WC GRP 3 HVY DUTY CAPT CHAIR PT 451-600 LBS  | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0854 | PWR WC GRP 3 XTRA HVY DTY SLNG SEAT PT 601 LBS OR GRT | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0855 | PWR WC GRP 3X HVY DTY CHR PT WT CAP 601 LB OR GRT     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0856 | PWR WC GRP 3 STD 1 PWR SLING SEAT PT TO AND EQ 300 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0857 | PWR WC GRP 3 STD 1 PWR CAPT CHAIR PT TO AND EQ 300 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0858 | PWR WC GRP 3 HD 1 PWR SLING SEAT PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0859 | PWR WC GRP 3 HD 1 PWR CAPT CHAIR PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0860 | PWR WC GRP 3 V HD 1 PWR SLING SEAT PT 451-600 LB      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0861 | PWR WC GRP 3 STD MX PWR SLNG SEAT PT TO AND EQ 300 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0862 | PWR WC GRP 3 HD MX PWR SLING SEAT PT 301-450 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0863 | PWR WC GRP 3 V HD MX PWR SLNG SEAT PT 451-600 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0864 | PWR WC GRP 3 XTR HD MX PWR SLNG SEAT PT 601 LB OR GRT | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0868 | PWR WC GRP 4 STD SLING SEAT PT TO AND EQ 300 LBS      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0869 | PWR WC GRP 4 STD CAPTAIN CHAIR<br>PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0870 | PWR WC GRP 4 HVY DUTY SLING<br>SEAT PT 301-450 LBS     | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0871 | PWR WC GRP 4 V HVY DUTY SLING SEAT PT 451-600 LB      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0877 | PWR WC GRP 4 STD 1 PWR SLING SEAT PT TO AND EQ 300 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0878 | PWR WC GRP 4 STD 1 PWR CAPT CHAIR PT TO AND EQ 300 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0879 | PWR WC GRP 4 HD 1 PWR SLING SEAT PT 301-450 LBS       | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0880 | PWR WC GRP 4 V HD 1 PWR SLING SEAT PT 451-600 LB      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0884 | PWR WC GRP 4 STD MX PWR SLNG SEAT PT TO AND EQ 300 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0885 | PWR WC GRP 4 STD MX PWR CAPT<br>CHR PT TO AND EQ 300 LBS | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0886 | PWR WC GRP 4 HD MX PWR SLING<br>SEAT PT 301-450 LBS      | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0890 | PWR WC GRP 5 PED 1 PWR SLING SEAT PT TO AND EQ 125 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0891 | PWR WC GRP 5 PED MX PWR SLNG SEAT PT TO AND EQ 125 LB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS PMD 7 Element Order</p> <p>1.Beneficiary's name</p> <p>2.Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3.Equipment Recommended</p> <p>4.Diagnosis or conditions related to the need for the power mobility device</p> <p>5.Length of need</p> <p>6.Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7.Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | K0900 | CUSTOMIZED DME OTHER THAN WHEELCHAIR             | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS PMD 7 Element Order</p> <p>1. Beneficiary's name</p> <p>2. Face to Face Completion Date</p> <p>The in-person visit (with the physician) and the mobility evaluation (with the therapist) are often referred to as the complete face-to-face examination. The results of both components are combined to address power mobility algorithm in its entirety.</p> <p>Either the date of the physician's visit, or the date of the physician's signature and concurrence with the therapist's evaluation - whichever date is the latest in sequence - is considered to be the completion of the face-to-face, or F2F completion date. The documented the Face to Face evaluation should include a detailed, narrative note in the patient's medical record. The record should include relevant information. Document the decision to prescribe a PMD.</p> <p>3. Equipment Recommended</p> <p>4. Diagnosis or conditions related to the need for the power mobility device</p> <p>5. Length of need</p> <p>6. Physician's signature</p> <p>The physician who performed the face-to-face mobility examination (ordering physician) must complete and sign with a valid signature. Ink or valid electronic signatures only – no stamps.</p> <p>7. Date the physician signed the PMD order</p> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 10/1/2022         | K1027 | ORAL DEV/APPL RED U AW COL WO F MCH HNG CSTM FAB | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> <p>CMS DME 6 Element Order</p> <p>1. Beneficiary's name</p> <p>2. A description of the item of DME ordered--the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</p> <p>3. Quantity</p> <p>4. Signature of the prescribing physician/practitioner</p> <p>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</p> <p>6. The date of the order</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes          | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | 4/1/2020       | L2006 | KAF DVC ANY MATERIAL<br>ADJUSTABILITY CUSTOM FAB    | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 4/1/2020       | L8033 | NIPPLE PROSTH CSTM FAB REUSABL<br>ANY MATL ANY T EA | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | 7/1/2023       | L8678 | ELECTRICAL STIM SUP EXT USE W/I<br>NEUROSTIM PER MO | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes          | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria Utilized                         | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME) | Prior to 9/1/2019 | S1034 | ARTIF PANCREAS DEVC SYS THAT CMNCT W ALL DEVC    | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | S1035 | SENSOR; INVASV DSPBL USE ARTIF PANCREAS DEVC SYS | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Durable Medical Equipment (DME) | Prior to 9/1/2019 | S1036 | TRANSMITTER; EXT USE W ARTIF PANCREAS DEVC SYS   | Information generally required to support authorization decision making includes:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br><br>CMS DME 6 Element Order<br>1. Beneficiary's name<br>2. A description of the item of DME ordered—the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number<br>3. Quantity<br>4. Signature of the prescribing physician/practitioner<br>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)<br>6. The date of the order | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes           | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Criteria Utilized                                                             | Notes | Date of Annual Review |
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| Durable Medical Equipment (DME)  | Prior to 9/1/2019 | S1037 | RECEIVER; EXTERNAL USE W ARTIF PANCREAS DEVC SYS        | <p>Information generally required to support authorization decision making includes:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> <p>CMS DME 6 Element Order</p> <ol style="list-style-type: none"> <li>1. Beneficiary's name</li> <li>2. A description of the item of DME ordered-the description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number</li> <li>3. Quantity</li> <li>4. Signature of the prescribing physician/practitioner</li> <li>5. Prescribing physician/practitioner's National Practitioner Identifier (NPI)</li> <li>6. The date of the order</li> </ol> | Texas Medicaid Provider Procedures Manual                                     |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0214T | NJX DX THER PARAVER FCT JT W US CER THOR 2ND LVL        | <p>Information generally required to support authorization decision making includes, but not limited to:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0215T | NJX PARAVERTBRL FACET JT W US CER THOR 3RD AND OVER LVL | <p>Information generally required to support authorization decision making includes, but not limited to:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0216T | NJX DX THER PARAVER FCT JT W US LUMB SAC 1 LVL          | <p>Information generally required to support authorization decision making includes, but not limited to:</p> <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |

| Service Category Notes           | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                             | Notes | Date of Annual Review |
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| Experimental and Investigational | Prior to 9/1/2019 | 0217T | NIX DX THER PARAVERT JT W US LUMB SAC LVL 2           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0218T | NIX PARAVERTBRL FCT JT W US LUMB SAC 3RD AND OVER LVL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0274T | PERC LAMINO- LAMINECTOMY IMAGE GUIDE CERV THORAC      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                     |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0362T | BEHAVIOR ID SUPPORT ASSMT EA 15 MIN TECH TIME         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                     |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0402T | COLLAGEN CROSS-LINKING OF CORNEA MED SEPARATE         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                     |       | 2/19/2025             |

| Service Category Notes           | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| Experimental and Investigational | Prior to 9/1/2019 | 0479T | FRACTIONAL ABL LSR FENESTRATION FIRST 100 SQCM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0483T | TMVI W PROSTHETIC VALVE PERCUTANEOUS APPROACH    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0484T | TMVI W PROSTHETIC VALVE TRANSTHORACIC EXPOSURE   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 0488T | DIABETES PREV ONLINE ELECTRONIC PRGRM PR 30 DAYS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Experimental and Investigational | 4/1/2020          | 0569T | TTVR PERCUTANEOUS APPROACH INITIAL PROSTHESIS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes           | Effective Date | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| Experimental and Investigational | 4/1/2020       | 0570T | TVR PERCUTANEOUS APPROACH EACH ADDL PROSTHESIS     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Experimental and Investigational | 10/1/2023      | 0795T | TCAT INSJ PERM DUAL CHAMBER LDLS PM COMPL SYS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| Experimental and Investigational | 10/1/2023      | 0796T | TCAT INSJ PERM 2CHMBR LDLS PM R ATR PM COMPNT D    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| Experimental and Investigational | 10/1/2023      | 0797T | TCAT INSJ PERM 2CHMBR LDLS PM R VENTR PM COMPNT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| Experimental and Investigational | 10/1/2023      | 0805T | TCAT SUPR&IVC PROSTC VLV IMPLTJ PERQ FEM VN APPR D | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes           | Effective Date | Code  | Definition                                                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| Experimental and Investigational | 10/1/2023      | 0806T | TCAT SUPR&IVC PROSTC VLV IMPLTJ<br>OPEN FEM VN APPR                                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| Experimental and Investigational | 4/1/2025       | 31242 | NASAL/SINUS NDSC DSTRJ RF<br>ABLATION PST NSL NRV                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                               |       | 5/21/2025             |
| Experimental and Investigational | 4/1/2025       | 31243 | NASAL/SINUS NDSC DSTRJ<br>CRYOABLATION PST NSL NRV                                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                               |       | 5/21/2025             |
| Experimental and Investigational | 4/1/2020       | 34717 | EVASC RPR ILAC ART BIFUR ENDGRFT<br>CATHJ RS AND I UNI                                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Experimental and Investigational | 1/1/2023       | 43290 | ESPHGGSTRDUDNSCPY, FLXIBL,<br>TRNSORAL; WITH DPLYMNT OF<br>INTRGASTRIC BARIATRIC BALLON | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |

| Service Category Notes           | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                                                                 | Notes | Date of Annual Review |
|----------------------------------|-------------------|-------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------|-----------------------|
| Experimental and Investigational | 1/1/2021          | 93895 | CAROTID INTIMA MEDIA & CAROTID ATHEROMA EVAL BI | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul>  | Molina Clinical Policy: Measurement of Carotid Intima-Media Thickness for Prediction of Clinical Vascular Events. |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | 95803 | ACTIGRAPHY TESTING RECORDING ANALYSIS I AND R   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual                                                                         |       | 2/19/2025             |
| Experimental and Investigational | 10/1/2023         | C9784 | ENDO SLEEVE GASTRO W/TUBE                       | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Additional information is required to define this code and determine criteria.                                    |       | 2/19/2025             |
| Experimental and Investigational | 10/1/2023         | C9785 | ENDO OUTLET RESTRICT W/TUBE                     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Additional information is required to define this code and determine criteria.                                    |       | 2/19/2025             |
| Experimental and Investigational | 7/1/2023          | E1905 | VIRTUAL REALITY CBT INCLUDING PP TX SOFTWARE    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy: Prescription Digital Therapeutics                                                         |       | 2/19/2025             |

| Service Category Notes           | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|----------------------------------|-------------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Experimental and Investigational | 1/1/2021          | K1007 | BIL HKAFO DEVC PWR INCL PELV<br>COMP UP KNEE JOINTS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Experimental and Investigational | Prior to 9/1/2019 | L8608 | MISC EXT COMP SPL ACSS FOR<br>ARGUS II RET PROS SYS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing   | Prior to 9/1/2019 | 0005U | ONCO PRST8 GENE XPRS PRFL 3<br>GENE UR ALG RSK SCOR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing   | Prior to 9/1/2019 | 0006M | ONCOLOGY HEP MRNA 161 GENES<br>RISK CLASSIFIER      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing   | Prior to 9/1/2019 | 0007M | ONCOLOGY GASTRO 51 GENES<br>NOMOGRAM DISEASE INDEX  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |



| Service Category Notes         | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 0009M | FETAL ANEUPLOIDY 21 18 SEQ ANALY TRISOM RISK         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | 10/1/2019         | 0022U | TRGT GEN SEQ ALYS NONSM LNG NEO DNA AND RNA 23 GENES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 0037U | TRGT GEN SEQ ALYS SLD ORGN NEO DNA 324 GENES         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 0057U | ONC SLD ORG NEO MRNA 51 GENES ALG NML PCT RANK       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020          | 0152U | NFCT DS MCRB CLL FR DNA UNTRGT NEXT GENRJ SEQ        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |

| Service Category Notes         | Effective Date | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                       | Notes | Date of Annual Review |
|--------------------------------|----------------|-------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | 7/1/2020       | 0172U | ONC SLD TUM SOMATIC MUT ALYS BRCA1 BRCA2 ALG    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 7/1/2020       | 0175U | PSYCHIATRY GEN ALYS PNL W/VARIANT ALYS 15 GENES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 10/1/2020      | 0215U | RARE DS XOM DNA ALYS EA COMP                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 10/1/2020      | 0216U | NEURO INH ATAXIA DNA 12 COM                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 10/1/2020      | 0217U | NEURO INH ATAXIA DNA 51 GENE                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |

| Service Category Notes         | Effective Date | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                       | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | 1/1/2021       | 0239U | TRGT GEN SEQ ALYS SLD ORGN NEO<br>CLL-FR DNA 311 Plus | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2024       | 0345U | PSYC GENOMIC ALYS PANEL VARIANT<br>ALYS 15 GENES      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 10/1/2023      | 0401U | CRD C HRT DS 9 GEN 12 VRNTS TRGT<br>VRNT GNOTYP ALG   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 10/1/2023      | 0411U | PSYC GENOMIC ALYS PANEL VARIANT<br>ALYS 15 GENES      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 10/1/2023      | 0419U | NEUROPSYCHIATRY GEN SEQ ALYS<br>PNL VRNT ALY 13 GEN   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |

| Service Category Notes         | Effective Date | Code  | Definition              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                       | Notes | Date of Annual Review |
|--------------------------------|----------------|-------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | 4/1/2020       | 80145 | DRUG ASSAY ADALIMUMAB   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020       | 80187 | DRUG ASSAY POSACONAZOLE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020       | 80230 | DRUG ASSAY INFLIXIMAB   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020       | 80235 | DRUG ASSAY LACOSAMIDE   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020       | 80280 | DRUG ASSAY VEDOLIZUMAB  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | 4/1/2020          | 80285 | DRUG ASSAY VORICONAZOLE                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81120 | IDH1 COMMON VARIANTS                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81121 | IDH2 COMMON VARIANTS                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81161 | DMD DUPLICATION DELETION ANALYSIS                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81162 | BRCA1 BRCA2 GENE ALYS FULL SEQ FULL DUP DEL ALYS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81163 | BRCA1 BRCA2 GENE ANALYSIS FULL SEQUENCE ANALYSIS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81164 | BRCA1 BRCA2 GENE ANALYSIS FULL DUP DEL ANALYSIS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81165 | BRCA1 GENE ANALYSIS FULL SEQUENCE ANALYSIS       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81166 | BRCA1 GENE ANALYSIS FULL DUP DEL ANALYSIS        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81167 | BRCA2 GENE ANALYSIS FULL DUP DEL ANALYSIS        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81173 | AR GENE ANALYSIS FULL GENE SEQUENCE              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81175 | ASXL1 GENE ANALYSIS FULL GENE SEQUENCE           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2021          | 81194 | NTRK TRANSLOCATION ANALYSIS                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81201 | APC GENE ANALYSIS FULL GENE SEQUENCE             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81212 | BRCA1 BRCA 2 GEN ALYS 185DELAG 5385INSC 6174DELT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81225 | CYP2C19 GENE ANALYSIS COMMON VARIANTS              | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81226 | CYP2D6 GENE ANALYSIS COMMON VARIANTS               | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81227 | CYP2C9 GENE ANALYSIS COMMON VARIANTS               | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81228 | CYTOGENOM CONST MICROARRAY COPY NUMBER VARIANTS    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81229 | CYTOGENOM CONST MICROARRAY COPY NUMBER AND SNP VAR | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |



| Service Category Notes         | Effective Date    | Code  | Definition                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                       | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81230 | CYP3A4 GENE ANALYSIS COMMON VARIANTS  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81231 | CYP3A5 GENE ANALYSIS COMMON VARIANTS  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81232 | DYPD GENE ANALYSIS COMMON VARIANTS    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81236 | EZH2 GENE ANALYSIS FULL GENE SEQUENCE | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81249 | G6PD GENE ANALYSIS FULL GENE SEQUENCE | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria        |       | 11/19/2025            |

| Service Category Notes         | Effective Date    | Code  | Definition                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | 1/1/2021          | 81275 | KRAS GENE ANALYSIS VARIANTS IN EXON 2     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2021          | 81276 | KRAS GENE ANALYSIS ADDITIONAL VARIANT(S)  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | 1/1/2021          | 81277 | CYTOGENOMIC NEOPLASIA MICROARRAY ANALYSIS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81287 | MGMT GENE PROMOTER METHYLATION ANALYSIS   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81292 | MLH1 GENE ANALYSIS FULL SEQUENCE ANALYSIS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81295 | MSH2 GENE ANALYSIS FULL SEQUENCE ANALYSIS       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81298 | MSH6 GENE ANALYSIS FULL SEQUENCE ANALYSIS       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020          | 81307 | PALB2 GENE ANALYSIS (FULL GENE SEQ)             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020          | 81309 | PIK3CA GENE ANALYSIS TARGETED SEQUENCE ANALYSIS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81314 | PDGFRA GENE ANALYS TARGETED SEQUENCE ANALYS     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |

| Service Category Notes         | Effective Date    | Code  | Definition                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81317 | PMS2 GENE ANALYSIS FULL SEQUENCE          | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81321 | PTEN GENE ANALYSIS FULL SEQUENCE ANALYSIS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | 1/1/2021          | 81351 | TP53 GENE ANALYSIS FULL GENE SEQUENCE     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81404 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 5     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81405 | MOLECULAR PATHOLOGY PROCEDURE LEVEL 6     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |

| Service Category Notes         | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81406 | MOLECULAR PATHOLOGY<br>PROCEDURE LEVEL 7            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81407 | MOLECULAR PATHOLOGY<br>PROCEDURE LEVEL 8            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81408 | MOLECULAR PATHOLOGY<br>PROCEDURE LEVEL 9            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81410 | AORTIC DYSFUNCTION DILATION<br>GENOMIC SEQ ANALYSIS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81411 | AORTIC DYSFUNCTION DILATION<br>DUP DEL ANALYSIS     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |

| Service Category Notes         | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                       | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | Prior to 9/1/2019 | 81412 | ASHKENAZI JEWISH ASSOC DSRDRS<br>GEN SEQ ANAL 9 GEN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81413 | CAR ION CHNNLPATH GENOMIC SEQ<br>ALYS INC 10 GNS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81414 | CAR ION CHNNLPATH DUP DEL GN<br>ALYS PANEL 2 GENES  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81415 | EXOME SEQUENCE ANALYSIS                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81416 | EXOME SEQUENCE ANALYSIS EACH<br>COMPARATOR EXOME    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | 1/1/2023          | 81418 | RX METAB GENOMIC SEQ ALYS<br>PANEL AT LEAST 6 GENES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2021          | 81419 | EPILEPSY GENOMIC SEQUENCE<br>ANALYSIS PANEL         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81422 | FETAL CHROMOSOMAL MICRODELTJ<br>GENOMIC SEQ ANALYS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81425 | GENOME SEQUENCE ANALYSIS                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81426 | GENOME SEQUENCE ANALYSIS EACH<br>COMPARATOR GENOME  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |

| Service Category Notes         | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | Prior to 9/1/2019 | 81427 | GENOME RE-EVALUATION OF PREC OBTAINED GENOME SEQ | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81430 | HEARING LOSS GENOMIC SEQUENCE ANALYSIS 60 GENES  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81431 | HEARING LOSS DUP DEL ANALYSIS                    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81432 | HEREDITARY BRST CA-RELATED GEN SEQ ANALYS 10 GEN | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81434 | HEREDITARY RETINAL DSRDRS GEN SEQ ANALYS 15 GEN  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |



| Service Category Notes         | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                       | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81435 | HEREDITARY COLON CA DSRDRS GEN SEQ ANALYS 10 GEN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81437 | HEREDTRY NURONDCRN TUM DSRDRS GEN SEQ ANAL 6 GEN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81439 | HEREDITARY CARDIOMYOPATHY GEN SEQ ANALYS 5 GEN   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81440 | NUCLEAR MITOCHONDRIAL 100 GENE GENOMIC SEQ       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2023          | 81441 | IBMFS SEQUENCE ANALYSIS PANEL AT LEAST 30 GENES  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | Prior to 9/1/2019 | 81443 | GENETIC TESTING FOR SEVERE INHERITED CONDITIONS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81445 | GEN SEQ ANALYS SOLID ORGAN NEOPLASM 5-50 GENE   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81448 | HEREDITARY PERIPHERAL NEUROPATHY GEN SEQ PNL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2023          | 81449 | TGSAP SOLID ORGAN NEOPLASM 5-50 RNA ANALYSIS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81450 | GEN SEQ ANALYS HEMATOLYMPHOID NEO 5-50 GENE     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |

| Service Category Notes         | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | 1/1/2023          | 81451 | TGSAP HEMATOLYMPHOID NEO/DO 5-50 RNA ANALYSIS         | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81455 | GEN SEQ ANALYS SOL ORG HEMTOLMPHOID NEO 51 OR GRT GEN | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | 1/1/2023          | 81456 | TGSAP SO/HEMATOLYMPHOID NEO/DO 51 OR GT RNA ANALYSIS  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 11/19/2025            |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81460 | WHOLE MITOCHONDRIAL GENOME                            | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81465 | WHOLE MITOCHONDRIAL GENOME ANALYSIS PANEL             | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81470 | X-LINKED INTELLECTUAL DBLT GENOMIC SEQ ANALYS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81471 | X-LINKED INTELLECTUAL DBLT DUP DEL GENE ANALYS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81518 | ONCOLOGY BREAST MRNA GENE EXPRESSION 11 GENES  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81519 | ONCOLOGY BREAST MRNA GENE EXPRESSION 21 GENES  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81520 | ONC BREAST MRNA GENE XPRSN PRFL HYBRD 58 GENES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | Prior to 9/1/2019 | 81521 | ONC BREAST MRNA MICRORA GENE XPRSN PRFL 70 GENES    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020          | 81522 | BREAST ONCOLOGY, MRNA, GENE EXPRESSION PROFILING    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2022          | 81523 | ONC BRST MRNA NEXT GNRJ SEQ GEN XPRSN 70 CNT and 31 | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81525 | ONCOLOGY COLON MRNA GENE EXPRESSION 12 GENES        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2021          | 81529 | ONC CUTAN MLNMA MRNA GENE XPRS PRFL 31 GENES ALG    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                       | Notes | Date of Annual Review |
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| Genetic Counseling and Testing | Prior to 9/1/2019 | 81540 | ONCOLOGY TUM UNKNOWN ORIGIN MRNA 92 GENES                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria        |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81541 | ONC PRST8 MRNA GENE XPRSN PRFL RT-PCR 46 GENES                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 4/1/2020          | 81542 | PROSTATE ONCOLOGY, MRNA, MICORARRAY GENE EXPRESSION PROFILING | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2021          | 81546 | ONC THYR MRNA 10,196 GENES FINE NDL ASPIRATE ALG              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria        |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81551 | ONC PRST8 PRMTR METHYLATION PRFL R-T PCR 3 GENES              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | 4/1/2020          | 81552 | UVEAL MELANOMA, MRNA, GENE EXPRESSION PROFILING          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2021          | 81554 | PULM DS IPF MRNA 190 GENE TRANSBRONCHIAL BX ALG          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | 1/1/2022          | 81560 | RNSPLJ PED LVR and BWL MES CD154 Plus T CLL WHL PRPH BLD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 81595 | CARDIOLOGY HRT TRNSPL MRNA GENE EXPRESS 20 GENES         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | 84999 | UNLISTED CHEMISTRY PROCEDURE                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes         | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|--------------------------------|-------------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Genetic Counseling and Testing | 4/1/2020          | 87563 | IADNA MYCOPLASMA GENITALIUM AMPLIFIED PROBE TECH    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Genetic Counseling and Testing | Prior to 9/1/2019 | S3722 | DOSE OPTIMIZ AUC ANALY INFUSIONAL 5-FLUOROURACIL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Genetic Testing   |       | 2/19/2025             |
| All Home Health Care Services  | Prior to 9/1/2019 | G0151 | SERVICE PHYS THERAP HOME HLTH HOSPICE EA 15 MIN     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services  | Prior to 9/1/2019 | G0152 | SERVICE OCCUP THERAP HOME HLTH HOSPICE EA 15 MIN    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services  | Prior to 9/1/2019 | G0153 | SRVC SPCH AND LANG PATH HOME HLTH HOSPICE EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |



| Service Category Notes        | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|-------------------------------|-------------------|-------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| All Home Health Care Services | Prior to 9/1/2019 | G0155 | SRVC CLINICAL SOCIAL WORKER HH HOSPICE EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0156 | SRVC HH HOSPICE AIDE IN HH HOSPICE SET EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0157 | SERVICES PT ASSIST HOME HEALTH HOSPICE EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0158 | SERVICE OT ASSIST HOME HEALTH HOSPICE EA 15 MIN  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0159 | SERVICES PT HOME HEALTH EST DEL PT MP EA 15 MINS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes        | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                                             | Date of Annual Review |
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| All Home Health Care Services | Prior to 9/1/2019 | G0160 | SERVICES OT HOME HEALTH EST DEL OT MP EA 15 MINS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                   | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0161 | SERVICE SLP HH EST DEL SPCH-LANG PATH MP EA 15 M    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                                                   | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0162 | SKILLED SERVICE RN M AND E PLAN OF CARE; EA 15 MINS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |                                                                                                                                                                                                                                                                   | 2/19/2025             |
| All Home Health Care Services | 7/1/2023          | G0299 | DIRECT SNS RN HOME HEALTH HOSPICE SET EA 15 MIN     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial admit visit and six (6) subsequent visits do not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| All Home Health Care Services | 7/1/2023          | G0300 | DIRECT SNS LPN HOME HLTH HOSPICE SET EA 15 MIN      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial admit visit and six (6) subsequent visits do not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes        | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| All Home Health Care Services | Prior to 9/1/2019 | G0490 | FACE-TO-FACE HH NSG VST RHC<br>FQHC AREA SHTG HHA      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0493 | SKILLED SERVICES RN OBV AND<br>ASMT PT COND EA 15 MIN  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0494 | SKILLED SRVC LPN OBS AND ASMT<br>PT COND EA 15 MIN     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0495 | SKD SRVC RN TRAIN AND EDU PT<br>FAM HH HOSPC EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | G0496 | SKD SRVC LPN TRAIN AND EDU PT<br>FAM HH HOSPC E 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes        | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| All Home Health Care Services | Prior to 9/1/2019 | S5116 | HOME CARE TRAINING NON-FAMILY; PER SESSION      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S5130 | HOMEMAKER SERVICE NOS; PER 15 MINUTES           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S5135 | COMPANION CARE ADULT ; PER 15 MINUTES           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | 7/1/2023          | S9110 | TELEMONITORING PT HOME ALL NEC EQUIP; PER MONTH | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S9122 | HOM HLTH AIDE CERT NURSE ASST PROV CARE HOM;-HR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes        | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| All Home Health Care Services | Prior to 9/1/2019 | S9123 | NURSING CARE THE HOME; REGISTERED NURSE PER HOUR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S9124 | NURSING CARE IN THE HOME; BY LPN PER HOUR        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S9128 | SPEECH THERAPY IN THE HOME PER DIEM              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S9129 | OCCUPATIONAL THERAPY IN THE HOME PER DIEM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S9131 | PHYSICAL THERAPY; IN THE HOME PER DIEM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes        | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| All Home Health Care Services | Prior to 9/1/2019 | S9470 | NUTRITIONAL COUNSELING<br>DIETITIAN VISIT       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | S9977 | MEALS PER DIEM NOT OTHERWISE<br>SPECIFIED       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | T1000 | PRIV DUTY INDEPEND NRS SERVICE<br>LIC UP 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | T1002 | RN SERVICES UP TO 15 MINUTES                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | T1003 | LPN LVN SERVICES UP TO 15<br>MINUTES            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes        | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| All Home Health Care Services | 10/1/2019         | T1019 | PERSONAL CARE SERVICES PER 15 MINUTES             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | T1022 | CONTRACT HOME HEALTH SRVC UNDER CONTRACT DAY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | T1030 | NURSING CARE THE HOME REGISTERED NURSE PER DIEM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| All Home Health Care Services | Prior to 9/1/2019 | T1031 | NURSING CARE IN THE HOME BY LPN PER DIEM          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Hyperbaric/Wound Care         | 7/1/2025          | 15271 | APP SKN SUB GRFT T/A/L AREA/100SQ CM OR LT 1ST 25 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| Hyperbaric/Wound Care  | 7/1/2025       | 15272 | APP SKN SUB GRFT T/A/L AREA/100SQ CM EA ADL 25SC           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025       | 15273 | APP SKN SUBGRFT T/A/L AREA/100SQ CM 1ST 100SQ CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025       | 15274 | APP SKN SUB GRFT T/A/L AREA GT or equal to 100SCM ADL 100S | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025       | 15275 | SUB GRFT F/S/N/H/F/G/M/D LT 100SQ CM 1ST 25 SQ CM          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025       | 15276 | SUB GRFT F/S/N/H/F/G/M/D LT 100SQ CM EA ADDL25SQ CM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 8/27/2025             |



| Service Category Notes | Effective Date    | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 7/1/2025          | 15277 | SUB GRFT F/S/N/H/F/G/M/D GT or equal to 100SCM 1ST 100SQ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                   |                                                                                     | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025          | 15278 | SUB GRFT F/S/N/H/F/G/M/D GT or equal to 100SCM ADL 100SQ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                   |                                                                                     | 8/27/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | 99183 | PHYS QHP ATTN AND SUPVJ HYPRBARIC OXYGEN TX SESSION      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                   |                                                                                     | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022         | A2001 | INNOVAMATRIX AC PER SQ CM                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022         | A2002 | MIRRAGEN ADVANCED WOUND MATRIX PER SQ CM                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | A2004 | XCELLITEM PER SQ CM                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025       | A2005 | MICROLYTE MATRIX PER SQ CM               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2006 | NOVOSORB SYNPATH DERMAL MATRIX PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2007 | Restrata Per Sq Cm                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2008 | Theragenesis Per Sq Cm                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | A2009 | Symphony Per Sq Cm         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2010 | Apis Per Sq Cm             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2011 | Supra SDRM, per sq cm      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2012 | Suprathel, per sq cm       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2013 | Innovamatrix FS, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | A2014 | OMEZA COLLAGEN MATRIX PER 100 MG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2015 | PHOENIX WOUND MATRIX PER SQ CM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2016 | PERMEADERM B PER SQ CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2017 | PERMEADERM GLOVE EACH            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2018 | PERMEADERM C PER SQ CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 7/1/2023       | A2019 | Kerecis Omega3 MariGen Shield, per sq cm | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | A2020 | AC5 Advanced Wound System                | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | A2021 | NeoMatrix, per sq cm                     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | A2022 | INNOVABURN OR INNOVAMATRIX XL PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2023 | INNOVAMATRIX PD 1 MG                     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | A2024 | RESOLVE MATRIX OR XENOPATCH PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2025 | MIRO3D PER CU CM                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2026 | RESTRATA MINIMATRIX 5 MG              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2027 | MATRIDERM PER SQ CM                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2028 | MICROMATRIX FLEX PER MG               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | A2029 | MIROTRACT WOUND MATRIX SHEET PER CC         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 10/1/2025      | A2030 | Miro3d fibers, per milligram                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2031 | Mirodry wound matrix, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2032 | Myriad matrix, per square centimeter        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2033 | Myriad morcells, 4 milligrams               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | A2034 | Foundation drs solo, per square centimeter          | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | A2035 | Corplex P or Theracor P or Allacor P, per milligram | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | A2036 | Cohealyx Collagen Derman Matrix, per sq cm          | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2037 | G4derm Plus, per mm                                 | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | A2038 | Marigen Pacto, per sq cm                            | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |



| Service Category Notes | Effective Date    | Code  | Definition                                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026          | A2039 | Innovamatrix fd, per sq cm                                                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 10/1/2025         | A4100 | Skin substitute, FDA-cleared as a device, not otherwise specified          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | C9250 | Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | G0277 | HPO UND PRESS FULL BODY CHMBR PER 30 MIN INT                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                   |                                                                                     | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022         | Q4101 | APLIGRAF PER SQ CM                                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4102 | Oasis wound matrix, per sq cm                                                                         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4103 | Oasis burn matrix, per sq cm                                                                          | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4104 | Integra bilayer matrix wound dressing (BMWD), per sq cm                                               | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4105 | Integra dermal regeneration template (DRT) or Integra Omnigraft dermal regeneration matrix, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4107 | GRAFTJACKET, per sq cm                                                                                | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4108 | Integra matrix, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4110 | Primatrix, per square centimeter      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4111 | Gammagraft, per sq cm                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4112 | Cymetra, injectable, 1cc              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4113 | Graftjacket xpress, injectable, 1cc   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                           | Notes                                                                                                                                                         | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4114 | Integra flowable wound matrix, injectable, 1cc | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4115 | Alloskin, per sq cm                            | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4116 | AlloDerm, per sq cm                            | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.<br><br>No Prior Authorization is required with a breast cancer diagnosis. |                       |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4117 | Hyalomatrix, per sq cm                         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4118 | Matristem micromatrix, 1mg                     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                           | Notes                                                                                                                                                         | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2022      | Q4121 | THERASKIN PER SQ CM                                         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4122 | DermACELL, DermACELL AWM or DermACELL AWM Porous, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.<br><br>No Prior Authorization is required with a breast cancer diagnosis. |                       |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4123 | AlloSkin RT, per sq cm                                      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4124 | OASIS ultra tri-layer wound matrix, per sq cm               | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4125 | ARTHROFLEX PER SQ CM                                        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                                                                                                         | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2022      | Q4126 | MEMODERM DERMASPERM<br>TRANZGRT/INTEGUPPLY PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4127 | Talymed, per sq cm                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4128 | FLEXHD ALLOPATCHHD OR MATRIX<br>HD PER SQ CM         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.<br><br>No Prior Authorization is required with a breast cancer diagnosis. |                       |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4130 | STRATTICE PER SQ CM                                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4132 | GRAFIX CORE AND GRAFIXPL CORE<br>PER SQUARE CM       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                                                                           | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|----------------|-------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 10/1/2022      | Q4133 | GRAFIX PRM GRAFIXPL PRM STRAVIX AND STRAVIXPL P SC              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4134 | Hmatrix, per sq cm                                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4135 | Mediskin, per sq cm                                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4136 | E-Z Derm, per sq cm                                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4137 | Amnioexcel, amnioexcel plus or biodexcel, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|----------------|-------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 10/1/2025      | Q4138 | Biodfense dryflex, per square centimeter          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4139 | Amniomatrix or biodmatrix, injectable, 1 cc       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4140 | BioDFence, per square centimeter                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4141 | Alloskin AC, per square centimeter                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4142 | Xcm biologic tissue matrix, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |



| Service Category Notes | Effective Date | Code  | Definition                                                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4143 | Repriza, per square centimeter                                                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4145 | Epifix, injectable, 1 mg                                                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4146 | Tensix, per square centimeter                                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4147 | Architect, Architect PX, or Architect FX, extracellular matrix, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4148 | Neox Cord 1K, Neox Cord RT, or Clarix Cord 1K, per square centimeter                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4149 | Excellagen, 0.1 cc                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4150 | ALLOWRAP DS OR DRY PER SQUARE CENTIMETER    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4151 | AMNIOBAND OR GUARDIAN PER SQUARE CENTIMETER | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4152 | DermaPure, per sq cm                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4153 | Dermavest and Plurivest, per sq cm          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4154 | Biovance, per sq cm                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4155 | Neox Flo or Clarix Flo 1 mg          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4156 | NEOX 100 OR CLARIX 100 PER SQUARE CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4157 | REVITALON PER SQUARE CENTIMETER      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4158 | KERECIS OMEGA3 PER SQUARE CM         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2022         | Q4159 | AFFINITY PER SQUARE CENTIMETER      | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022         | Q4160 | NUSHIELD PER SQUARE CENTIMETER      | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4161 | bio-ConneKt wound matrix, per sq cm | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4162 | WOUNDEX FLOW BIOSKIN FLOW 0.5 CC    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4163 | WOUNDEX BIOSKIN PER SQUARE CM       | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|----------------|-------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 7/1/2025       | Q4164 | HELICOLL PER SQUARE CENTIMETER    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4165 | Keramatrix or Kerasorb, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4166 | Cytal, per square centimeter      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4167 | Truskin, per square centimeter    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4168 | AmnioBand, 1 mg                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4169 | Artacent wound, per sq cm                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4170 | Cygnus, per sq cm                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4171 | Interfyl, 1 mg                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4173 | Palingen or Palingen Xplus, per sq cm     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4174 | Palingen or promatrx, 0.36 mg per 0.25 cc | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|-------------------|-------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 10/1/2025         | Q4175 | Miroderm, per sq cm                        | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4176 | Neopatch or Therion, per square centimeter | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4177 | Floweramnioflo, 0.1 cc                     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4178 | FLOWERAMNIOPATCH PER SQUARE CM             | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4179 | FLOWERDERM PER SQUARE CM                   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4180 | REVITA PER SQUARE CM                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4181 | AMNIO WOUND PER SQUARE CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4182 | TRANSCYTE PER SQUARE CM             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4183 | Surgigraft, per sq cm               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4184 | Cellesta or Cellesta Duo, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |



| Service Category Notes | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025         | Q4185 | Cellesta flowable amnion (25 mg per cc); per 0.5 cc | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4186 | EPIFIX PER SQ CM                                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4187 | EPICORD PER SQ CM                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4188 | AmnioArmor, per sq cm                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4189 | Artacent ac, 1 mg                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4190 | Artacent AC, per sq cm             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2025       | Q4191 | RESTORIGIN PER SQ CM               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4192 | Restorigin, 1 cc                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4193 | Coll-e-derm, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025       | Q4194 | NOVACHOR PER SQ CM                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4195 | PURAPLY PER SQ CM                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4196 | PURAPLY AM PER SQ CM                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4197 | PURAPLY XT PER SQ CM                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4198 | Genesis amniotic membrane, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2026          | Q4199 | CYGNUS MATRIX PER SQ CM                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date    | Code  | Definition                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025         | Q4200 | SkinTE, per sq cm              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4201 | Matrion, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025         | Q4202 | Kerxxx (2.5g/cc), 1cc          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | Prior to 9/1/2019 | Q4203 | DERMA-GIDE PER SQ CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2025          | Q4204 | XWRAP PER SQ CM                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2022      | Q4205 | MEMBRANE GRAFT OR MEMBRANE WRAP PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4206 | Fluid flow or fluid gf, 1 cc              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4208 | Novafix, per sq cm                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4209 | SurGraft, per sq cm                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4211 | Amnion Bio or AxoBioMembrane, per sq cm   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                          | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4212 | Allogen, per cc                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes                                | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4213 | Ascent, 0.5 mg                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes                                | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4214 | Cellesta Cord, per sq cm               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes                                | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4215 | AXOLOTL AMBIENT OR AXOLOTL CRYO 0.1 MG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes;<br>Plantar Fascitis Treatment | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4216 | Artacent Cord, per sq cm               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes                                | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4217 | WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound Xplus, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4218 | SURGICORD PER SQ CM                                                                           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4219 | SURGIGRAFT-DUAL PER SQ CM                                                                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4220 | BellaCell HD or Surederm, per sq cm                                                           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2022      | Q4221 | AMNIO WRAP2 PER SQ CM                                                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4222 | ProgenaMatrix, per sq cm                                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4224 | Human Health Factor 10 Amniotic Patch (HHF10-P), per sq cm            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4225 | Amniobind or derma tl, per sq cm                                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4226 | MyOwn Skin, includes harvesting and preparation procedures, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2025       | Q4227 | AMNIOCORETM PER SQ CM                                                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |



| Service Category Notes | Effective Date | Code  | Definition                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2025       | Q4229 | COGENEX AMNIOTIC MEMBRANE PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4230 | Cogenex Flowable Amnion, per 0.5 cc | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4232 | Corplex, per sq cm                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4233 | SurFactor or NuDyn, per 0.5 cc      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4234 | XCellerate, per sq cm               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4235 | AMNIOREPAIR or Alt iPly, per sq cm       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2025       | Q4236 | CAREPATCH PER SQ CM                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4237 | Cryo-Cord, per sq cm                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2025       | Q4238 | DERM-MAXX PER SQ CM                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4239 | Amnio-Maxx or Amnio-Maxx Lite, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2022      | Q4240 | CORECYTE FOR TOPICAL USE ONLY<br>PER 0.5 CC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4241 | PolyCyte, for topical use only, per 0.5 cc  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4242 | AmnioCyte Plus, per 0.5 cc                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4245 | AmnioText, per cc                           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4246 | CoreText or ProText, per cc                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4247 | Amniotext patch, per sq cm                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2025       | Q4248 | DERMACYTE AMNIOTIC MEMBRANE ALLOGRAFT PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4249 | AMNIPLY, for topical use only, per sq cm        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2021       | Q4250 | AMNIOAMP-MP, PER SQUARE CENTIMETER              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4251 | VIM PER SQ CM                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2022       | Q4252 | VENDAJE PER SQ CM                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4253 | ZENITH AMNIOTIC MEMBRANE PER SQ CM       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4254 | Novafix DL, per sq cm                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4255 | REGUaRD, for topical use only, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4256 | MLG-Complete, per sq cm                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4257 | Relese, per sq cm                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4258 | Enverse, per sq cm                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4259 | CELERA DUAL LAYER/CELERA DUAL MEMBRANE PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4260 | SIGNATURE APATCH PER SQ CM                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4261 | TAG PER SQ CM                                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4262 | Dual Layer Impax Membrane, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4263 | SurGraft TL, per sq cm               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4264 | Cocoon Membrane, per sq cm           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | Q4265 | NEOSTIM TL, PER SQ CM                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | Q4266 | NEOSTIM MEMBRANE PER SQ CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|----------------|-------|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 7/1/2023       | Q4267 | EOSTIM DL PER SQ CM   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | Q4268 | URGRAFT FT PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | Q4269 | SURGRAFT XT PER SQ CM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | Q4270 | COMPLETE SL PER SQ CM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 7/1/2023       | Q4271 | COMPLETE FT PER SQ CM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |



| Service Category Notes | Effective Date | Code  | Definition           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2023      | Q4272 | ESANO A, PER SQ CM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4273 | ESANO AAA, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4274 | ESANO AC, PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4275 | ESANO ACA, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4276 | ORION, PER SQ CM     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2023      | Q4278 | Epiffect, per square centimeter     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4279 | Vendaje ac, per square centimeter   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4280 | XCELL AMNIO MATRIX, PER SQ CM       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4281 | BARRERA SL OR BARRERA DL, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4282 | CYGNUS DUAL, PER SQ CM              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2023      | Q4283 | BIOVANCE TRI-LAYER OR BIOVANCE 3L, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2023      | Q4284 | DERMABIND SL, PER SQ CM                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4285 | NUDYN DL OR NUDYN DL MESH PER SQ CM          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4286 | NUDYN SL OR NUDYN SLW PER SQ CM              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4287 | Dermabind dl, per square centimeter          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4288 | Dermabind ch, per square centimeter                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4289 | Revoshield + amniotic barrier, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4290 | Membrane wrap-hydro, per square centimeter           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4291 | Lamellas xt, per square centimeter                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4292 | Lamellas, per square centimeter                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4293 | Acesso dl, per square centimeter      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 4/1/2025       | Q4294 | AMNIO QUAD-CORE PER SQ CM             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 5/21/2025             |
| Hyperbaric/Wound Care  | 4/1/2025       | Q4295 | AMNIO TRI-CORE AMNIOTIC PER SQ        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 5/21/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4296 | Rebound matrix, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4297 | Emerge matrix, per square centimeter  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4298 | Amnicore pro, per square centimeter    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 4/1/2025       | Q4299 | AMNICORE PRO Plus PER SQ CM            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 5/21/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4300 | Acesso tl, per square centimeter       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4301 | Activate matrix, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4302 | Complete ACA, per sq cm                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4303 | Complete aa, per square centimeter         | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4304 | Grafix plus, per square centimeter         | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4305 | AMERICAN AMNION AC TRI-LAYER PER SQUARE CM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4306 | AMERICAN AMNION AC PER SQUARE CENTIMETER   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4307 | AMERICAN AMNION PER SQUARE CENTIMETER      | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | Q4308 | SANOPELLIS PER SQUARE CENTIMETER | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4309 | VIA MATRIX PER SQUARE CENTIMETER | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4310 | PROCENTA PER 100 MG              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4311 | Acesso, per square centimeter    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4312 | Acesso ac, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |



| Service Category Notes | Effective Date | Code  | Definition                                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4313 | Dermabind fm, per square centimeter                           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4314 | Reeva ft, per square centimeter                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4315 | Regenelink amniotic membrane allograft, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4316 | AmchoPlast, per sq cm                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4317 | Vitograft, per square centimeter                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4318 | E-graft, per square centimeter    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4319 | Sanograft, per square centimeter  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4320 | Pellograft, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4321 | Renograft, per square centimeter  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4322 | Caregraft, per square centimeter  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4323 | Alloply, per square centimeter           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4324 | Amniotx, per square centimeter           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4325 | Acapatch, per square centimeter          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 7/1/2024       | Q4326 | WOUNDPLUS MEMBRANE OR E-GRAFT, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4327 | Duoamnion, per square centimeter         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4328 | Most, per square centimeter              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4329 | Singlay, per square centimeter           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4330 | Total, per square centimeter             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4331 | Axolotl graft, per square centimeter     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4332 | Axolotl dualgraft, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4333 | Ardeograft, per square centimeter       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4334 | Amnioplast 1, per square centimeter     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4335 | Amnioplast 2, per square centimeter     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4336 | Artacent c, per square centimeter       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4337 | Artacent trident, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4338 | Artacent velos, per square centimeter    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4339 | Artacent vericlen, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4340 | Simpligraft, per square centimeter       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4341 | Simplimax, per square centimeter         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4342 | Theramend, per square centimeter         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4343 | Dermacyte ac matrix amniotic membrane allograft, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4344 | Tri-membrane wrap, per square centimeter                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4345 | Matrix hd allograft dermis, per square centimeter                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4346 | Shelter dm matrix, per square centimeter                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4347 | Rampart dl matrix, per square centimeter                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4348 | Sentry sl matrix, per square centimeter   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4349 | Mantle dl matrix, per square centimeter   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4350 | Palisade dm matrix, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4351 | Enclose tl matrix, per square centimeter  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4352 | Overlay sl matrix, per square centimeter  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |



| Service Category Notes | Effective Date | Code  | Definition                                                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|----------------|-------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 10/1/2025      | Q4353 | Xceed tl matrix, per square centimeter                                          | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4354 | PALINGEN DUAL LAYER MEMBRANE PER SQ CENTIMETER                                  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4355 | Abiomend xplus membrane and abiomend xplus hydromembrane, per square centimeter | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4356 | Abiomend membrane and abiomend hydromembrane, per square centimeter             | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4357 | Xwrap plus, per square centimeter                                               | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4358 | Xwrap dual, per square centimeter   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4359 | Choriply, per square centimeter     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4360 | AMCHOPLAST FD PER SQUARE CENTIMETER | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4361 | Epixpress, per square centimeter    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4362 | Cygnus disk, per square centimeter  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 10/1/2025      | Q4363 | Amnio burgeon membrane and hydromembrane, per square centimeter             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4364 | Amnio burgeon xplus membrane and xplus hydromembrane, per square centimeter | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4365 | Amnio burgeon dual-layer membrane, per square centimeter                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4366 | Dual layer amnio burgeon x-membrane, per square centimeter                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |
| Hyperbaric/Wound Care  | 10/1/2025      | Q4367 | Amniocore sl, per square centimeter                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 8/27/2025             |

| Service Category Notes | Effective Date | Code  | Definition                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | Q4368 | AMCHOTHICK PER SQ CM      | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4369 | AMNIOPLAST 3 PER SQ CM    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4370 | AEROGUARD PER SQ CM       | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4371 | NEOGUARD PER SQ CM        | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4372 | AMCHOPLAST EXCL PER SQ CM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | Q4373 | MEMBRANE WRP LT PER SQ CM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4375 | DUOGRAFT AC PER SQ CM     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4376 | DUOGRAFT AA PER SQ CM     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4377 | TRIGRAFT FT PER SQ CM     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4378 | RENEW FT MATRIX PER SQ CM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|----------------|-------|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 1/1/2026       | Q4379 | AMNIODEFEND FT MATRIX PER SQ CM    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4380 | ADVOGRAFT ONE PER SQ CM            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4382 | ADVOGRAFT DUAL PER SQ CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4383 | Axolotl Graft Ultra, per sq cm     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4384 | Axolotl DualGraft Ultra, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | Q4385 | Apollo FT, per sq cm          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4386 | Acesso TrifACA, per sq cm     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4387 | NeoThelium FT, per sq cm      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4388 | NeoThelium 4L, per sq cm      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4389 | NeoThelium 4L Plus, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |

| Service Category Notes | Effective Date | Code  | Definition                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | Q4390 | Ascension, per sq cm         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4391 | AminoPlast Double, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4392 | GRAFIX Duo, per sq cm        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4393 | SurGraft AC, per sq cm       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4394 | SurGraft ACA, per sq cm      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |



| Service Category Notes | Effective Date | Code  | Definition            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 1/1/2026       | Q4395 | Acelagraft, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4396 | Natalin, per sq cm    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 1/1/2026       | Q4397 | Summit AAA, per sq cm | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 11/19/2025            |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4398 | SUMMIT AC, PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4399 | SUMMIT FX, PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |

| Service Category Notes | Effective Date | Code  | Definition                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 4/1/2026       | Q4400 | POLYGON3 MEMBRANE, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4401 | ABSOLV3 MEMBRANE, PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4402 | XWRAP 2.0, PER SQ CM         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4403 | XWRAP DUAL PLUS, PER SQ CM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4404 | XWRAP HYDRO PLUS, PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |

| Service Category Notes | Effective Date | Code  | Definition                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
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| Hyperbaric/Wound Care  | 4/1/2026       | Q4405 | XWRAP FENESTRA PLUS, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4406 | XWRAP FENESTRA, PER SQ CM      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4407 | XWRAP TRIBUS, PER SQ CM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4408 | XWRAP HYDRO, PER SQ CM         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4409 | AMNIOMATRIXF3X, PER SQ CM      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |

| Service Category Notes | Effective Date | Code  | Definition                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                               | Date of Annual Review |
|------------------------|----------------|-------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------|
| Hyperbaric/Wound Care  | 4/1/2026       | Q4410 | AMCHOMATRIXDL, PER SQ CM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4411 | AMNIOMATRIXF4X, PER SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4412 | CHORIOFIX, PER SQ CM      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4413 | CYGNUS SOLO, PER SQ CM    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |
| Hyperbaric/Wound Care  | 4/1/2026       | Q4414 | SIMPLICHOR, PER SQ CM     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. |                       |

| Service Category Notes    | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                                                          | Date of Annual Review |
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| Hyperbaric/Wound Care     | 4/1/2026          | Q4415 | ALEXIGUARD SL-T, PER SQ CM                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                            |                       |
| Hyperbaric/Wound Care     | 4/1/2026          | Q4416 | ALEXIGUARD TL-T, PER SQ CM                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                            |                       |
| Hyperbaric/Wound Care     | 4/1/2026          | Q4417 | ALEXIGUARD DL-T, PER SQ CM                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations.                            |                       |
| Imaging and Special Tests | Prior to 9/1/2019 | 0331T | MYOCDR SYMPATHETIC INNERVAJ<br>IMG PLNR QUAL AND QUANT  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                            | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 0332T | MYOCDR SYMP INNERVAJ IMG PLNR<br>QUAL AND QUANT W SPECT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                            | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------|
| Imaging and Special Tests | 1/1/2021       | 0609T | MRS DISCOGENIC PAIN ACQUISJ<br>SINGLE Voxel DATA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0610T | MRS DISC PAIN TRANSMIS DATA                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0611T | MRS DISC PAIN ALG ALYS DATA                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0612T | MRS DISCOGENIC PAIN I&R                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0633T | CT BREAST W/3D RENDERING UNI<br>WITHOUT CONTRAST | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------|
| Imaging and Special Tests | 1/1/2021       | 0634T | CT BREAST W/3D RENDERING UNI WITH CONTRAST       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0635T | CT BRST W/3D RENDERING UNI WO CNTRST FLWD CNTRST | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0636T | CT BREAST W/3D RENDERING BI WITHOUT CONTRAST     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0637T | CT BREAST W/3D RENDERING BI WITH CONTRAST        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 0638T | CT BRST W/3D RENDERING BI WO CNTRST FLWD CNTRST  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes                                                                                                          | Date of Annual Review |
|---------------------------|-------------------|-------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------|
| Imaging and Special Tests | 1/1/2022          | 0710T | N-INVAS ARTL PLAQ ALYS DATA PRP QUAN REVIEW I and R  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Texas Medicaid Provider Procedures Manual | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2022          | 0711T | N-INVAS ARTL PLAQ ALYS DATA PREP and TRANSMISSION    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Texas Medicaid Provider Procedures Manual | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2022          | 0712T | N-INVAS ARTL PLAQ ALYS QUAN STRUX and COMPOS VSL WAL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Texas Medicaid Provider Procedures Manual | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2022          | 0713T | N-INVAS ARTL PLAQ ALYS DATA REVIEW I and R           | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Texas Medicaid Provider Procedures Manual | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70450 | CT HEAD BRAIN W O CONTRAST MATERIAL                  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria          | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |



| Service Category Notes    | Effective Date    | Code  | Definition                                                                                                                                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 70460 | CT HEAD BRAIN W CONTRAST MATERIAL                                                                                                                                 | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70470 | CT HEAD BRAIN W O AND W CONTRAST MATERIAL                                                                                                                         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 4/1/2026          | 70472 | CT CRBRL PRFSN ANLYSS WTH CONTRST MTRL(S), INCLDNG IMG PSTPRCSSNG PRFRMD WITH CONCRRT CT OR CT ANGGRPHY SAME ANTMY (LIST SPRTLY IN ADDTN TO CODE FOR PRIM PROCDR) | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal |                       |
| Imaging and Special Tests | 4/1/2026          | 70473 | CT CRBRL PRFSN ANLYSS WTH CONTRST MTRL(S), INCLDNG IMG PSTPRCSSNG PRFRMD WITHOUT CNCRRNT CT OR CT ANGGRPHY SAME ANTMY                                             | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal |                       |
| Imaging and Special Tests | Prior to 9/1/2019 | 70496 | CT ANGIOGRAPHY HEAD W CONTRAST NONCONTRAST                                                                                                                        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
|---------------------------|-------------------|-------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------|
| Imaging and Special Tests | Prior to 9/1/2019 | 70498 | CT ANGIOGRAPHY NECK W CONTRAST NONCONTRAST       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70540 | MRI ORBIT FACE AND NECK W O CONTRAST             | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70542 | MRI ORBIT FACE AND NECK W CONTRAST MATERIAL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70543 | MRI ORBIT FACE AND NECK W O AND W CONTRAST MATRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70544 | MRA HEAD W O CONTRST MATERIAL                    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
|---------------------------|-------------------|-------|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------|
| Imaging and Special Tests | Prior to 9/1/2019 | 70545 | MRA HEAD W CONTRAST MATERIAL         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70546 | MRA HEAD W O AND W CONTRAST MATERIAL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70547 | MRA NECK W O CONTRST MATERIAL        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70548 | MRA NECK W CONTRAST MATERIAL         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70549 | MRA NECK W O AND W CONTRAST MATERIAL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 70551 | MRI BRAIN BRAIN STEM W O CONTRAST MATERIAL        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70552 | MRI BRAIN BRAIN STEM W CONTRAST MATERIAL          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70553 | MRI BRAIN BRAIN STEM W O W CONTRAST MATERIAL      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70554 | MRI BRAIN FUNCTIONAL W O PHYSICIAN ADMINISTRATION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 70555 | MRI BRAIN FUNCTIONAL W PHYSICIAN ADMINISTRATION   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 71275 | CT ANGIOGRAPHY CHEST W CONTRAST NONCONTRAST | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 71550 | MRI CHEST W O CONTRAST MATERIAL             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 71551 | MRI CHEST W CONTRAST MATERIAL               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 71552 | MRI CHEST W O AND W CONTRAST MATERIAL       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 71555 | MRA CHEST W O AND W CONTRAST MATERIAL       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 72128 | CT THORACIC SPINE W O CONTRAST MATERIAL       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72129 | CT THORACIC SPINE W CONTRAST MATERIAL         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72130 | CT THORACIC SPINE W O AND W CONTRAST MATERIAL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72131 | CT LUMBAR SPINE W O CONTRAST MATERIAL         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72132 | CT LUMBAR SPINE W CONTRAST MATERIAL           | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
|---------------------------|-------------------|-------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------|
| Imaging and Special Tests | Prior to 9/1/2019 | 72133 | CT LUMBAR SPINE W O AND W CONTRAST MATERIAL  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72141 | MRI SPINAL CANAL CERVICAL W O CONTRAST MATRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72142 | MRI SPINAL CANAL CERVICAL W CONTRAST MATRL   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72146 | MRI SPINAL CANAL THORACIC W O CONTRAST MATRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72147 | MRI SPINAL CANAL THORACIC W CONTRAST MATRL   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
|---------------------------|-------------------|-------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------|
| Imaging and Special Tests | Prior to 9/1/2019 | 72148 | MRI SPINAL CANAL LUMBAR W O CONTRAST MATERIAL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72149 | MRI SPINAL CANAL LUMBAR W CONTRAST MATERIAL     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72156 | MRI SPINAL CANAL CERVICAL W O AND W CONTR MATRL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72157 | MRI SPINAL CANAL THORACIC W O AND W CONTR MATRL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72158 | MRI SPINAL CANAL LUMBAR W O AND W CONTR MATRL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |



| Service Category Notes    | Effective Date    | Code  | Definition                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                    | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 72159 | MRA SPINAL CANAL W WO CONTRAST MATERIAL      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: MRI Angiography Spinal Canal | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72191 | CT ANGIOGRAPHY PELVIS W CONTRAST NONCONTRAST | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72192 | CT PELVIS W O CONTRAST MATERIAL              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72193 | CT PELVIS W CONTRAST MATERIAL                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72194 | CT PELVIS W O AND W CONTRAST MATERIAL        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 72195 | MRI PELVIS W O CONTRAST MATERIAL                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72196 | MRI PELVIS W CONTRAST MATERIAL                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72197 | MRI PELVIS W O AND W CONTRAST MATERIAL          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 72198 | MRA PELVIS W WO CONTRAST MATERIAL               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73218 | MRI UPPER EXTREMITY OTH THAN JT W O CONTR MATRL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 73219 | MRI UPPER EXTREMITY OTH THAN JT W CONTR MATRL    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73220 | MRI UPPER EXTREM OTHER THAN JT W O AND W CONTRAS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73221 | MRI ANY JT UPPER EXTREMITY W O CONTRAST MATRL    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73222 | MRI ANY JT UPPER EXTREMITY W CONTRAST MATRL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73223 | MRI ANY JT UPPER EXTREMITY W O AND W CONTR MATRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 73225 | MRA UPPER EXTREMITY W WO CONTRAST MATERIAL       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73718 | MRI LOWER EXTREM OTH THN JT W O CONTR MATRL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73719 | MRI LOWER EXTREM OTH THN JT W CONTRAST MATRL     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73720 | MRI LOWER EXTREM OTH THN JT W O AND W CONTR MATR | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73721 | MRI ANY JT LOWER EXTREM W O CONTRAST MATRL       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 73722 | MRI ANY JT LOWER EXTREM W CONTRAST MATERIAL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73723 | MRI ANY JT LOWER EXTREM W O AND W CONTRAST MATRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 73725 | MRA LOWER EXTREMITY W WO CONTRAST MATERIAL       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74150 | CT ABDOMEN W O CONTRAST MATERIAL                 | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74160 | CT ABDOMEN W CONTRAST MATERIAL                   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 74170 | CT ABDOMEN W O AND W CONTRAST MATERIAL             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74174 | CT ANGIO ABD AND PLVIS CNTRST MTRL W WO CNTRST IMG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74175 | CT ANGIOGRAPHY ABDOMEN W CONTRAST NONCONTRAST      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74176 | CT ABDOMEN AND PELVIS W O CONTRAST MATERIAL        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74177 | CT ABDOMEN AND PELVIS W CONTRAST MATERIAL          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 74178 | CT ABDOMEN AND PELVIS W O CONTRST 1 OR GRT BODY RE | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74181 | MRI ABDOMEN W O CONTRAST MATERIAL                  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74182 | MRI ABDOMEN W CONTRAST MATERIAL                    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74183 | MRI ABDOMEN W O AND W CONTRAST MATERIAL            | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74185 | MRA ABDOMEN W WO CONTRAST MATERIAL                 | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 74261 | CT COLONOGRPHY DX IMAGE POSTPROCESS W O CONTRAST | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74262 | CT COLONOGRPHY DX IMAGE POSTPROCESS W CONTRAST   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 74263 | CT COLONOGRAPHY SCREENING IMAGE POSTPROCESSING   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 75557 | CARDIAC MRI MORPHOLOGY AND FUNCTION W O CONTRAST | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 75559 | CARDIAC MRI W O CONTRAST W STRESS IMAGING        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |



| Service Category Notes    | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 75561 | CARDIAC MRI W WO CONTRAST AND FURTHER SEQ          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 75563 | CARDIAC MRI W W O CONTRAST W STRESS                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 75571 | CT HEART NO CONTRAST QUANT EVAL CORONRY CALCIUM    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 75572 | CT HEART CONTRAST EVAL CARDIAC STRUCTURE AND MORPH | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 75573 | CT HRT CONTRST CARDIAC STRUCT AND MORPH CONG HRT D | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                                                                                                                                                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                          | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 75574 | CTA HRT CORNRY ART BYPASS GRFTS CONTRST 3D POST                                                                                                                                                      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria                                           | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 4/1/2026          | 75577 | QNTFCTN CHRCTRZTN CRNRY ATHRSLRTC PLQ ASSESS SVRTY CRNRY DISSE, DRVD FRM AGMNTTV SFTWRE ANLYSS DATA SET FRM CRNRY CMPTD TMGRPHC ANGRPHY, W NTRPRTTN AND RPORT BY PHYS OR OTHR QLFD HLTH CRE PRFSSNAL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria                                           | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal |                       |
| Imaging and Special Tests | Prior to 9/1/2019 | 75635 | CTA ABDL AORTA AND BI ILIOFEM W CONTRAST AND POSTP                                                                                                                                                   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria                                           | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 76376 | 3D RENDERING W INTERP AND POSTPROCESS SUPERVISION                                                                                                                                                    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy: 3D Interpretation and Reporting of Imaging Studies | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 76377 | 3D RENDERING W INTERP AND POSTPROC DIFF WORK STATION                                                                                                                                                 | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy: 3D Interpretation and Reporting of Imaging Studies | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | 4/1/2021          | 76390 | MRI SPECTROSCOPY                                | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 76391 | MAGNETIC RESONANCE ELASTOGRAPHY                 | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 76497 | UNLISTED COMPUTED TOMOGRAPHY PROCEDURE          | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 76498 | UNLISTED MAGNETIC RESONANCE PROCEDURE           | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 77046 | MRI BREAST WITHOUT CONTRAST MATERIAL UNILATERAL | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 77047 | MRI BREAST WITHOUT CONTRAST MATERIAL BILATERAL       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 77048 | MRI BREAST W OUT AND WITH CONTRAST W CAD UNILATERAL  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 77049 | MRI BREAST WITHOUT AND WITH CONTRAST W CAD BILATERAL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 77261 | THERAPEUTIC RADIOLOGY TX PLANNING SIMPLE             | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 77372 | RADIATION DELIVERY STEREOTACTIC CRANIAL LINEAR       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 77425 | INTRAOP RADIAJ TX DELIVER<br>ELECTRONS SNGL TX SESS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78206 | LIVER IMAGING SPECT W VASCULAR<br>FLOW                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests | 4/1/2020          | 78429 | MYOCDR IMG PET METAB EVAL<br>SINGLE STUDY CNCRNT CT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 4/1/2020          | 78430 | MYOCDR IMG PET PRFUJ 1STD<br>REST/STRESS CNCRNT CT     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 4/1/2020          | 78431 | MYOCDR IMG PET PRFUJ MLT STD<br>RST AND STRS CNCRNT CT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | 4/1/2020          | 78432 | MYOCDR IMG PET PRFUJ W/METAB DUAL RADIOTRACER   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 4/1/2020          | 78433 | MYOCDR IMG PET PRFUJ W/METAB 2RTRACER CNCRNT CT | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78451 | MYOCARDIAL SPECT SINGLE STUDY AT REST OR STRESS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78452 | MYOCARDIAL SPECT MULTIPLE STUDIES               | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78453 | MYOCARDIAL PERFUSION PLANAR 1 STUDY REST STRES  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 78454 | MYOCARDIAL PERFUSION PLANAR MULTIPLE STUDIES     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78459 | MYOCARDIAL IMAGING PET METABOLIC EVALUATION      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78466 | MYOCARDIAL IMAGING INFARCT AVID PLANAR QUAL QUAN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78468 | MYOCDR IMG INFARCT AVID PLNR EJEK FXJ 1ST PS TQ  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78469 | MYOCDR INFARCT AVID PLNR TOMOG SPECT W WO QUANTJ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 78481 | CARD BL POOL PLANAR 1 STDY WAL<br>MOTN EJECT FRACT  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78483 | CARD BL POOL PLNR MLT STDY WAL<br>MOTN EJECT FRACT  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78491 | MYOCDR IMAGE PET PERFUS SINGLE<br>STUDY REST STRESS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78492 | MYOCDR IMAGE PET PERFUS<br>MULTPL STUDY REST STRESS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78499 | UNLISTED CARDIOVASCULAR PX DX<br>NUCLEAR MEDICINE   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |



| Service Category Notes    | Effective Date    | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 78607 | BRAIN IMAGING TOMOGRAPHIC SPECT          | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78608 | BRAIN IMAGING PET METABOLIC EVALUATION   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78609 | BRAIN IMAGING PET PERFUSION EVALUATION   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78811 | PET IMAGING LIMITED AREA CHEST HEAD NECK | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78812 | PET IMAGING SKULL BASE TO MID-THIGH      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | Prior to 9/1/2019 | 78813 | PET IMAGING WHOLE BODY                                  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78814 | PET IMAGING CT FOR ATTENUATION LIMITED AREA             | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78815 | PET IMAGING CT ATTENUATION SKULL BASE MID-THIGH         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 78816 | PET IMAGING FOR CT ATTENUATION WHOLE BODY               | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021          | 93241 | EXTERNAL ECG REC GT 48HR LT 7D SCAN ALYS REPORT R and I | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information</li> </ul>  | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Criteria Utilized                | Notes | Date of Annual Review |
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| Imaging and Special Tests | 1/1/2021       | 93242 | EXTERNAL ECG REC GT 48HR LT 7D RECORDING                 | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 93243 | EXTERNAL ECG REC GT 48HR LT 7D SCANNING ALYS W/REPORT    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 93244 | EXTERNAL ECG REC GT 48HR LT 7D REVIEW and INTERPRETATION | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 93245 | EXTERNAL ECG REC GT 7D LT 15D SCAN ALYS REPORT R and I   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021       | 93246 | EXTERNAL ECG REC GT 7D LT 15D RECORDING                  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information</li></ul> | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests | 1/1/2021          | 93247 | EXTERNAL ECG REC GT 7D LT 15D<br>SCANNING ALYS W/REPORT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests | 1/1/2021          | 93248 | EXTERNAL ECG REC GT 7D LT 15D<br>REVIEW and INTERPRETATION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | 93998 | UNLISTED NONINVASIVE VASCULAR<br>DIAGNOSTIC STUDY          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | C8909 | MR ANGIOGRAPHY WITH CONTRAST<br>CHEST                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| Imaging and Special Tests | Prior to 9/1/2019 | C8910 | MR ANGIOGRAPHY WITHOUT<br>CONTRAST CHEST                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |

| Service Category Notes                                                                 | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Criteria Utilized                        | Notes                                                                                                          | Date of Annual Review |
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| Imaging and Special Tests                                                              | Prior to 9/1/2019 | G0297 | LOW DOSE CT SCAN FOR LUNG<br>CANCER SCREENING    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.                                                             | Third Party Proprietary Criteria         |                                                                                                                | 2/19/2025             |
| Imaging and Special Tests                                                              | Prior to 9/1/2019 | S8080 | SCINTIMAMMOGRAPHY UNI INCL<br>SUPPLY RADIOPHARM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.                                                             | Third Party Proprietary Criteria         | For advanced imaging authorization requests - you may submit a request by fax at 877-731-7218 or in the portal | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | 94657 | VENTILATOR SUPPLEMENT                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |                                                                                                                | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | 97532 | COGNITIVE REHABILITATIVE THERAPY                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |                                                                                                                | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | 97537 | COMMUNITY/WORK<br>REINTEGRATION TRAING EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |                                                                                                                | 2/19/2025             |

| Service Category Notes                                                                 | Effective Date | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Criteria Utilized                        | Notes | Date of Annual Review |
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| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | H2023 | SUPPORTED EMPLOYMENT PER 15 MINUTES            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | H2025 | ONGOING SUPPORT MAINTAIN EMPLOYMENT PER 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | S5101 | DAY CARE SERVICES ADULT; PER HALF DAY          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | S5125 | ATTENDANT CARE SERVICES; PER 15 MINUTES        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | S5140 | FOSTER CARE ADULT; PER DIEM                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |

| Service Category Notes                                                                 | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Criteria Utilized                        | Notes | Date of Annual Review |
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| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | S5151 | UNSKILLED RESPITE CARE NOT HOSPICE; PER DIEM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | S5160 | EMERGENCY RESPONSE SYSTEM; INSTALLATION AND TESTING | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | S5161 | EMERGENCY RESPONSE SYSTEM; SERVICE FEE PER MONTH    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | S5165 | HOME MODIFICATIONS; PER SERVICE                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | Prior to 9/1/2019 | S5170 | HOME DELIV MEALS INCLUDING PREPARATION; PER MEAL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |

| Service Category Notes                                                                 | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Criteria Utilized                        | Notes | Date of Annual Review |
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| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | Prior to 9/1/2019 | S9123 | NURSING CARE THE HOME;<br>REGISTERED NURSE PER HOUR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | Prior to 9/1/2019 | S9124 | NURSING CARE IN THE HOME; BY<br>LPN PER HOUR        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | S9128 | SPEECH THERAPY IN THE HOME PER<br>DIEM              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | S9129 | OCCUPATIONAL THERAPY IN THE<br>HOME PER DIEM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022          | S9131 | PHYSICAL THERAPY; IN THE HOME<br>PER DIEM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |



| Service Category Notes                                                                 | Effective Date | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Criteria Utilized                        | Notes | Date of Annual Review |
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| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | T1001 | NURSING ASSESSMENT/EVALUATION                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2021       | T1005 | RESPIRE CARE SERVICES UP TO 15 MINUTES          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | T2003 | NON-EMERGENCY TRANSPORTATION; ENCOUNTER/TRIP    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | T2017 | HABILITATION RESIDENTIAL WAIVER; PER 15 MINUTES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment. | 2/1/2022       | T2031 | ASSISTED LIVING WAIVER; PER DIEM                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook |       | 2/19/2025             |

| Service Category Notes                                                                             | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Criteria Utilized                         | Notes                                        | Date of Annual Review |
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| <b>Long Term Services and Support:</b><br>All codes require authorization for payment.             | Prior to 9/1/2019 | T2038 | COMMUNITY TRANSITION WAIVER;<br>PER SERVICE         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook  |                                              | 2/19/2025             |
| <b>Long Term Services and Support:</b><br>All codes require authorization for payment.             | 2/1/2022          | T2040 | FINANCIAL MGMT SELF-DIRECTED<br>WAIVER; PER 15 MIN  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.<br>•Documentation outlined in the Star+Plus Waiver Handbook | Texas Medicaid Star Plus Waiver Handbook  |                                              | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 1/1/2020          | 95700 | EEG CONT REC W/VIDEO BY TECH<br>MIN 8 CHANNELS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.                                                             | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020          | 95708 | EEG W/O VID BY TECH EA INCR 12-<br>26HR UNMONITORED | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.                                                             | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020          | 95709 | EEG W/O VID BY TECH EA INCR 12-26<br>HR INTMT MNTR  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information.                                                             | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                                                                             | Effective Date | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                        | Date of Annual Review |
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| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95710 | EEG W/O VID TECH EA INCR 12-26 HR<br>CONT R-T MNTR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95711 | EEG BY TECH 2-12 HOURS<br>UNMONITORED              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95712 | VEEG BY TECH 2-12 HR<br>INTERMITTENT MONITORING    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95713 | VEEG BY TECH 2-12 HR CONTINUOUS<br>R-T MONITORING  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95714 | VEEG BY TECH EA INCR 12-26 HR<br>UNMONITORED       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                                                                             | Effective Date | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                        | Date of Annual Review |
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| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95715 | VEEG BY TECH EA INCR 12-26 HR<br>INTERMITTENT MNTR       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95716 | VEEG BY TECH EA INCR 12-26 HR<br>CONT R-T MNTR           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95721 | EEG COMPLETE STD PHYS/QHP GT 36<br>HR LT 60 HR W/O VIDEO | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95722 | EEG COMPLETE STD PHYS/QHP GT 36<br>HR LT 60 HR W/VEEG    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020       | 95723 | EEG COMPLETE STD PHYS/QHP GT 60<br>HR LT 84 HR W/O VIDEO | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes                                                                             | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                        | Date of Annual Review |
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| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020          | 95724 | EEG COMPLETE STD PHYS/QHP GT 60 HR LT 84 HR W/VEEG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020          | 95725 | EEG COMPLETE STD PHYS/QHP GT 84 HR W/O VID         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | 4/1/2020          | 95726 | EEG COMPLETE STD PHYS/QHP GT 84 HR W/VEEG          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | Prior to 9/1/2019 | 95957 | DIGITAL ANALYSIS<br>ELECTROENCEPHALOGRAM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | Prior Authorization required in any setting. | 2/19/2025             |
| <b>Neuropsychological and Psychological Tests:</b><br>Prior Authorization required in any setting. | Prior to 9/1/2019 | 96125 | STANDARDIZED COGNITIVE<br>PERFORMANCE TESTING      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | Prior Authorization required in any setting. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes                                                                                                                                                                                                                                       | Date of Annual Review |
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| Occupational Therapy   | 7/1/2023       | 97012 | APPL MODALITY 1 OR GT AREAS TRACTION MECHANICAL   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97014 | APPL MODALITY 1 OR GT AREAS ELEC STIMJ UNATTENDED | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97016 | APPL MODALITY 1 OR GT AREAS VASOPNEUMATIC DEVICES | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97018 | APPL MODALITY 1 OR GT AREAS PARAFFIN BATH         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97022 | APPLICATION MODALITY 1 OR GT AREAS WHIRLPOOL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
|------------------------|----------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| Occupational Therapy   | 7/1/2023       | 97024 | APPLICATION MODALITY 1 OR GT AREAS DIATHERMY        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97026 | APPLICATION MODALITY 1 OR GT AREAS INFRARED         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97028 | APPL MODALITY 1 OR GT AREAS ULTRAVIOLET             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97032 | APPL MODALITY 1 OR GT AREAS ELEC STIMJ EA 15 MIN    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97033 | APPL MODALITY 1 OR GT AREAS IONTOPHORESIS EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes                                                                                                                                                                                                                                       | Date of Annual Review |
|------------------------|-------------------|-------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| Occupational Therapy   | 7/1/2023          | 97034 | APPL MODALITY 1 OR GT AREAS CONTRAST BATHS EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023          | 97035 | APPL MODALITY 1 OR GT AREAS ULTRASOUND EA 15 MIN     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97110 | THERAPEUTIC PX 1 OR GRT AREAS EACH 15 MIN EXERCISES  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97112 | THER PX 1 OR GRT AREAS EACH 15 MIN NEUROMUSC REEDUCA | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97113 | THER PX 1 OR GT AREAS EACH 15 MIN AQUA THER W/XERSS  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |



| Service Category Notes | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Occupational Therapy   | Prior to 9/1/2019 | 97116 | THER PX 1 OR GRT AREAS EA 15 MIN<br>GAIT TRAINJ W STAIR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97124 | THER PX 1 OR GRT AREAS EACH 15<br>MINUTES MASSAGE       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | 4/1/2020          | 97129 | THER IVNTJ COG FUNCJ CNTCT 1ST<br>15 MINUTES            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | 4/1/2020          | 97130 | THER IVNTJ COG FUNCJ CNTCT EA<br>ADDL 15 MINUTES        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97140 | MANUAL THERAPY TQS 1 OR GRT<br>REGIONS EACH 15 MINUTES  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes                                                                                                                                                                                                                                       | Date of Annual Review |
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| Occupational Therapy   | Prior to 9/1/2019 | 97150 | THERAPEUTIC PROCEDURES GROUP 2 OR GRT INDIVIDUALS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97168 | OCCUPATIONAL THER RE-EVAL EST PLAN CARE 30 MINS   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97530 | THERAPEUT ACTIVITY DIRECT PT CONTACT EACH 15 MIN  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97533 | SENSORY INTEGRATIVE TECHNIQUES EACH 15 MINUTES    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | Prior to 9/1/2019 | 97535 | SELF-CARE HOME MGMT TRAINING EACH 15 MINUTES      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes                                                                                                                                                                                                                                       | Date of Annual Review |
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| Occupational Therapy   | 7/1/2023       | 97537 | COMMUNITY/WORK REINTEGRATION TRAING EA 15 MIN         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97750 | PHYSICAL PERFORMANCE TEST/MEAS W/REPRT EA 15 MIN      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97760 | ORTHOTICS MGMT AND TRAING INITIAL ENCTR EA 15 MINS    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97761 | PROSTHETICS TRAINING INITIAL ENCTR EA 15 MINS         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |
| Occupational Therapy   | 7/1/2023       | 97763 | ORTHOTICS/PROSTH MGMT and /TRAINING SBSQ ENCTR 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual | <p><b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.</p> <p><b>Non-participating Providers:</b> All visits require prior authorization.</p> | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0674T | LAPS INSJ NEW/RPLCMT PERM ISDSS AGMNTJ CAR FUNCJ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0675T | LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS 1ST LEAD    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0676T | LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS EA ADL LEAD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0677T | APS REPOS LEAD PERM ISDSS 1ST REPOSITIONED LEAD  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0678T | LAPS REPOS LEAD PERM ISDSS EA ADDL REPOS LEAD    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0679T | LAPAROSCOPIC REMOVAL LEAD<br>PERM ISDSS          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0680T | INSI/RPLCMT PULSE GENERATOR<br>ONLY ISDSS        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0681T | RELOCATION PULSE GENERATOR<br>ONLY ISDSS         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0682T | REMOVAL PULSE GENERATOR ONLY<br>ISDSS            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022       | 0683T | PROGRAMMING DEVICE<br>EVALUATION IN PERSON ISDSS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 0684T | PERIPROCEDURAL DEVICE<br>EVALUATION IN PERSON ISDSS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 0685T | INTERROGATION DEVICE<br>EVALUATION IN PERSON ISDSS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 0707T | NJX BONE SUB MATRL INTO<br>SUBCHONDRAL BONE DEFECT  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 15786 | ABRASION 1 LESION                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 15830 | EXCISION SKIN ABD INFRAUMBILICAL<br>PANNICULECTOMY  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 17360 | CHEMICAL EXFOLIATION ACNE                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 19303 | MASTECTOMY SIMPLE COMPLETE                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2020          | 20560 | NEEDLE INSERTION W/O INJECTION 1 OR 2 MUSCLES    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2020          | 20561 | NEEDLE INSERTION W/O INJECTION 3 OR MORE MUSCLES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21073 | MANIPULATION TMJ THERAPEUTIC REQUIRE ANESTHESIA  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                             | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21120 | GENIOPLASTY AUGMENTATION                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21121 | GENIOPLASTY SLIDING OSTEOTOMY<br>SINGLE PIECE     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21122 | GENIOPLASTY 2 OR GRT SLIDING<br>OSTEOTOMIES       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21123 | GENIOP SLIDING AGMNTJ W<br>INTERPOSAL BONE GRAFTS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21125 | AGMNTJ MNDBLR BODY ANGLE<br>PROSTHETIC MATERIAL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21127 | AGMNTJ MNDBLR BDY ANGL W GRF<br>ONLAY INTERPOSAL      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21137 | REDUCTION FOREHEAD<br>CONTOURING ONLY                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21138 | RDCTJ FHD CNTRG AND<br>PROSTHETIC MATRL BONE GRAFT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21139 | RDCTJ FHD CNTRG AND SETBACK<br>ANT FRONTAL SINUS WALL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21141 | RCNSTJ MIDFACE LEFORT I 1 PIECE W<br>O BONE GRAFT     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21142 | RCNSTJ MIDFACE LEFORT I 2 PIECES<br>W O BONE GRAFT       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21143 | RCNSTJ MIDFACE LEFORT I 3 OR GRT<br>PIECE W O BONE GRAFT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21145 | RCNSTJ MIDFACE LEFORT I 1 PIECE W<br>BONE GRAFTS         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21146 | RCNSTJ MIDFACE LEFORT I 2 PIECES<br>W BONE GRAFTS        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21147 | RCNSTJ MIDFACE LEFORT I 3 OR GRT<br>PIECE W BONE GRAFTS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21150 | RCNSTJ MIDFACE LEFORT II ANTERIOR INTRUSION  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21151 | RCNSTJ MIDFACE LEFORT II W BONE GRAFTS       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21154 | RCNSTJ MIDFACE LEFORT III W O LEFORT I       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21155 | RCNSTJ MIDFACE LEFORT III W LEFORT I         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21159 | RCNSTJ MIDFACE LEFORT III W FHD W O LEFORT I | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21160 | RCNSTJ MIDFACE LEFORT III W FHD<br>W LEFORT I         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21172 | RCNSTJ SUPERIOR-LATERAL ORBITAL<br>RIM AND LOWER FHD  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21175 | RCNSTJ BIFRONTAL SUPERIOR-LAT<br>ORB RIMS AND LWR FHD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21240 | ARTHRP TEMPOROMANDIBULAR<br>JOINT W WO AUTOGRAFT      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21242 | ARTHROPLASTY<br>TEMPOROMANDIBULAR JT W<br>ALLOGRAFT   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21243 | ARTHRP TMPRMAND JOINT W<br>PROSTHETIC REPLACEMENT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21270 | MALAR AUGMENTATION<br>PROSTHETIC MATERIAL         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21280 | MEDIAL CANTHOPEXY SEPARATE<br>PROCEDURE           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21282 | LATERAL CANTHOPEXY                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21295 | REDUCTION MASSETER MUSCLE<br>AND BONE EXTRAORAL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 21296 | REDUCTION MASSETER MUSCLE<br>AND BONE INTRAORAL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22100 | PRTL EXC PST VRT INTRNSC B1Y LES 1<br>VRT SGM CRV  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22101 | PRTL EXC PST VRT INTRNSC B1Y LES 1<br>VRT SGM THRC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22102 | PRTL EXC PST VRT INTRNSC B1Y LES 1<br>VRT SGM LMBR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22110 | PRTL EXC VRT BDY B1Y LES W O SPI<br>CORD 1 SGM CRV | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22112 | PRTL EXC VRT BDY B1Y LES W O SPI<br>CORD 1 SGM THRC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22114 | PRTL EXC VRT BDY B1Y LES W O SPI<br>CORD 1 SGM LMBR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22206 | OSTEOTOMY SPINE POSTERIOR 3<br>COLUMN THORACIC      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22207 | OSTEOTOMY SPINE POSTERIOR 3<br>COLUMN LUMBAR        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22210 | OSTEOTOMY SPINE PST PSTLAT APPR<br>1 VRT SGM CRV    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22212 | OSTEOTOMY SPINE PST PSTLAT APPR<br>1 VRT SGM THRC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22214 | OSTEOTOMY SPINE PST PSTLAT APPR<br>1 VRT SGM LMBR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22220 | OSTEOTOMY SPINE W DSKC ANT<br>APPR 1 VRT SGM CRV  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22222 | OSTEOTOMY SPINE W DSKC ANT<br>APPR 1 VRT SGM THRC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22224 | OSTEOTOMY SPINE W DSKC ANT<br>APPR 1 VRT SGM LMBR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22526 | PERQ.INTRDSCL ELECTROTHRM<br>ANNULOPLASTY 1 LEVEL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22527 | PERQ.INTRDSCL ELECTROTHRM<br>ANNULOPLASTY ADDL LVL  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22532 | ARTHRODESIS LATERAL<br>EXTRACAVITARY THORACIC       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22533 | ARTHRODESIS LATERAL<br>EXTRACAVITARY LUMBAR         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22548 | ARTHRD ANT TRANSORL XTRORAL C1<br>C2 W WO EXC ODNTD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22551 | ARTHRD ANT INTERBODY<br>DECOMPRESS CERVICAL BELW C2 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 22552 | ARTHRD ANT INTERDY CERVCL BELW<br>C2 EA ADDL NTRSPC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22554 | ARTHRD ANT MIN DISCECT<br>INTERBODY CERV BELOW C2   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22556 | ARTHRD ANT MIN DISCECTOMY<br>INTERBODY THORACIC     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22558 | ARTHRODESIS ANTERIOR INTERBODY<br>LUMBAR            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22586 | ARTHRODESIS PRESACRAL INTRBDY W INSTRUMENT LS-S1 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22590 | ARTHRODESIS POSTERIOR CRANIOCERVICAL             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22595 | ARTHRODESIS POSTERIOR ATLAS-AXIS C1-C2           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22600 | ARTHRODESIS PST PSTLAT CERVICAL BELW C2 SGM      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22610 | ARTHRODESIS POSTERIOR POSTEROLATERAL THORACIC    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22612 | ARTHRODESIS POSTERIOR<br>POSTEROLATERAL LUMBAR     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22630 | ARTHRODESIS POSTERIOR<br>INTERBODY LUMBAR          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22633 | ARTHDSIS POST POSTEROLATRL<br>POSTINTERBODY LUMBAR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22800 | ARTHRODESIS POSTERIOR SPINAL<br>DFRM UP 6 VRT SEG  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22802 | ARTHRODESIS POSTERIOR SPINAL<br>DFRM 7-12 VRT SEG  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22804 | ARTHRODESIS POSTERIOR SPINAL<br>DFRM 13 OR GRT VRT SEG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22808 | ARTHRODESIS ANTERIOR SPINAL<br>DFRM 2-3 VRT SEG        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22810 | ARTHRODESIS ANTERIOR SPINAL<br>DFRM 4-7 VRT SEG        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22812 | ARTHRODESIS ANTERIOR SPINAL<br>DFRM 8 OR GRT VRT SEG   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22818 | KYPHECTOMY SINGLE OR TWO<br>SEGMENTS                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22819 | KYPHECTOMY 3 OR MORE SEGMENTS                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22849 | REINSERTION SPINAL FIXATION DEVICE             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22850 | REMOVAL POSTERIOR NONSEGMENTAL INSTRUMENTATION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22852 | REMOVAL POSTERIOR SEGMENTAL INSTRUMENTATION    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22855 | REMOVAL ANTERIOR INSTRUMENTATION               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22856 | TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC CRV  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22857 | TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC LMBR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 22860 | TOTAL DISC ARTHRP ANT SECOND INTERSPACE LUMBAR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22861 | REVJ RPLCMT DISC ARTHROPLASTY ANT 1 NTRSPC CRV   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22862 | REVJ RPLCMT DISC ARTHROPLASTY ANT 1 NTRSPC LMBR  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22864 | RMVL DISC ARTHROPLASTY ANT 1<br>INTERSPACE CERVICAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22865 | RMVL DISC ARTHROPLASTY ANT 1<br>INTERSPACE LUMBAR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22867 | INSJ STABLJ DEV W DCMPRN<br>LUMBAR SINGLE LEVEL     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22868 | INSJ STABLJ DEV W DCMPRN<br>LUMBAR SECOND LEVEL     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22869 | INSJ STABLJ DEV W O DCMPRN<br>LUMBAR SINGLE LEVEL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 22870 | INSJ STABLI DEV W O DCMPRN<br>LUMBAR SECOND LEVEL       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 23470 | ARTHROPLASTY GLENOHUMRL JT<br>HEMIARTHROPLASTY          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 23472 | ARTHROPLASTY GLENOHUMERAL<br>JOINT TOTAL SHOULDER       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 23473 | REVIS SHOULDER ARTHRPLSTY<br>HUMERAL/GLENOID COMPNT     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 23474 | REVIS SHOULDER ARTHRPLSTY<br>HUMERAL AND GLENOID COMPNT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27125 | HEMIARTHROPLASTY HIP PARTIAL                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27130 | ARTHRP ACETBLR PROX FEM PROSTC<br>AGRFT ALGRFT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27132 | CONV PREV HIP TOT HIP ARTHRP W<br>WO AGRFT ALGRFT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27134 | REVJ TOT HIP ARTHRP BTH W WO<br>AGRFT ALGRFT      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27137 | REVJ TOT HIP ARTHRP ACTBLR W WO<br>AGRFT ALGRFT   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27138 | REVJ TOT HIP ARTHRP FEM ONLY W<br>WO ALGRFT         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2024          | 27278 | ARTHRD SI JT PRQ W/PLMT IARTIC<br>IMPLT WO TFXJ DEV | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 27412 | AUTOLOGOUS CHONDROCYTE<br>IMPLANTATION KNEE         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 27415 | OSTEOCHONDRAL ALLOGRAFT KNEE<br>OPEN                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27438 | ARTHROPLASTY PATELLA W<br>PROSTHESIS                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27440 | ARTHROPLASTY KNEE TIBIAL PLATEAU                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27441 | ARTHRP KNEE TIBIAL PLATEAU DBRDMT AND PRTL SYNVCT  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27442 | ARTHROPLASTY FEM CONDYLES TIBIAL PLATEAU KNEE      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27443 | ARTHRP FEM CONDYLES TIBL PLATU KNE DBRDMT AND PRTL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27446 | ARTHRP KNEE CONDYLE AND PLATEAU MEDIAL LAT CMPRT   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27447 | ARTHRP KNE CONDYLE AND PLATU<br>MEDIAL AND LAT COMPARTMENTS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27486 | REVJ TOTAL KNEE ARTHRP W WO<br>ALGRFT 1 COMPONENT           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 27487 | REVJ TOT KNEE ARTHRP FEM AND<br>ENTIRE TIBIAL COMPONE       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28035 | RELEASE TARSAL TUNNEL                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28060 | FASCIECTOMY PLANTAR FASCIA<br>PARTIAL SPX                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28062 | FASCIOTOMY PLANTAR FASCIA<br>RADICAL SPX            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28080 | EXCISION INTERDIGITAL MORTON<br>NEUROMA SINGLE EACH | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28090 | EXC LESION TENDON SHEATH<br>CAPSULE W SYNCT FOOT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28092 | EXC LESION TENDON SHEATH<br>CAPSULE W SYNCT TOE EA  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28104 | EXC CURTG BONE CYST B9<br>TUMORTARSAL METATARSAL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28108 | EXC CURTG CST B9 TUM PHALANGES FOOT            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28110 | OSTECTOMY PRTL 5TH METAR HEAD SPX              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28111 | OSTECTOMY COMPLETE 1ST METATARSAL HEAD         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28112 | OSTECTOMY COMPLETE OTHER METATARSAL HEAD 2 3 4 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28113 | OSTECTOMY COMPLETE 5TH METATARSAL HEAD         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28118 | OSTECTOMY CALCANEUS                                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28119 | OSTECTOMY CALCANEUS SPUR W<br>WO PLNTAR FASCIAL RLS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28120 | PARTIAL EXCISION BONE TALUS<br>CALCANEUS            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28122 | PRTL EXC B1 TARSAL METAR B1 XCP<br>TALUS CALCANEUS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28124 | PARTICAL EXCISION BONE PHALANX<br>TOE               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28200 | RPR TDN FLXR FOOT 1 2 W O FREE GRAFG EACH TENDON | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28202 | RPR TENDON FLXR FOOT SEC W FREE GRAFT EA TENDON  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28208 | REPAIR TENDON EXTENSOR FOOT 1 2 EACH TENDON      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28210 | RPR TENDON XTNSR FOOT SEC W FREE GRAFT EA TENDON | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28270 | CAPSUL MTTARPHLNGL JT W WO TENORRHAPHY EA JT SPX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28285 | CORRECTION HAMMERTOES                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28286 | CORRECTION COCK-UP 5TH TOE W PLASTIC CLOSURE         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28288 | OSTEOARTHRITIS OF THE CONDYLE OF THE MANDIBULAR HEAD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28289 | HALLUX RIGIDUS W CHEILECTOMY 1ST MP JT W O IMPLT     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28291 | HALLUX RIGIDUS W CHEILECTOMY 1ST MP JT W IMPLT       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28292 | CORRJ HALLUX VALGUS W SESMDC<br>W RESCJ PROX PHAL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28295 | CORRJ HALLUX VALGUS W SESMDC<br>W PROX METAR OSTEOT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28296 | CORRJ HALLUX VALGUS W SESMDC<br>W DIST METAR OSTEOT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28297 | CORRJ HALLUX VALGUS W SESMDC<br>W 1METAR MEDIAL CNF | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28298 | CORRJ HALLUX VALGUS W SESMDC<br>W PROX PHLNX OSTEOT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28299 | CORRJ HALLUX VALGUS W SESMDC W 2 OSTEOT        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28300 | OSTEOTOMY CALCANEUS W WO INTERNAL FIXATION     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28304 | OSTEOTOMY TARSAL BONES OTH THN CALCANEUS TALUS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28305 | OSTEOT TARSAL OTH THN CALCANEUS TALUS W AGRFT  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28306 | OSTEOT W WO LNGTH SHRT CORRJ 1ST METAR         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28307 | OSTEOT W WO LNGTH SHRT CORRJ<br>METAR XCP 1ST TOE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28308 | OSTEOT W WO LNGTH SHRT CORRJ<br>METAR XCP 1ST EA  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28309 | OSTEOT W WO LNGTH SHRT<br>ANGULAR CORRJ METAR MLT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28310 | OSTEOT SHRT CORRJ PROX PHALANX<br>1ST TOE         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28312 | OSTEOT SHRT CORRJ OTH<br>PHALANGES ANY TOE        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28313 | RCNSTJ ANGULAR DFRM TOE SOFT<br>TISS PX ONLY     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28315 | SESAMOIDECTOMY FIRST TOE SPX                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28320 | REPAIR NONUNION MALUNION<br>TARSAL BONES         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28322 | RPR NON MALUNION METARSAL W<br>WO BONE GRAFT     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28345 | RCNSTJ TOE SYNDACTLY W WO<br>SKIN GRAFT EACH WEB | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28705 | ARTHRODESIS PANTALAR                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28715 | ARTHRODESIS TRIPLE                                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28725 | ARTHRODESIS SUBTALAR                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28730 | ARTHRD MIDTARSL<br>TARSOMETATARSAL MULT<br>TRANSVRS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28735 | ARTHRD MIDTARSL TARS MLT<br>TRANSVRS W OSTEO        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28737 | ARTHRD W TDN LNGTH AND<br>ADVMNT TARSL NVCLR-CUNEIFOR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28740 | ARTHRODESIS<br>MIDTARSOMETATARSAL SINGLE<br>JOINT     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28750 | ARTHRODESIS GREAT TOE<br>METATARSOPHALANGEAL JOINT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28755 | ARTHRODESIS GREAT TOE<br>INTERPHALANGEAL JOINT        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28760 | ARTHRD W XTNSR HALLUCIS LONGUS<br>TR 1ST METAR NCK    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 28890 | ESWT HI NRG PHYS QHP W US GDN<br>INVG PLNTAR FASCIA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 29805 | ARTHROSCOPY SHOULDER DX W/WO<br>SYNOVIAL BIOPSY SPX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29806 | ARTHROSCOPY SHOULDER SURGICAL<br>CAPSULORRHAPHY     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29807 | ARTHROSCOPY SHOULDER SURGICAL<br>REPAIR SLAP LESION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29819 | ARTHROSCOPY SHOULDER SURGICAL<br>REMOVAL LOOSE FB   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29820 | ARTHROSCOPY SHOULDER SURG<br>SYNOVECTOMY PARTIAL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29821 | ARTHROSCOPY SHOULDER SURG<br>SYNOVECTOMY COMPLETE  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29822 | ARTHROSCOPY SHOULDER SURG<br>DEBRIDEMENT LIMITED   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29823 | ARTHROSCOPY SHOULDER SURG<br>DEBRIDEMENT EXTENSIVE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29824 | ARTHROSCOPY SHOULDER DISTAL<br>CLAVICULECTOMY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29825 | ARTHROSCOPY SHOULDER<br>AHESIOLYSIS W WO MANIPJ     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29827 | ARTHROSCOPY SHOULDER ROTATOR<br>CUFF REPAIR         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29828 | ARTHROSCOPY SHOULDER BICEPS<br>TENODESIS            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 29860 | ARTHROSCOPY HIP DIAGNOSTIC<br>W/WO SYNOVIAL BYP SPX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 29862 | ARTHRHS HIP DEBRIDEMENT/SHAVING<br>ARTICULAR CRTLG  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021       | 29863 | ARTHROSCOPY HIP SURGICAL<br>W/SYNOVECTOMY              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021       | 29866 | ARTHROSCOPY KNEE<br>OSTEOCHONDRAL AGRFT<br>MOSAICPLAST | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021       | 29867 | ARTHROSCOPY KNEE<br>OSTEOCHONDRAL ALLOGRAFT            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021       | 29868 | ARTHROSCOPY KNEE MENISCAL<br>TRNSPLJ MED/LAT           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021       | 29870 | ARTHROSCOPY KNEE DIAGNOSTIC<br>W/WO SYNOVIAL BX SPX    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29873 | ARTHROSCOPY KNEE LATERAL RELEASE                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29874 | ARTHROSCOPY KNEE REMOVAL LOOSE FOREIGN BODY        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29875 | ARTHROSCOPY KNEE SYNOVECTOMY LIMITED SPX           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29876 | ARTHROSCOPY KNEE SYNOVECTOMY 2 OR GRT COMPARTMENTS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29877 | ARTHRS KNEE DEBRIDEMENT SHAVING ARTCLR CRTLG       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29879 | ARTHRS KNEE ABRASION ARTHRP<br>MLT DRLG MICROFX       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29880 | ARTHRS KNEE W MENISCECTOMY<br>MED AND LAT W SHAVING   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29881 | ARTHRS KNE SURG W<br>MENISCECTOMY MED LAT W SHVG      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29882 | ARTHROSCOPY KNEE W MENISCUS<br>RPR MEDIAL LATERAL     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29883 | ARTHROSCOPY KNEE W MENISCUS<br>RPR MEDIAL AND LATERAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29884 | ARTHROSCOPY KNEE W LYSIS<br>ADHESIONS W WO MANJ SPX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29885 | ARTHRS KNEE DRILL<br>OSTEOCHONDritis DISSECANS GRFG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29886 | ARTHRS KNEE DRILLING<br>OSTEOCHOND DISSECANS LESION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29887 | ARTHRS KNEE DRLG OSTEOCHOND<br>DISSECANS INT FIXJ   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29888 | ARTHRS AIDED ANT CRUCIATE LIGM<br>RPR AGMNTJ RCNSTJ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29889 | ARTHRS AIDED PST CRUCIATE LIGM<br>RPR AGMNTJ RCNSTJ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29891 | ARTHRS ANKLE EXC OSTCHNDRL<br>DFCT W DRLG DFCT      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29892 | ARTHRS AID RPR LES TALAR DOME FX<br>TIBL PLAFOND FX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29893 | ENDOSCOPIC PLANTAR FASCIOTOMY                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29894 | ARTHROSCOPY ANKLE W REMOVAL<br>LOOSE FOREIGN BODY   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29895 | ARTHROSCOPY ANKLE SURGICAL<br>SYNOVECTOMY PARTIAL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29897 | ARTHROSCOPY ANKLE SURGICAL<br>DEBRIDEMENT LIMITED   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29898 | ARTHROSCOPY ANKLE SURGICAL<br>DEBRIDEMENT EXTENSIVE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29899 | ARTHROSCOPY ANKLE SURGICAL W<br>ANKLE ARTHRODESIS   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29914 | ARTHROSCOPY HIP W<br>FEMOROPLASTY                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29915 | ARTHROSCOPY HIP W<br>ACETABULOPLASTY               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 29916 | ARTHROSCOPY HIP W LABRAL<br>REPAIR                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 30465 | REPAIR NASAL VESTIBULAR STENOSIS                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 30469 | RPR NSL VLV COLLAPSE LW NRG<br>SUBQ/SBMCSL RMDLG   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31253 | NASAL SINUS NDSC TOT W FRNT SINS<br>EXPL TISS RMVL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31257 | NASAL SINUS NDSC TOTAL WITH SPHENOIDOTOMY        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31259 | NASAL SINUS NDSC TOT W SPHENDT W SPHEN TISS RMVL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31295 | NASAL SINUS NDSC SURG W DILAT MAXILLARY SINUS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31296 | NASAL SINUS NDSC SURG W DILATION FRONTAL SINUS   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31297 | NASAL SINUS NDSC SURG W DILATION SPHENOID SINUS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                              | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31298 | NASAL SINUS NDSC W FRONTAL AND SPHEN SINS DILATION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria               |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31660 | BRONCHOSCOPIC THERMOPLASTY ONE LOBE                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Bronchial Thermoplasty |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 31661 | BRONCHOSCOPIC THERMOPLASTY 2 OR GRT LOBES          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Bronchial Thermoplasty |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33206 | INS NEW RPLCMT PRM PACEMAKR W TRANSV ELTRD ATRIAL  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria               |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33207 | INS NEW RPLC PRM PACEMAKER W TRANSV ELTRD VENTR    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria               |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33208 | INS NEW RPLCMT PRM PM W<br>TRANSV ELTRD ATRIAL AND VENT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 33210 | INSI/RPLCMT TEMP TRANSVNS<br>1CHMBR ELTRD/PM CATH       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 33211 | INSI/RPLCMT TEMP TRANSVNS<br>2CHMBR PACG ELTRDS SPX     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33212 | INS PM PLS GEN W EXIST SINGLE<br>LEAD                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33213 | INS PACEMAKER PULSE GEN ONLY W<br>EXIST DUAL LEADS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33214 | UPG PACEMAKER SYS CONVERT<br>1CHMBR SYS 2CHMBR SYS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 33216 | INSJ 1 TRANSVNS ELTRD PERM<br>PACEMAKER/IMPLTBL DFB | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 33217 | INSJ 2 TRANSVNS ELTRD PERM<br>PACEMAKER/IMPLTBL DFB | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33221 | INS PACEMAKER PULSE GEN ONLY W<br>EXIST MULT LEADS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33224 | INSJ ELTRD CAR VEN SYS ATTCH PREV<br>PM DFB PLS GEN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33225 | INSJ ELTRD CAR VEN SYS TM INSJ DFB PM PLS GEN    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33230 | INSJ IMPLNTBL DEFIB PULSE GEN W EXIST DUAL LEADS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33231 | INSJ IMPLNTBL DEFIB PULSE GEN W EXIST MULTILEADS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33240 | INSJ IMPLNTBL DEFIB PULSE GEN W 1 EXISTING LD    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33249 | INSJ RPLCMT PERM DFB W TRNSVNS LDS 1 DUAL CHMBR  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                                                                                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33262 | RMVL IMPLTBL DFB PLSE GEN W<br>REPL PLSE GEN 1 LEAD                                                                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33263 | RMVL IMPLTBL DFB PLSE GEN W<br>RPLCMT PLSE GEN 2 LD                                                                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33264 | RMVL IMPLTBL DFB PLS GEN W<br>RPLCMT PLS GEN MLT LD                                                                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 33267 | Exclusion of left atrial appendage,<br>open, any method (eg, excision,<br>isolation via stapling, oversewing,<br>ligation, plication, clip) | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 33268 | EXCLUSION LAA OPEN TM<br>STRNT/THRCM ANY METHOD                                                                                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 33269 | EXCLUSION L ATR APPENDAGE<br>THORACOSCOPIC ANY METH | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33270 | INS RPLCMNT PERM SUBQ IMPLTBL<br>DFB W SUBQ ELTRD   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33274 | TCAT INSJ RPL PERM LEADLESS<br>PACEMAKER RV W IMG   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33275 | TCAT REMOVAL PERM LEADLESS<br>PACEMAKER R VENTR     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 33285 | INSERTION SUBQ CARDIAC RHYTHM<br>MONITOR W/PRGRMG   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33289 | TCAT IMPL WRLS P-ART PRS SNR L-T<br>HEMODYN MNTR      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 33370 | TRANSCATHETER PLACEMENT and<br>SBSQ REMOVAL CEPD PERQ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 33975 | INSJ VENTRIC ASSIST DEV XTRCORP<br>SINGLE VENTRICLE   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 33976 | INSJ VENTRIC ASSIST DEV XTRCORP<br>BIVENTRICULAR      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 33979 | INSJ VENTR ASSIST DEV IMPLTABLE<br>ICORP 1 VNTRC      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36465 | NIX NONCMPND SCLEROSANT SINGLE INCMPTNT VEIN    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36466 | NIX NONCMPND SCLEROSANT MULTIPLE INCMPTNT VEINS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36468 | INJECTIONS SCLEROSANT FOR SPIDER VEINS LIM TRNK | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36470 | INJECTION SCLEROSANT SINGLE INCMPTNT VEIN       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36471 | INJECTION SCLEROSANT MULTIPLE INCMPTNT VEINS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 36473 | ENDOVEN ABLTJ INCMPTNT VEIN MCHNCHEM 1ST VEIN        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36475 | ENDOVEN ABLTJ INCMPTNT VEIN XTR RF 1ST VEIN          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36476 | ENDOVEN ABLTJ INCMPTNT VEIN XTR RF 2ND PLUS VEINS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36478 | ENDOVEN ABLTJ INCMPTNT VEIN XTR LASER 1ST VEIN       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36479 | ENDOVEN ABLTJ INCMPTNT VEIN XTR LASER 2ND PLUS VEINS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                  | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36482 | ENDOVEN ABLTI THER CHEM<br>ADHESIVE 1ST VEIN          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                   |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 36483 | ENDOVEN ABLTI THER CHEM<br>ADHESIVE SBSQ VEIN         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                   |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37243 | VASCULAR EMBOLIZE OCCLUDE<br>ORGAN TUMOR INFARCT      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria for uterine or urologic procedure.<br><br>Molina Clinical Policy: Genicular Artery Embolizaiton of the Knee for Osteoarthritis for knee procedure |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37700 | LIG AND DIV LONG SAPH VEIN<br>SAPHFEM JUNCT INTERRUPT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                   |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37718 | LIGJ DIVJ AND STRIPPING SHORT<br>SAPHENOUS VEIN       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                   |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37722 | LIGJ DIVJ AND STRIP LONG SAPH<br>SAPHFEM JUNCT KNE BELW | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37735 | LIGJ AND DIVJ RADICAL STRIP LONG<br>SHORT SAPHENOUS     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37760 | LIG PRFRATR VEIN SUBFSCAL RAD<br>INCL SKN GRF 1 LEG     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37761 | LIG PRFRATR VEIN SUBFSCAL OPEN<br>INCL US GID 1 LEG     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37765 | STAB PHLEBT VARICOSE VEINS 1 XTR<br>10-20 STAB INCS     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                                                                                             | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37766 | STAB PHLEBT VARICOSE VEINS 1 XTR<br>OVER 20 INCS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                                                                                                                                              |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37780 | LIGJ AND DIV SHORT SAPH VEIN<br>SAPHENOPOP JUNCT SPX  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                                                                                                                                              |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 37785 | LIGJ DIVJ AND EXCJ VARICOSE VEIN<br>CLUSTER 1 LEG     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                                                                                                                                              |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38204 | MGMT RCP HEMATOP PROGENITOR<br>CELL DONOR AND ACQUISJ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                                                                                                                                              |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38207 | TRNSPL PREPJ HEMATOP PROGEN<br>CELLS CRYOPRSRV STOR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic<br>Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic<br>Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous<br>Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                                                                                    | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38208 | TRNSPL PREP HEMATOP PROGEN<br>THAW PREV HRV PER DNR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38209 | TRNSP PREP HMATOP PROG THAW<br>PREV HRV WSH PER DNR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38210 | TRNSPL PREPJ HEMATOP PROGEN<br>DEPLJ IN HRV T-CELL  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38211 | TRNSPL PREPJ HEMATOP PROGEN<br>TUM CELL DEPLJ       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38212 | TRNSPL PREPJ HEMATOP PROGEN<br>RED BLD CELL RMVL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                                                                                    | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38213 | TRNSPL PREPJ HEMATOP PROGEN<br>PLTLT DEPLJ                                                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38214 | TRNSPL PREPJ HEMATOP PROGEN<br>PLSM VOL DEPLJ                                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38215 | TRNSPL PREPJ HEMATOP PROGEN<br>CONCENTRATION PLSM                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 38232 | BONE MARROW HARVEST<br>TRANSPLANTATION AUTOLOGOUS                                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                            |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 43291 | ESPHGGSTRDUDNSCPY, FLXIBLE,<br>TRNSORAL; WITH RMVL OF<br>INTRAGASTRIC BARIATRIC BALLON(S) | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                                                                                                                                     |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43644 | LAPS GSTR RSTCV PX W BYP ROUX-EN-Y LIMB UNDER 150 CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43645 | LAPS GSTR RSTCV PX W BYP AND SM INT RCNSTJ           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43647 | LAPS IMPLTJ RPLCMT GASTRIC NSTIM ELTRD ANTRUM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43648 | LAPS REVISION RMVL GASTRIC NSTIM ELTRD ANTRUM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43770 | LAPS GASTRIC RESTRICTIVE PROCEDURE PLACE DEVICE      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43771 | LAPS GASTRIC RESTRICTIVE PX<br>REVISION DEVICE          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43772 | LAPS GASTRIC RESTRICTIVE PX<br>REMOVE DEVICE            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43773 | LAPS GASTRIC RESTRICTIVE PX<br>REMOVE AND RPLCMT DEVICE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43774 | LAPS GASTRIC RESTRICTIVE PX<br>REMOVE DEVICE AND PORT   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43775 | LAPS GSTRC RSTRCTIV PX<br>LONGITUDINAL GASTRECTOMY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43842 | GASTRIC RSTCV W O BYP VERTICAL-BANDED GASTROPLY  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43843 | GSTR RSTCV W O BYP OTH THN VER-BANDED GSTP       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43845 | GASTRIC RSTCV W PRTL GASTRECTOMY 50-100 CM       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43846 | GASTRIC RSTCV W BYP W SHORT LIMB 150 CM OR LESS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43847 | GASTRIC RSTCV W BYP W SM INT RCNSTJ LIMIT ABSRPJ | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43848 | REVISION OPEN GASTRIC<br>RESTRICTIVE PX NOT DEVICE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43881 | IMPLTJ RPLCMT GASTRIC NSTIM<br>ELTRDE ANTRUM OPEN  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43882 | REVISION RMVL GASTRIC NSTIM<br>ELTRDE ANTRUM OPEN  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43886 | GSTR RSTCV PX OPN REVJ SUBQ<br>PORT COMPONENT ONLY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 43888 | GSTR RSTCV OPN RMVL AND<br>RPLCMT SUBQ PORT        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 50590 | LITHOTRIPSY XTRCORP SHOCK WAVE                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 52441 | CYSTO INSERTION TRANSPROSTATIC IMPLANT SINGLE    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 52649 | LASER ENUCLEATION PROSTATE W MORCELLATION        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 53410 | URETHROPLASTY 1 STG RECNST MALE ANTERIOR URETHRA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 53420 | URTP 2-STG RCNSTJ/RPR PROSTAT/URETHRA 1ST STAGE  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 53425 | URTP 2-STG RCNSTJ/RPR<br>PROSTAT/URETHRA 2ND STAGE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 53430 | URETHROPLASTY RCNSTJ FEMALE<br>URETHRA             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 53850 | TRURL DSTRJ PRSTATE TISS<br>MICROWAVE THERMOTH     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 53852 | TRURL DSTRJ PRSTATE TISS RF<br>THERMOTH            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 53854 | TRURL DSTRJ PRST8 TISS RF WV<br>THERMOTHERAPY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2025          | 53865 | CYSTOURETHROSCOPY INS TEMP<br>PROS IMPL/STENT         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 54125 | AMPUTATION PENIS COMPLETE                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 54401 | INSJ PENILE PROSTHESOS<br>INFLATABLE SELF-CONTAINED   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 54405 | INSJ MULTI-COMPONENT<br>INFLATABLE PENILE PROSTH      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 54410 | RMVL AND RPLCMT INFLATABLE<br>PENILE PROSTH SAME SESS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 54411 | RMVL AND RPLCMT NFLTBL PENILE PROSTH INFECTED FIEL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 54416 | RMVL AND RPLCMT NON-NFLTBL/NFLTBL PENILE PROSTHESI | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 54417 | RMVL AND RPLCMT PENILE PROSTHESIS INFECTED FIELD   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 54520 | ORCHIECTOMY SIMPLE SCROTAL/INGUINAL APPROACH       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 54690 | LAPAROSCOPY SURGICAL ORCHIECTOMY                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                    | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 55866 | LAPS PROSTECT RETROPUBIC RAD W/NRV SPARING ROBOT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 55867 | LAPS SURG PRST8ECT SMPL STOT ROBOTIC ASSISTANCE  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 55874 | TRANSPERINEAL PLMT BIODEGRADABLE MATRL 1 MLT NJX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Hydrogel Spacer for Prostate |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 55880 | TRANSRECTAL ABLTJ MAL PRST8 TISSUE HIFU W/US     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 55970 | NTERSEX SURG MALE FEMALE                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                     | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date | Code  | Definition                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                  | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 55980 | INTERSEX SURG FEMALE MALE                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 56625 | VULVECTOMY SIMPLE COMPLETE               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 56800 | PLASTIC REPAIR INTROITUS                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 56805 | CLITOROPLASTY INTERSEX STATE             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual and/ or Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 57106 | VAGINECTOMY PARTIAL REMOVAL VAGINAL WALL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                  | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 57110 | VAGINECTOMY COMPLETE REMOVAL VAGINAL WALL       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 57291 | CONSTRUCTION ARTIFICIAL VAGINA W/O GRAFT        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 57292 | CONSTRUCTION ARTIFICIAL VAGINA W/GRAFT          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 57296 | REVJ W/RMVL PROSTHETIC VAGINAL GRAFT ABDML APPR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                   | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023       | 57335 | VAGINOPLASTY INTERSEX STATE                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual and/ or Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                                                                       | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 57426 | REVISION PROSTHETIC VAGINAL GRAFT LAPAROSCOPIC     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | No prior auth required for service when associated with a cancer diagnosis. | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58150 | TOTAL ABDOMINAL HYSTERECT W WO RMVL TUBE OVARY     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58152 | TOT ABD HYST W WO RMVL TUBE OVARY W COLPURETHRX    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58180 | SUPRACERVICAL ABDL HYSTER W WO RMVL TUBE OVARY     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58200 | TOT ABD HYST W PARAORTIC AND PELVIC LYMPH NODE SAM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                                                                             | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58210 | RAD ABDL HYSTERECTOMY W BI<br>PELVIC LMPHADENECTOMY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58260 | VAGINAL HYSTERECTOMY UTERUS<br>250 GM OR LESS            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58262 | VAG HYST 250 GM OR LESS W RMVL<br>TUBE AND OVARY         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58263 | VAG HYST 250 GM OR LESS W RMVL<br>TUBE OVARY W RPR NTRCL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58267 | VAG HYST 250 GM OR LESS W<br>COLPO-URTCSTOPEXY           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58270 | VAGINAL HYSTERECTOMY 250 GM OR LESS W RPR ENTEROCELE   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58285 | VAGINAL HYSTERECTOMY RADICAL SCHAUTA OPERATION         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58290 | VAGINAL HYSTERECTOMY UTERUS OVER 250 GM                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58291 | VAG HYST OVER 250 GM RMVL TUBE AND OVARY               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58292 | VAG HYST OVER 250 GM RMVL TUBE AND OVARY W RPR ENTRCLE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58294 | VAGINAL HYSTERECTOMY OVER 250 GM RPR ENTEROCELE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58321 | ARTIFICIAL INSEMINATION INTRA-CERVICAL          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58322 | ARTIFICIAL INSEMINATION INTRA-UTERINE           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58323 | SPERM WASHING ARTIFICIAL INSEMINATION           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58345 | TRANSCERV FALLOPIAN TUBE CATH W WO HYSTOSALPING | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58350 | CHROMOTUBATION OVIDUCT W MATERIALS                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58356 | ENDOMETRIAL CRYOABLATION W US AND ENDOMETRIAL CR      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58540 | HYSTEROPLASTY RPR UTERINE ANOMALY                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58541 | LAPAROSCOPY SUPRACERVICAL HYSTERECTOMY 250 GM OR LESS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58542 | LAPS SUPRACRV HYSTERECT 250 GM OR LESS RMVL TUBE OVAR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58543 | LAPS SUPRACERVICAL<br>HYSTERECTOMY OVER 250           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58544 | LAPS SUPRACRV HYSTEREC OVER<br>250 G RMVL TUBE OVARY  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58545 | LAPS MYOMECTOMY EXC 1-4<br>MYOMAS 250 GM OR LESS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58546 | LAPS MYOMECTOMY EXC 5 OR GRT<br>MYOMAS OVER 250 GRAMS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58550 | LAPS VAGINAL HYSTERECTOMY<br>UTERUS 250 GM OR LESS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58552 | LAPS W VAG HYSTERECT 250 GM AND RMVL TUBE AND OVARIES  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58553 | LAPS W VAGINAL HYSTERECTOMY OVER 250 GRAMS             | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58554 | LAPS VAGINAL HYSTERECT OVER 250 GM RMVL TUBE AND OVAR  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58570 | LAPAROSCOPY W TOTAL HYSTERECTOMY UTERUS 250 GM OR LESS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58571 | LAPS TOTAL HYSTERECT 250 GM OR LESS W RMVL TUBE OVARY  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58572 | LAPAROSCOPY TOTAL<br>HYSTERECTOMY UTERUS OVER 250<br>GM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58573 | LAPAROSCOPY TOT HYSTERECTOMY<br>OVER 250 G W TUBE OVAR  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58660 | LAPAROSCOPY W LYSIS OF<br>ADHESIONS                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58662 | LAPS FULG EXC OVARY VISCERA<br>PERITONEAL SURFACE       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58672 | LAPAROSCOPY FIMBRIOPLASTY                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58673 | LAPAROSCOPY SALPINGOSTOMY                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58720 | SALPINGO-OOPHORECTOMY COMPL<br>PRTL UNI BI SPX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58740 | LYSIS OF ADHESIONS SALPINX OVARY               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58750 | TUBOTUBAL ANASTATOMOSIS                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58752 | TUBOUTERINE IMPLANTATION                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58760 | FIMBRIOPLASTY                                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58770 | SALPINGOSTOMY                                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58940 | OOPHORECTOMY PARTIAL TOTAL<br>UNI BI             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58970 | FOLLICLE PUNCTURE OOCYTE<br>RETRIEVAL ANY METHOD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58974 | EMBRYO TRANSFER INTRAUTERINE                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 58976 | GAMETE ZYGOTE EMBRYO<br>FALLOPIAN TRANSFER ANY METH    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 61863 | STRCTC IMPLTJ NSTIM ELTRD W O<br>RECORD 1ST ARRAY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 61867 | STRCTC IMPLTJ NSTIM ELTRD W<br>RECORD 1ST ARRAY        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 61885 | INSJ RPLCMT CRANIAL NEUROSTIM<br>PULSE GENERATOR       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 61886 | INSJ RPLCMT CRANIAL NEUROSTIM<br>GENER 2 OR GRT ELTRDS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                                                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 62324 | NJX DX THER SBST INTRLMNR CRV THRC W O IMG GDN                                                                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 62325 | NJX DX THER SBST INTRLMNR CRV THRC W IMG GDN                                                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 62326 | NJX DX THER SBST INTRLMNR LMBR SAC W O IMG GDN                                                                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 62327 | NJX DX THER SBST INTRLMNR LMBR SAC W IMG GDN                                                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2026          | 62330 | Bilateral percutaneous lumbar decompression with partial removal of the ligamentum flavum at one lumbar interspace | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 11/19/2025            |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes                 | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2026          | 62331 | Each additional interspace treatment in the same session as 62330 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria | Add-on code to 62330. | 11/19/2025            |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 62380 | NDSC DCMPRN SPINAL CORD 1 W LAMOT NTRSPC LUMBAR                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63001 | LAM W O FACETEC FORAMOT DSKC 1 2 VRT SEG CRV                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63003 | LAMINECTOMY W O FFD 1 2 VERT SEG THORACIC                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63005 | LAMINECTOMY W O FFD 1 2 VERT SEG LUMBAR                           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |                       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63011 | LAMINECTOMY W O FFD 1 2 VERT SEG SACRAL      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63012 | LAMINECTOMY W RMVL ABNORMAL FACETS LUMBAR    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63015 | LAMINECTOMY W O FFD OVER 2 VERT SEG CERVICAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63016 | LAMINECTOMY W O FFD OVER 2 VERT SEG THORACIC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63017 | LAMINECTOMY W O FFD OVER 2 VERT SEG LUMBAR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63020 | LAMNOTMY INCL W DCMPRSN NRV<br>ROOT 1 INTRSPC CERV      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63030 | LAMNOTMY INCL W DCMPRSN NRV<br>ROOT 1 INTRSPC LUMBR     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63040 | LAMOT PRTL FFD EXC DISC REEXPL 1<br>NTRSPC CERVICAL     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63042 | LAMOT PRTL FFD EXC DISC REEXPL 1<br>NTRSPC LUMBAR       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63045 | LAM FACETECTOMY AND<br>FORAMOTOMY 1 SEGMENT<br>CERVICAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63046 | LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT THORACIC    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63047 | LAM FACETECTOMY AND FORAMOTOMY 1 SEGMENT LUMBAR      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 63048 | LAM FACETECTOMY and FORAMTOMY 1 SGM EA CRV THRC/LMBR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63050 | LAMOP CERVICAL W DCMPRN SPI CORD 2 OR GRT VERT SEG   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63051 | LAMOPLASTY CERVICAL DCMPRN CORD 2 OR GRT SEG RCNSTJ  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 63052 | LAM FACETEC/FORAMOT DRG<br>ARTHRD LUMBAR 1 VRT SGM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 63053 | LAM FACETEC/FORAMOT DRG<br>ARTHRD LMBR EA ADDL SGM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63055 | TRANSPEDICULAR DCMPRN SPINAL<br>CORD 1 SEG THORACIC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63056 | TRANSPEDICULAR DCMPRN SPINAL<br>CORD 1 SEG LUMBAR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 63057 | TRANSPEDICULAR DCMPRN 1 SEG EA<br>THORACIC/LUMBAR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63064 | COSTOVERTEBRAL DCMPRN SPINAL CORD THORACIC 1 SEG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63075 | DISCECTOMY ANT DCMPRN CORD CERVICAL 1 NTRSPC     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 63076 | DISCECTOMY ANT DCMPRN CORD CERVICAL EA NTRSPC    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63077 | DISCECTOMY ANT DCMPRN CORD THORACIC 1 NTRSPC     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63081 | VERTEBRAL CORPECTOMY ANT DCMPRN CERVICAL 1 SEG   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63087 | VCRPEC THORACOLMBR DCMPRN<br>LWR THRC LMBR 1 SEG    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 63090 | VCRPEC TRANSPRTL RPR DCMPRN<br>THRC LMBR SAC 1 SEG  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021          | 63300 | VCRPEC LES 1 SGM XDRL CERVICAL                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021          | 63304 | VERTEBRAL CORPECTOMY EXC LES 1<br>SEG IDRL CERVICAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021          | 63308 | VERTEBRAL CORPECTOMY EXC INDRL<br>LES EACH SEG      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 64553 | PRQ IMPLTJ NEUROSTIMULATOR<br>ELTRD CRANIAL NERVE       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 64568 | INC IMPLTJ CRNL NRV NSTIM ELTRDS<br>AND PULSE GENER     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 64569 | REVISION REPLMT<br>NEUROSTIMULATOR ELTRD CRANIAL<br>NRV | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 64570 | REMOVAL CRNL NRV NSTIM ELTRDS<br>AND PULSE GENERATO     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 64582 | OPEN IMPLTJ HPGLSL NRV NSTIM RA<br>PG and RESPIR SENSOR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                               | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 64590 | INSERTION RPLCMT PERIPHERAL GASTRIC NPGR                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 64628 | THERMAL DSTRJ INTRAOSSEOUS BASOVERTEBRAL NERVE 1ST 2 LMBR/SAC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Radiofrequency Nerve Ablation for Neck and Back Pain |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 64912 | NERVE REPAIR W NERVE ALLOGRAFT FIRST STRAND                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 65771 | RADIAL KERATOTOMY                                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 67900 | REPAIR BROW PTOSIS                                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 67901 | RPR BLEPHAROPTOSIS FRONTALIS MUSC SUTR OTH MATRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 67902 | RPR BLEPHAROPT FRONTALIS MUSC AUTOL FASCAL SLING | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 67903 | RPR BLEPHAROPTOSIS LEVATOR RESCJ ADVMNT INTERNAL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 67909 | REDUCTION OVERCORRECTION PTOSIS                  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 67950 | CANTHOPLASTY                                     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 69714 | IMPLTJ OSSEOINTEGRATED<br>TEMPORAL BONE W MASTOID             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2022          | 69716 | IMPL OI IMPLT SKULL MAG TC<br>ATTACHMENT ESP LT 100           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 69729 | IMPL OI IMPLT SKULL MAG TC<br>ATTACHMENT ESP GT or equal to 1 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2023          | 69730 | RPLCMT OI IMPLT SKULL MAG TC<br>ATTACHMENT ESP GT or equal to | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 69930 | COCHLEAR DEVICE IMPLANTATION W<br>WO MASTOIDECTOMY            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes                              | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021          | 93025 | MICROVOLT T-WAVE ASSESS<br>VENTRICULAR ARRHYTHMIAS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria                                               |                                    | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2023          | 93228 | XTRNL MOBILE CV TELEMETRY W/I<br>and REPORT 30 DAYS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Mobile Cardiac Outpatient Telemetry:<br>Policy No. 428 | Allowed 1 unit per rolling 30 days | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 93229 | XTRNL MOBILE CV TELEMETRY W<br>TECHNICAL SUPPORT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Mobile Cardiac Outpatient Telemetry:<br>Policy No. 428 | Allowed 1 unit per rolling 30 days | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96567 | PDT DSTR PRMLG LES SKN ILLUM<br>ACTIVJ PER DAY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                               |                                    | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96573 | PDT DSTR PRMLG LES SKN ILLUM<br>ACTIVJ BY PHYS QHP  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                               |                                    | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96574 | DEBRIDEMENT PRMLG<br>HYPERKERATOTIC LES W PDT       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96900 | ACTINOTHERAPY ULTRAVIOLET<br>LIGHT                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96910 | PHOTOCHEMOTX TAR AND UVB<br>PETROLATUM UVB          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96912 | PHOTOCHEMOTX PSORALENS AND<br>ULTRAVIOLET PUVA      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96913 | PHOTOCHEMOTHERAPY<br>DERMATOSES 4-8 HRS SUPERVISION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96920 | LASER SKIN DISEASE PSORIASIS TOT AREA UNDER 250 SQ CM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96921 | LASER SKIN DISEASE PSORIASIS 250-500 SQ CM            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | 96922 | LASER SKIN DISEASE PSORIASIS OVER 500 SQ CM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | C2616 | BRACHYTHERAPY NONSTRANDED YTTRIUM-90 PER SOURCE       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | C9747 | ABLATION PROSTATE TRANSRECTAL HIFU INCL I GUID        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date | Code  | Definition                                                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2020       | C9757 | LAMINOTOMY DECOMP NERVE ROOT; 1 INTERSPACE LUMB                               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 1/1/2021       | C9761 | CS URS and /PYELOSCPY LITH and VAC ASPIR K COLL SYS and URETHRA IF APPLICABLE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021       | C9765 | REV EVAR ANY VES;IV LITHOTRIPSY and TL STENT PLCMT                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021       | C9766 | REV EVAR ANY VES);IV LITHOTRIPSY AND ATHERECTOMY                              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021       | C9767 | REV EVAR ANY VES;IV LITHO and TL STNT PLCMT and ATHERECT                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria |       | 2/19/2025             |

| Service Category Notes                                                                                            | Effective Date    | Code  | Definition                                                  | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                           | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021          | C9772 | RVSC EVAR OPN/PERC TIB/PER ART<br>IVASC LITHOTRIPSY         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria                                                            |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021          | C9773 | RVSC EVAR OPEN/PC<br>TIBIAL/PA;IVASC LITH and TL SP         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria                                                            |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021          | C9774 | RVSC EVAR OPN/PERQ TIB/PER<br>ART;IVASC LITH and ATHREC     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria                                                            |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | 4/1/2021          | C9775 | RVSC EVAR OPN/P TIB/PA;IVASC LITH<br>and TL STNT PL and ATH | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information  | Third Party Proprietary Criteria                                                            |       | 2/19/2025             |
| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaiton | Prior to 9/1/2019 | S2095 | TRNSCATH OCCL EMBOLIZ TUMR<br>DESTRUC PERQ METH USI         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy: Radioembolization for Primary and<br>Metastatic Tumors of the Liver |       | 2/19/2025             |



| Service Category Notes                                                                                           | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                         | Notes | Date of Annual Review |
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| <b>Outpatient Hospital and Ambulatory Surgery Center (ASC) Prodedures:</b><br>All Inpatient Require Authorizaion | 1/1/2021          | S2118 | METL-ON-METL TOT HIP RESRFC<br>ACETAB AND FEM CMPNT     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                          |       | 2/19/2025             |
| <b>Pain Management Procedures</b>                                                                                | Prior to 9/1/2019 | 27279 | ARTHRODESIS SACROILIAC JOINT<br>PERCUTANEOUS            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Minimally Invasive Sacroiliac Joint Fusion                                     |       | 2/19/2025             |
| <b>Pain Management Procedures</b>                                                                                | Prior to 9/1/2019 | 62263 | PRQ LYSIS EPIDURAL ADHESIONS<br>MULT SESS 2 OR GRT DAYS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Percutaneous Epidural Adhesiolysis for Chronic Low Back Pain<br>Racz Procedure |       | 2/19/2025             |
| <b>Pain Management Procedures</b>                                                                                | Prior to 9/1/2019 | 62264 | PRQ LYSIS EPIDURAL ADHESIONS<br>MULT SESSIONS 1 DAY     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Percutaneous Epidural Adhesiolysis for Chronic Low Back Pain<br>Racz Procedure |       | 2/19/2025             |
| <b>Pain Management Procedures</b>                                                                                | Prior to 9/1/2019 | 62320 | NJX DX THER SBST INTRLMNR CRV<br>THRC W O IMG GDN       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain                             |       | 2/19/2025             |

| Service Category Notes     | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                             | Notes | Date of Annual Review |
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| Pain Management Procedures | Prior to 9/1/2019 | 62321 | NJX DX THER SBST INTRLMNR CRV THRC W IMG GDN   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 62322 | NJX DX THER SBST INTRLMNR LMBR SAC W O IMG GDN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 62323 | NJX DX THER SBST INTRLMNR LMBR SAC W IMG GDN   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 62351 | IMPLTJ REVJ RPSG ITHCL EDRL CATH W LAM         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                              |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 62360 | IMPLTJ RPLCMT ITHCL EDRL DRUG NFS SUBQ RSVR    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                              |       | 2/19/2025             |

| Service Category Notes     | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Pain Management Procedures | Prior to 9/1/2019 | 62361 | IMPLTJ RPLCMT FS NON-PRGRBL PUMP               | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 62362 | IMPLTJ RPLCMT ITHCL EDRL DRUG NFS PRGRBL PUMP  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria          |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 63650 | PRQ IMPLTJ NSTIM ELECTRODE ARRAY EPIDURAL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 63655 | LAM IMPLTJ NSTIM ELTRDS PLATE PADDLE EDRL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 63663 | REVJ INCL RPLCMT NSTIM ELTRD PRQ RA INCL FLUOR | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria          |       | 2/19/2025             |

| Service Category Notes     | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                             | Notes                                                                                                                                                                            | Date of Annual Review |
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| Pain Management Procedures | Prior to 9/1/2019 | 63664 | REVJ INCL RPLCMT NSTIM ELTRD PLT<br>PDLE INCL FLUOR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                              |                                                                                                                                                                                  | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 63685 | INSJ RPLCMT SPI NPGR DIR INDUXIVE<br>COUPLING         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                     |                                                                                                                                                                                  | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 63688 | REVJ RMVL IMPLANTED SPINAL<br>NEUROSTIM GENERATOR     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                              |                                                                                                                                                                                  | 2/19/2025             |
| Pain Management Procedures | 10/1/2019         | 64450 | INJECTION ANES OTHER PERIPHERAL<br>NERVE BRANCH       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain | No PA required in office or ASC setting.<br>PA required if done in hospital setting outside of another procedure.<br>No PA required if combined with another surgical procedure. | 2/19/2025             |
| Pain Management Procedures | 4/1/2020          | 64451 | INJECTION AA and /STRD NERVES<br>NRVTG SI JOINT W/IMG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |                                                                                                                                                                                  | 2/19/2025             |

| Service Category Notes     | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                             | Notes | Date of Annual Review |
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| Pain Management Procedures | 4/1/2020          | 64454 | INJECTION AA and /STRD GENICULAR NRV BRANCHES W/IMG | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Genicular Radiofrequency Ablation and Genicular Nerve Blocks for Chronic Knee Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64479 | NJX ANES AND STRD W IMG TFRML EDRL CRV THRC 1 LVL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain                                 |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64480 | NJX ANES AND STRD W IMG TFRML EDRL CRV THRC EA LV   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain                                 |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64483 | NJX ANES AND STRD W IMG TFRML EDRL LMBR SAC 1 LVL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain                                 |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64484 | NJX ANES AND STRD W IMG TFRML EDRL LMBR SAC EA LV   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain                                 |       | 2/19/2025             |

| Service Category Notes     | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                             | Notes | Date of Annual Review |
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| Pain Management Procedures | Prior to 9/1/2019 | 64490 | NJX DX THER AGT PVRT FACET JT CRV THRC 1 LEVEL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64491 | NJX DX THER AGT PVRT FACET JT CRV THRC 2ND LEVEL    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64492 | NJX DX THER AGT PVRT FACET JT CRV THRC 3 PLUS LEVEL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64493 | NJX DX THER AGT PVRT FACET JT LMBR SAC 1 LEVEL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64494 | NJX DX THER AGT PVRT FACET JT LMBR SAC 2ND LEVEL    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain |       | 2/19/2025             |

| Service Category Notes     | Effective Date    | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                         | Notes | Date of Annual Review |
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| Pain Management Procedures | Prior to 9/1/2019 | 64495 | NIX DX THER AGT PVRT FACET JT<br>LMBR SAC 3 PLUS LEVEL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain                                                             |       | 2/19/2025             |
| Pain Management Procedures | 4/1/2020          | 64624 | DESTRUCTION NEUROLYTIC AGT<br>GENICULAR NERVE W/IMG    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Genicular Radiofrequency Ablation and Genicular Nerve Blocks for Chronic Knee Pain                             |       | 2/19/2025             |
| Pain Management Procedures | 4/1/2020          | 64625 | RADIOFREQUENCY ABLTJ NRV<br>NRVTG SI JT W/IMG GDN      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Radiofrequency Nerve Ablation for Neck and Back Pain                                                           |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64633 | DSTR NROLYTC AGNT PARVERTEB<br>FCT SNGL CRVCL THORA    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain<br><br>Radiofrequency Nerve Ablation for Neck and Back Pain |       | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64634 | DSTR NROLYTC AGNT PARVERTEB<br>FCT ADDL CRVCL THORA    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain<br><br>Radiofrequency Nerve Ablation for Neck and Back Pain |       | 2/19/2025             |

| Service Category Notes     | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Pain Management Procedures | Prior to 9/1/2019 | 64635 | DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR SACRAL  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain<br><br>Radiofrequency Nerve Ablation for Neck and Back Pain |                                                                                                                                                                                                                                      | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64636 | DSTR NROLYTC AGNT PARVERTEB FCT ADDL LMBR SACRAL  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Injections and Nerve Blocks for Neck and Back Pain<br><br>Radiofrequency Nerve Ablation for Neck and Back Pain |                                                                                                                                                                                                                                      | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 64640 | DSTRJ NEUROLYTIC AGENT OTHER PERIPHERAL NERVE     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                          |                                                                                                                                                                                                                                      | 2/19/2025             |
| Pain Management Procedures | Prior to 9/1/2019 | 97812 | ACUPUNCTURE 1 OR GRT NDLS W ELEC STIMJ 1ST 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                          |                                                                                                                                                                                                                                      | 2/19/2025             |
| Physical Therapy           | 7/1/2023          | 97012 | APPL MODALITY 1 OR GT AREAS TRACTION MECHANICAL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                 | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |



| Service Category Notes | Effective Date | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Physical Therapy       | 7/1/2023       | 97014 | APPL MODALITY 1 OR GT AREAS ELEC STIMJ UNATTENDED | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97016 | APPL MODALITY 1 OR GT AREAS VASOPNEUMATIC DEVICES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97018 | APPL MODALITY 1 OR GT AREAS PARAFFIN BATH         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97022 | APPLICATION MODALITY 1 OR GT AREAS WHIRLPOOL      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97024 | APPLICATION MODALITY 1 OR GT AREAS DIATHERMY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes | Effective Date | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Physical Therapy       | 7/1/2023       | 97026 | APPLICATION MODALITY 1 OR GT AREAS INFRARED          | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97028 | APPL MODALITY 1 OR GT AREAS ULTRAVIOLET              | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97032 | APPL MODALITY 1 OR GT AREAS ELEC STIMJ EA 15 MIN     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97033 | APPL MODALITY 1 OR GT AREAS IONTOPHORESIS EA 15 MIN  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023       | 97034 | APPL MODALITY 1 OR GT AREAS CONTRAST BATHS EA 15 MIN | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Physical Therapy       | 7/1/2023          | 97035 | APPL MODALITY 1 OR GT AREAS ULTRASOUND EA 15 MIN     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97110 | THERAPEUTIC PX 1 OR GT AREAS EACH 15 MIN EXERCISES   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97112 | THER PX 1 OR GRT AREAS EACH 15 MIN NEUROMUSC REEDUCA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97113 | THER PX 1 OR GT AREAS EACH 15 MIN AQUA THER W/XERSS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97116 | THER PX 1 OR GRT AREAS EA 15 MIN GAIT TRAINJ W STAIR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Physical Therapy       | Prior to 9/1/2019 | 97124 | THER PX 1 OR GRT AREAS EACH 15 MINUTES MASSAGE      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 4/1/2020          | 97129 | THER IVNTJ COG FUNCJ CNTCT 1ST 15 MINUTES           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 4/1/2020          | 97130 | THER IVNTJ COG FUNCJ CNTCT EA ADDL 15 MINUTES       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97140 | MANUAL THERAPY TQS 1 OR GRT REGIONS EACH 15 MINUTES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97150 | THERAPEUTIC PROCEDURES GROUP 2 OR GRT INDIVIDUALS   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Physical Therapy       | Prior to 9/1/2019 | 97164 | PHYSICAL THERAPY RE-EVAL EST PLAN CARE 20 MINS   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |                                                                                                                                                                                                                                      | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97530 | THERAPEUT ACTIVITY DIRECT PT CONTACT EACH 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97533 | SENSORY INTEGRATIVE TECHNIQUES EACH 15 MINUTES   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | Prior to 9/1/2019 | 97535 | SELF-CARE HOME MGMT TRAINING EACH 15 MINUTES     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy       | 7/1/2023          | 97537 | COMMUNITY/WORK REINTEGRATION TRAING EA 15 MIN    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                                                                              | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| Physical Therapy          | 7/1/2023       | 97750 | PHYSICAL PERFORMANCE TEST/MEAS W/REPT EA 15 MIN       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                                                                      | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy          | 7/1/2023       | 97760 | ORTHOTICS MGMT AND TRAING INITIAL ENCTR EA 15 MINS    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                                                                      | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy          | 7/1/2023       | 97761 | PROSTHETICS TRAINING INITIAL ENCTR EA 15 MINS         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                                                                      | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Physical Therapy          | 7/1/2023       | 97763 | ORTHOTICS/PROSTH MGMT and /TRAINING SBSQ ENCTR 15 MIN | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                                                                      | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L0462 | TLSO TRIPLANAR 3 SHELL ANT TO STERNL NOTCH PRFAB      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual;<br>under exceptional circumstances provision<br>Molina Clinical Policy: Back Braces |                                                                                                                                                                                                                                      | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                                                                              | Notes | Date of Annual Review |
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| Prosthetics and Orthotics | Prior to 9/1/2019 | L0480 | TLSO TRIPLANAR 1 PIECE W O INTERFCE LINER CSTM   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual;<br>under exceptional circumstances provision<br>Molina Clinical Policy: Back Braces |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L0482 | TLSO TRIPLANAR 1 PIECE W INTERFCE LINER CSTM     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual;<br>under exceptional circumstances provision<br>Molina Clinical Policy: Back Braces |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L0484 | TLSO TRIPLANAR 2 PIECE W O INTERFCE LINER CSTM   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual;<br>under exceptional circumstances provision<br>Molina Clinical Policy: Back Braces |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L0486 | TLSO TRIPLANAR 2 PIECE W INTERFCE LINER CSTM     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual;<br>under exceptional circumstances provision<br>Molina Clinical Policy: Back Braces |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L0636 | LSO SAGITTAL-CORONL CNTRL FLEX RIGID POST CUSTOM | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                                                                      |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Prosthetics and Orthotics | Prior to 9/1/2019 | L0637 | LUMB-SACRAL ORTHOS SAG-COR CNTRL RIGD A AND P PREFAB | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L0640 | LSO SAGITTAL-CORONAL RIGID SHELL PANEL CUSTM FAB     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L0650 | LSO SAGITTAL-CORONAL CNTRL RIGD ANT POST PANELS      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L0700 | CTLSO ANT-POSTERIOR-LAT CONTROL MOLDED PT MODEL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L0710 | CTLSO ANT-POST-LAT CNTRL MOLD PT-INTRFCE MATL        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes    | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Prosthetics and Orthotics | 7/1/2025          | L0720 | CTLSO ANTERIOR POSTERIOR LAT CNTRL PREFAB ITEM      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Molina Clinical Policy:<br>Back Braces    |       | 8/27/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L1000 | CTLSO INCLUSIVE FURNISHING INIT ORTHOS INCL MDL     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L1005 | TENSION BASED SCOLIOSIS ORTHOTIC AND ACCESSORY PADS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L1200 | TLSO INCLUSIVE FURNISHING INITIAL ORTHOSIS ONLY     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L1680 | HIP ORTHOT DYN PELV CONTROL THIGH CUFF CSTM FAB     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| Prosthetics and Orthotics | Prior to 9/1/2019 | L1685 | HIP ORTHOS ABDCT CNTRL POSTOP<br>HIP ABDCT CSTM       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L1730 | LEGG PERTHES ORTHOTIC SCOTTISH<br>RITE CUSTOM FAB     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L1844 | KNEE ORTHOSIS SINGLE UPRIGHT<br>THIGH AND CALF CUSTOM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L1846 | KNEE ORTHOSIS DOUBLE UPRIGHT<br>THIGH AND CALF CUSTOM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L1860 | KNEE ORTHOS MOD SUPRACONDYL<br>R PROS SOCKT CSTM FAB  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
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| Prosthetics and Orthotics | Prior to 9/1/2019 | L2000 | KAFO 1 UPRT FREE KNEE FREE ANK SOLID STIRUP CSTM     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2005 | KAFO ANY MATL AUTO LOCK AND SWNG RLSE W ANK JNT CSTM | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2010 | KAFO 1 UPRT SOLID STIRUP W O KNEE JNT CSTM FAB       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2020 | KAFO DBL UPRT SOLID STIRUP THI AND CALF CSTM FAB     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2030 | KAFO DBL UPRT SOLID STIRUP W O KNEE JNT CSTM         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|-------------------|-------|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2034 | KAFO PLASTIC MED LAT ROTAT<br>CNTRL CSTM FAB   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2036 | KAFO FULL PLASTIC DOUBLE<br>UPRIGHT CSTM FAB   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2037 | KAFO FULL PLASTIC SINGLE UPRIGHT<br>CUSTOM FAB | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2038 | KAFO FULL PLASTIC MX-AXIS ANKLE<br>CUSTOM FAB  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2090 | HKAFO UNI TORSION CABLE BALL<br>BEAR CSTM      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|-------------------|-------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2106 | AFO FX ORTHOTIC TIB FX CAST THERMOPLSTC CSTM FAB     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2108 | AFO FX ORTHOTIC TIB FX CAST ORTHOSIS CSTM FAB        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2126 | KAFO FEM FX CAST ORTHOTIC THERMOPLSTC CSTM FAB       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L2128 | KAFO FX ORTHOTIC FEM FX CAST ORTHOSIS CSTM FAB       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L2627 | ADD LW EXT PELV PLSTC MOLD PT MDL HIP JNT AND CABLES | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|-------------------|-------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024          | L2628 | ADD LW EXT PELV METL FRME RECIP HIP JNT AND CABLES | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L3900 | WHFO DYN FLEXOR HINGE WRST/FNGR DRIVEN CSTM FAB    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L3901 | WHFO DYN FLEXOR HINGE CABLE DRIVEN CSTM FAB        | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L3904 | WHFO EXTERNAL POWERED ELECTRIC CUSTOM FABRICATED   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L4631 | AFO WALK BOOT TYP ROCKR BOTTM ANT TIB SHELL CSTM   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5050 | ANKLE SYMES MOLDED SOCKET SACH FOOT                  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5060 | ANK SYMES METL FRME MOLD LEATHR SOCKT ARTIC ANK      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5100 | BELOW KNEE MOLDED SOCKET SHIN SACH FOOT              | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5105 | BELOW KNEE PLSTC SOCKT JNT AND THIGH LACER SACH FOOT | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5150 | KNEE DISRTC MOLD SOCKT EXT KNEE JNT SHIN SACH FT     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5160 | KNEE DISARTIC MOLD SOCKT BENT KNEE EXT KNEE JNT  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5200 | ABOVE KNEE MOLD SOCKT 1 AXIS CONSTANT FRICTION   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5210 | ABOVE KNEE SHRT PROSTH NO KNEE JNT NO ANK JNT EA | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5220 | ABOVE KNEE SHORT PROSTH W/ARTIC ANK/FOOT DYN     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5230 | ABOVE KNEE PROXIMAL FEM FOCAL DEFIC SACH FOOT    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5250 | HIP DISARTIC CANADIAN TYPE; MOLD SOCKT HIP JNT   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5270 | HIP DISRTC TILT TABLE; MOLD SCKT LOCK HIP JNT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5280 | HEMIPELVECT CANADIAN TYPE; MOLD SOCKT HIP JNT    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5301 | BELOW KNEE MOLD SOCKET SHIN SACH FT ENDOSKEL SYS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5312 | KNEE DISARTIC MOLD SOCKET 1 AXIS KNEE SACH FOOT  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5321 | ABOVE KNEE OPEN END SACH FT<br>ENDO SYS 1 AXIS KNEE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5331 | JOINT SINGLE AXIS KNEE SACH FOOT                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5341 | SINGLE AXIS KNEE SACH FOOT                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5500 | INIT BELOW KNEE PTB SOCKET NON-<br>ALIGN DIR FORMED | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5505 | INIT ABVE KNEE-DISARTC ISCH LEVL<br>SOCKT NON-ALIGN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5510 | PREP BELOW KNEE PTB SOCKET NON-ALIGN MOLD MODEL           | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5520 | PREP BK PTB SCKT NON-ALIGN THERMOPLSTC/ Equal to DIR FORM | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5530 | PREP BK PTB SCKT NON-ALIGN THERMOPLSTC/ Equal to MOLD MDL | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5535 | PREP BELOW KNEE PTB NON-ALIGN PRFAB ADJ OPEN END          | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5540 | PREP BK PTB SCKT NON-ALIGN LAMNATD SCKT MOLD MDL          | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5560 | PREP AK-DISRTC ISCH LEVL PLASTER SOCKET MOLD MDL           | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5570 | PREP AK-DISRTC ISCH LEVL THERMOPLSTC / Equal to DIR FORMED | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5580 | PREP AK-DISARTIC NON-ALIGN THERMOPLSTC/ Equal to MOLD MDL  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5585 | PREP AK-DISARTIC NON-ALIGN PRFAB ADJ OPN END SCKT          | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5590 | PREP AK-DISARTIC NON-ALIGN LAMINATED SOCKET MOLD           | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                               | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5595 | PREP HIP DISARTIC-HEMIPELVECT THERMOPLSTC/ Equal to MOLD | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5600 | PREP HIP DISARTIC-HEMIPELVECT LAMINATD SCKT MOLD         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5610 | ADD LW EXTRM ENDO SYS ABVE KNEE HYDRACADENCE SYS         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5611 | ADD LW EXTRM ENDO AK-DISRTC 4-BAR LINK W/FRICT           | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5613 | ADD LOW EXTRM ENDO AK-DISARTIC 4-BAR W/HYDRAULIC         | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5614 | ADD LOW EXT EXOSKEL SYS AK-DISARTC 4-BAR PNEUMAT | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5616 | ADD LOW EXTRM ENDO AK UNIVERSAL MXPLX SYS FRICT  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5639 | ADDITION LOWER EXTREMITY BELOW KNEE WOOD SOCKET  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5643 | ADD LW EXT HIP DISARTIC FLX INNR SOCKT EXT FRAME | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5649 | ADD LW EXT ISCHIAL CONTAINMENT/NARROW M-L SOCKET | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5651 | ADD LW EXT ABVE KNEE FLXIBLE<br>INNR SOCKT EXT FRME | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5681 | ADD LW EXT BK/AK CST INS<br>CNG/ATYP TRAUM AMP INIT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5683 | ADD LW EXTR BK/AK CST FAB NO<br>CNGN/TRAUM AMP INIT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5700 | REPLACEMENT SOCKET BELOW KNEE<br>BK MOLDED PT MODEL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5701 | REPL SOCKT ABOVE KNEE/KNEE<br>DISARTIC W/ATTCH PLAT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5702 | REPLCMT SOCKT HIP DISARTIC W/HIP JNT MOLD PT MDL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5703 | ANKLE SYMES MOLD PT MODEL SACH FOOT REPL ONLY    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5706 | CUSTOM SHAPED PROTECTIVE COVER KNEE DISARTIC     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5707 | CUSTOM SHAPED PROTECTIVE COVER HIP DISARTIC      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5718 | ADD EXOSKL KNEE-SHIN POLYCNTRC FRICT SWING CNTR  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes    | Effective Date | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5722 | ADD EXOSKEL KNEE-SHIN PNEUMAT SWING FRICT CNTRL    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5724 | ADD EXOSKEL KNEE-SHIN FLUID SWING PHASE CNTRL      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5726 | ADD EXOSKEL KNEE-SHIN EXT JOINT FL SWING CNTRL     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5728 | ADD EXOSKEL KNEE-SHIN FLUID SWING AND STANCE CNTRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5780 | ADD EXOSKL KNEE-SHIN PNEUMAT/HYDRA PNEUMAT CNTRL   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5781 | ADD LW LIMB PROS RESIDUL LIMB VOL MGMT SYS       | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5782 | ADD LW LIMB PROS RESIDUL LIMB MGMT SYS HEVY DUTY | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5783 | ADD LWR EXT USER ADJ MECH RES LIMB VOL MGMT SYS  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5795 | ADD EXOSKEL SYSTEM HIP DISARTIC ULTRA-LGHT MATL  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5814 | ADD ENDOSKEL KNEE-SHIN HYDRAULIC SWING MECH LOCK | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                              | Notes | Date of Annual Review |
|---------------------------|----------------|-------|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5816 | ADD ENDOSKEL KNEE-SHIN MECH STANCE PHASE LOCK     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5822 | ADD ENDOSKEL KNEE-SHIN PNEUMAT SWING FRICT CNTRL  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5824 | ADD ENDOSKEL KNEE-SHIN FLUID SWING PHASE CNTRL    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5826 | ADD ENDO KNEE-SHIN HYDRAUL SWNG MIN HI ACTV FRME  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2025       | L5827 | ENDOSKEL KN SHIN SGL AX ELMCH SW and ST PHS CNTRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Additional information is required to define this code and determine criteria. |       | 8/27/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5828 | ADD ENDO KNEE-SHIN FL SWING AND STANCE PHASE CNTRL | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5830 | ADD ENDOSKEL KNEE-SHIN PNEUMAT/SWING PHASE CNTRL   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5840 | ADD ENDO KNEE-SHIN 4-BAR LINK/MX-AXIAL PNEUMAT     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5841 | ADD ENDOSKEL KNEE-SHIN SYS PNEU SW and ST PH CTRL  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5845 | ADD ENDOSKEL KNEE-SHIN STANCE FLX FEATUR ADJ       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|-------------------|-------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024          | L5848 | ADD ENDOSKEL KNEE-SHIN SYS FLUID STANCE EXTENSN      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L5856 | ADD LOW EXT PROS KNEE-SHIN SYS SWING AND STANCE PHSE | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 10/1/2020         | L5857 | ADD LOW EXT PROS KNEE-SHIN SYS SWING PHASE ONLY      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 10/1/2020         | L5858 | ADD LW EXT PROS KNEE SHIN SYS STANCE PHASE ONLY      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 10/1/2020         | L5859 | ADD LOW EXT PROS KN-SHIN PROG FLX EXT ANY MOTOR      | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5930 | ADD ENDOSKEL SYSTEM HIGH ACTV KNEE CONTROL FRAME | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5961 | ADD ENDO SYS POLYCNTRC HIP JOINT ROTATION CNTRL  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5964 | ADD ENDOSKEL AK FLEXIBLE PROTVE OUTR SURF COVER  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5966 | ADD ENDO HIP DISRTC FLXIBL PROTVE OUTR SURF COVR | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5968 | ADD LW LIMB PROSTH MX-AXIAL ANK W/SWING PHASE    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5969 | ADDITION ENDOSKELETAL ANKLE-FOOT/ANK PWR ASSIST  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5973 | ENDOSKEL ANK FOOT SYS MICRPROCSS CONTROL PWR SRC | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5979 | ALL LW EXTRM PRSTH MX-AXL ANK DYN RSPN FT 1 PECE | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5980 | ALL LOWER EXTREMITY PROSTHESES FLEX-FOOT SYSTEM  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5981 | ALL LOWER EXTREM PROSTH FLEX-WALK SYSTEM/EQUAL   | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L5987 | ALL LW XTRM PRSTH SHNK FT SYS W/VRTCL LOAD PYLN  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5988 | ADD LW LIMB PROSTH VERTCL SHOCK RDOC PYLN FEATUR | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L5990 | ADD LOW EXTREM PROSTH USER ADJUSTBLE HEEL HT     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6000 | PARTIAL HAND THUMB REMAINING                     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6010 | PARTIAL HAND LITTLE AND OR RING FINGER REMAINING | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |



| Service Category Notes    | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|-------------------|-------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024          | L6020 | PARTIAL HAND NO FINGER REMAINING                 | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L6026 | TRANSCARPAL MC PART HAND DISARTICULATION PROS    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L6050 | WRST DISARTIC MOLD SOCKET FLEX ELB HNG TRICP PAD | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L6055 | WRST DISARTIC MOLD SOCKT W/XPNDABLE INTERFCE     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L6100 | BELW ELB MOLD SOCKT FLXIBLE ELB HINGE TRICP PAD  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6110 | BELOW ELBOW MOLDED SOCKET                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6120 | BELW ELB MOLD DBL WALL SCKT STEP-UP HNG 1/2 CUFF | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6130 | BELW ELB STUMP ACTVATD LOCK HINGE HALF CUFF      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6200 | ELB DISARTC MOLD SOCKT OUTSIDE LOCK HINGE FORARM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6205 | ELB DISARTC MOLD SCKT W/XPND INTRFC LOCK FORARM  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6250 | ABVE ELB MOLD DBL WALL SCKT<br>INTRL LCK ELB FORARM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6300 | SHLDR DISARTIC MOLD SOCKET<br>INTRL LOCK ELB FORARM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6310 | SHOULDER DISARTIC PASSIVE REST<br>COMPLETE PROSTH   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6320 | SHOULDER DISART PASSIVE REST<br>SHOULDER CAP ONLY   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6360 | INTERSCAPULAR THOR PASSIVE REST<br>CMPL PROSTH      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6370 | INTERSCAPULAR THOR PASSIVE REST SHLDR CAP ONLY   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6400 | BE MOLD SCKT ENDOSKEL SYS W/SFT PROSTH TISS SHAP | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6450 | ELB DISRTC MOLD SCKT ENDOSKEL W/SFT PROSTH TISS  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6500 | ABVE ELB MOLD SCKT ENDOSKEL W/SFT PROSTH TISS    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6550 | SHLDR DISRTC MOLD SCKT ENDOSKEL W/SFT PROS TISS  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6570 | INTRSCAP THOR MOLD SCKT<br>ENDOSKEL W/SFT PROS TISS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6580 | PREP WRST DISRTC/BELW ELB 1<br>WALL PLSTC SCKT MOLD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6582 | PREP WRST DISRTC/BELW ELB 1<br>WALL SCKT DIR FORMED | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6584 | PREP ELB DISRTC/ABVE ELB 1 WALL<br>PLSTC SOCKT MOLD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6586 | PREP ELB DISRTC/ABVE ELB 1 WALL<br>SOCKT DIR FORMED | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6588 | PREP SHLDR DISRTC THOR 1 WALL<br>PLSTC SKT MOLD    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6590 | PREP SHLDR DISRTC THOR 1 WALL<br>SOCKET DIR FORM   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6621 | UP EXTREM PROS ADD<br>FLEXION/EXTENSION WRIST      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6624 | UPPER EXTREMITY ADD FLX/EXT<br>ROTATION WRIST UNIT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6638 | UP EXT ADD PROS ELEC LOCK ONLY<br>W/MNL PWR ELB    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6646 | UP EXT ADD SHLDR JNT MX PSTN W/BDY/EXT PWR SYS   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6648 | UP EXTREM ADD SHLDR LOCK MECH EXT PWR ACTUATOR   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6693 | UPPER EXTREM ADD LOCK ELB FORARM COUNTERBALANCE  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6696 | ADD UP EXT PROS ELB CSTM CNGN/TRAUMAT AMP INIT   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6697 | ADD UP EXT PROS ELB CSTM NOT CNGN/TRAUM AMP INIT | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                              | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2025       | L6700 | UPPER EXT ADD EXTRNL PWR FTR MYOELEC CTRL MOD   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Additional information is required to define this code and determine criteria. |       | 8/27/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6707 | TERMINAL DEVICE HOOK MECH VOLUNTARY CLOSING     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6708 | TERMINAL DEVICE HAND MECH VOLUNTARY OPENING     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6709 | TERMINAL DEVICE HAND MECH VOLUNTARY CLOSING     | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6712 | TERM DVC HOOK MECH VOL CLOS ANY MATL ANY SZ PED | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |



| Service Category Notes    | Effective Date | Code  | Definition                                             | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6713 | TERM DVC HAND MECH VOL OPN<br>ANY MATL ANY SIZE PED    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6715 | TERM DEV MX ARTIC DIGIT<br>W/MOTORS INIT ISSUE/REPL    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6721 | TERM DEVC HOOK/HND HVY-DUTY<br>MECH VOL OPN ANY SZ     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6722 | TERM DEVC HOOK/HAND HVY-DUTY<br>MECH VOL CLOS          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6880 | ELEC HAND SWITCH/MYO-ELEC CNTRL<br>INDEP ARTIC DIG MTR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6881 | AUTOMATIC GRASP ADD UPPER LIMB ELEC PROSTH DEVC  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6882 | MICRPRROC55 CNTRL FEATUR ADD UP LIMB PROSTH DEVC | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6900 | HAND REST PART HAND W/GLOVE THUMB/1 FNGR REMAIN  | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6905 | HAND REST PART HAND W/GLOVE MX FNGR REMAIN       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6910 | HAND REST PART HAND W/GLOVE NO FNGR REMAIN       | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6920 | WRST DISARTIC OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVICE | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6925 | WRST DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6930 | BELOW ELBOW OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVICE   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6935 | BELOW ELBOW OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVICE  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6940 | ELBOW DISARTIC OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6945 | ELB DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6950 | ABOVE ELBOW OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC    | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6955 | ABOVE ELBOW OTTO BOCK/ Equal to MYOELEC CNTRL TERM DEVC   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6960 | SHLDR DISARTIC OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6965 | SHOULDR DISARTIC OTTO BOCK/ Equal to MYOELEC CNTRL TERM   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L6970 | INTERSCAP-THOR OTTO BOCK/ Equal to SWITCH CNTRL TERM DEVC | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L6975 | INTERSCAP-THOR OTTO BOCK/ Equal to MYOELEC CNTRL TERM DVC | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L7007 | ELECTRIC HAND SWITCH/MYOELECTRIC CONTROL ADULT            | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L7008 | ELECTRIC HAND SWITCH/MYOELECTRIC CNTRL PEDIATRIC          | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L7009 | ELECTRIC HOOK SWITCH/MYOELECTRIC CONTROL ADULT            | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|----------------|-------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024       | L7040 | PREHENSILE ACTUATOR SWITCH CONTROLLED                | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L7045 | ELEC HOOK SWITCH/MYOELECTRIC CONTOL PEDIATRIC        | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L7170 | ELECTRONIC ELBOW HOSMER/EQUAL SWITCH CONTROLLED      | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L7180 | ELEC ELB MICROPRC SEQUENTIAL CNTRL ELB AND TERM DEVC | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024       | L7181 | ELEC ELB MICROPRC SIMULTAN CNTRL ELB AND TERM DEVC   | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes    | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
|---------------------------|-------------------|-------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics | 7/1/2024          | L7185 | ELEC ELB ADOLES VRITY VILLAGE/EQUAL SWITCH CNTRL        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L7186 | ELEC ELB CHILD VRITY VILLAGE/EQUAL SWITCH CNTRL         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L7190 | ELEC ELB ADOLES VRITY VILLAGE/ Equal to MYOELEC CNTRL   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | 7/1/2024          | L7191 | ELEC ELB CHLD VRITY VILL/ Equal to MYOELECTRICALY CNTRL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| Prosthetics and Orthotics | Prior to 9/1/2019 | L7259 | ELECTRONIC WRIST ROTATOR ANY TYPE                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes              | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                              | Notes | Date of Annual Review |
|-------------------------------------|-------------------|-------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------|-----------------------|
| Prosthetics and Orthotics           | 7/1/2025          | L7406 | ADDITION TO UPPER EXTREMITY USER ADJ MECHANICAL     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Additional information is required to define this code and determine criteria. |       | 8/27/2025             |
| Prosthetics and Orthotics           | Prior to 9/1/2019 | L8614 | COCHLEAR DEVICE INCLUDES ALL INT AND EXT COMPONENTS | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics           | Prior to 9/1/2019 | L8692 | AUDITORY OSSEOINTEGRATED DEV EXT SOUND BODY WORN    | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Prosthetics and Orthotics           | Prior to 9/1/2019 | S1040 | CRANIAL REMOLDING ORTHOTIC PED RIGID CUSTOM FAB     | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| Radiation Therapy and Radio Surgery | Prior to 9/1/2019 | 81479 | UNLISTED MOLECULAR PATHOLOGY PROCEDURE              | Information generally required to support authorization decision making includes, but not limited to:<br><ul style="list-style-type: none"> <li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li> <li>•History of the presenting problem</li> <li>•Clinical exam;</li> <li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li> <li>•Treatment plan and progress notes;</li> <li>•Pertinent psychosocial history;</li> <li>•Information and consultations with the treating practitioner;</li> <li>•Pertinent evaluations from other health care practitioners and providers;</li> <li>•Pertinent charts, graphs or photographic information, as appropriate;</li> <li>•Rehabilitation evaluations;</li> <li>•Information regarding the local delivery system; and</li> <li>•Patient characteristics and information.</li> </ul> | Third Party Proprietary Criteria                                               |       | 2/19/2025             |



| Service Category Notes              | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                | Date of Annual Review |
|-------------------------------------|-------------------|-------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| Radiation Therapy and Radio Surgery | Prior to 9/1/2019 | 81503 | ONCO (OVARIAN) BIOCHEMICAL ASSAY FIVE PROTEINS        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                      | 2/19/2025             |
| Radiation Therapy and Radio Surgery | Prior to 9/1/2019 | 81599 | UNLISTED MULTIANALYTE ASSAY ALGORITHMIC ANALYSIS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                      | 2/19/2025             |
| Speech Therapy                      | Prior to 9/1/2019 | 92507 | TX SPEECH LANG VOICE COMMJ AND AUDITORY PROC IND      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Speech Therapy                      | Prior to 9/1/2019 | 92508 | TX SPEECH LANGUAGE VOICE COMMJ AUDITRY 2 OR GRT INDIV | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| Speech Therapy                      | 4/1/2020          | 92526 | TX SWALLOWING DYSFUNCTION AND ORAL FUNCJ FEEDING      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                    | Notes                                                                                                                                                                                                                                | Date of Annual Review |
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| <b>Speech Therapy</b>                                                                                                                  | 7/1/2023          | 92630 | AUDITORY REHABILITATION<br>PRELINGUAL HEARING LOSS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                            | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| <b>Speech Therapy</b>                                                                                                                  | 7/1/2023          | 92633 | AUDITORY REHABILITATION<br>POSTLINGUAL HEARING LOSS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                            | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| <b>Speech Therapy</b>                                                                                                                  | Prior to 9/1/2019 | S9152 | SPEECH THERAPY RE-EVALUATION                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                            | <b>Participating Providers:</b> Initial evaluation does not require prior authorization. All visits after that point require prior authorization.<br><br><b>Non-participating Providers:</b> All visits require prior authorization. | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 4/1/2020          | 0584T | PERCUTANEOUS ISLET CELL<br>TRANSPLANT               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreatic Islet Cell Transplantation (Autologous);<br>Pancreatic Cellular Replacement Therapy Lantidra (donislecel-jujn) |                                                                                                                                                                                                                                      | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 4/1/2020          | 0585T | LAPAROSCOPIC ISLET CELL<br>TRANSPLANT               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreatic Islet Cell Transplantation (Autologous);<br>Pancreatic Cellular Replacement Therapy Lantidra (donislecel-jujn) |                                                                                                                                                                                                                                      | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date | Code  | Definition                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                    | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 4/1/2020       | 0586T | OPEN ISLET CELL TRANSPLANT                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreatic Islet Cell Transplantation (Autologous);<br>Pancreatic Cellular Replacement Therapy Lantidra (donislecel-jujn) |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 32552 | SURGICAL PROCEDURES OF THE LUNG AND PLEURA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                     |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 32850 | SURGICAL PROCEDURES OF THE LUNG AND PLEURA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                     |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 32851 | SURGICAL PROCEDURES OF THE LUNG AND PLEURA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                     |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 32852 | SURGICAL PROCEDURES OF THE LUNG AND PLEURA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                     |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2020      | 32853 | LUNG TRANSPLANT 2 W O CARDIOPULMONARY BYPASS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                 |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 32854 | SURGICAL PROCEDURES OF THE LUNG AND PLEURA      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                 |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 32855 | SURGICAL PROCEDURES OF THE LUNG AND PLEURA      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                 |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 32856 | SURGICAL PROCEDURES OF THE LUNG AND PLEURA      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                 |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 33929 | REMOVAL TOTAL RPLCMT HEART SYS FOR HEART TRNSPL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                         | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 33930 | DONOR CARDIECTOMY - PNEUMONECTOMY                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation;<br>Lung Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 33933 | BKBENCH PREPI CADAVER DONOR HEART/LUNG ALLOGRAFT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation;<br>Lung Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 33935 | HEART-LUNG TRNSPL W/RECIPIENT CARDIECTOMY-PNUMEC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation;<br>Lung Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 33940 | OBTAINING DONOR CADAVER HEART                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation                          |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019      | 33944 | PREP OF DONOR HEART FOR TRANSPLANT               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation                          |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                                                                                      | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019         | 33945 | HEART TRANSPLANT W/WO RECIPIENT CARDIECTOMY         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation                                                                                                                                                                                                                                                       |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2021          | 33995 | INSJ PERQ VAD W/RS and I R HEART VENOUS ACCESS ONLY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                                                                                                                                       |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 38205 | BLD-DRV HEMATOP PROGEN CELL HRVG TRNSPLJ ALGNC      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policies:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 38206 | BLD-DRV HEMATOP PROGEN CELL HRVG TRNSPLJ AUTOL      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                              |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2025          | 38225 | CAR-T THERAPY HRVG BLD DRV T LYMPHCYT PR DAY        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                              |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2025          | 38226 | CAR-T THERAPY PREP BLD DRV T LYMPHCYT F TRNS       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2025          | 38227 | CAR-T THERAPY RECEIPT AND PREP CAR-T CELLS F ADMIN | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2025          | 38228 | CAR-T THERAPY AUTOLOGOUS CELL ADMINISTRATION       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 38230 | BONE MARROW HARVEST TRANSPLANTATION ALLOGENEIC     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 38240 | TRNSPLJ ALLOGENEIC HEMATOPOIETIC CELLS PER DONOR   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                                                                                             | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 38241 | TRNSPLJ AUTOLOGOUS<br>HEMATOPOIETIC CELLS PER DONOR | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                                     |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 38242 | ALLOGENEIC LYMPHOCYTE<br>INFUSIONS                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                                     |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 38243 | TRNSPLJ HEMATOPOIETIC CELL<br>BOOST                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic<br>Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic<br>Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous<br>Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2019         | 44137 | RMVL TRNSPLED INTESTINAL<br>ALLOGRAFT COMPL         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Small Bowel Multivisceral Transplantation;<br>Liver Transplantation                                                                                                                                                                                                                |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 44715 | BKBENCH PREP CADAVER LIVING<br>DONOR INTESTINE      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Small Bowel Multivisceral Transplantation;<br>Liver Transplantation                                                                                                                                                                                                                |       | 2/19/2025             |



| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                              | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 44720 | BKBENCH RCNSTJ INT ALGRFT VEN ANAST EA        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Small Bowel Multivisceral Transplantation;<br>Liver Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 44721 | BKBENCH RCNSTJ INT ALGRFT ARTL ANAST EA       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Small Bowel Multivisceral Transplantation;<br>Liver Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47133 | DONOR HEPATECTOMY CADAVER DONOR               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47135 | LVR ALTRNSPLJ ORTHOTOPIC PRTL WHL DON ANY AGE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47140 | DONOR HEPATECTOMY LIVING DONOR SEG II AND III | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                              | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47141 | DONOR HEPATECTOMY LIVING<br>DONOR SEG II III AND IV   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47142 | DONOR HEPATECTOMY LIVING<br>DONOR SEG V VI VII AND VI | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47143 | BKBENCH PREP CADAVER DONOR                            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47144 | BKBENCH PREPJ CADAVER WHOLE<br>LIVER GRF I AND IV VII | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47145 | BKBENCH PREPJ CADAVER DONOR<br>WHL LVR GRF I AND V VI | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                     | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47146 | BKBENCH RCNSTJ LVR GRF VENOUS ANAST EA         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation                        |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 47147 | BKBENCH RCNSTJ LVR GRF ARTL ANAST EA           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation                        |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 48160 | PANCREATECTOMY W TRNSPLJ PANCREAS ISLET CELLS  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreas Transplantation Procedures;<br>Pancreatic Islet Cell Transplantation (Autologous) |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 48550 | DONOR PANCREATECTOMY DUODENAL SGM TRANSPLANT   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreas Transplantation Procedures;<br>Small Bowel Multivisceral Transplantation          |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 48551 | BKBENCH PREPJ CADAVER DONOR PANCREAS ALLOGRAFT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreas Transplantation Procedures;<br>Pancreatic Islet Cell Transplantation (Autologous) |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                   | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 48552 | BKBENCH RCNSTJ CDVR PNCRS<br>ALGRFT VEN ANAST EA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreas Transplantation Procedures;<br>Pancreatic Islet Cell Transplantation (Autologous)                                                               |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 48554 | TRANSPLANTATION PANCREATIC<br>ALLOGRAFT          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreas Transplantation Procedures;<br>Pancreatic Cellular Replacement Therapy Lantidra (donislecel-jujn);<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 48556 | RMVL TRANSPLANTED PANCREATIC<br>ALLOGRAFT        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreas Transplantation Procedures;<br>Pancreatic Cellular Replacement Therapy Lantidra (donislecel-jujn)                                               |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50300 | DONOR NEPHRECTOMY CADAVER<br>DONOR UNI BILATERAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures                                                                                           |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50320 | DONOR NEPHRECTOMY OPEN LIVING<br>DONOR           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures                                                                                           |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50323 | BKBENCH PREPJ CADAVER DONOR<br>RENAL ALLOGRAFT      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures;<br>Pancreatic Islet Cell Transplantation (Autologous) |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50325 | BKBENCH PREPJ LIVING RENAL<br>DONOR ALLOGRAFT       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures;<br>Pancreatic Islet Cell Transplantation (Autologous) |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50327 | BKBENCH RCNSTJ RENAL ALGRFT<br>VENOUS ANAST EA      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures;<br>Pancreatic Islet Cell Transplantation (Autologous) |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50328 | BKBENCH RCNSTJ RENAL ALLOGRAFT<br>ARTERIAL ANAST EA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation                                                                                                |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50329 | BKBENCH RCNSTJ ALGRFT URETERAL<br>ANAST EA          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation                                                                                                |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                         | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50340 | RECIPIENT NEPHRECTOMY SEPARATE PROCEDURE       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50360 | RENAL ALTRNSPLJ IMPLTJ GRF W O RCP NEPHRECTOMY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50365 | RENAL ALTRNSPLJ IMPLTJ GRF W RCP NEPHRECTOMY   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50370 | RMVL TRNSPLED RENAL ALLOGRAFT                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation;<br>Pancreas Transplantation Procedures |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | 50380 | RENAL AUTOTRNSPLJ REIMPLANTATION KIDNEY        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Kidney Transplantation                                         |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date | Code  | Definition                                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                          | Notes                                                                                                                                 | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2023      | J1304 | INJECTION, TOFERSEN, 1 mg                                     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                  | Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                     | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 11/1/2023      | J1411 | INJ ETRANACOGENE DEZAPARVOVEC-DRLB PER THR DOSE (HEMGENIX)    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                  | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2024       | J1412 | INJ VALOCTOCOGENE ROXAPARVOVEC (ROCTAVIAN)                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                  | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2024       | J1413 | INJ DELANDISTROGENE MOXEPARVOVEC-ROKL PER THR DOSE (ELEVIDYS) | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                  | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2025       | J1414 | FIDANACOGENE ELAPARVOVEC-DZKT (BEQVEZ)                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Beqvez (fidanacogene elaparvec) | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date | Code  | Definition                                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                 | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2026       | J3387 | INJECTION ELIVALDOGENE AUTOTEMCEL (SKYSONA), PER TREATMENT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 11/19/2025            |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2026       | J3389 | PRADEMAGENE ZAMIKERACEL (ZEVASKYN)                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                     | 11/19/2025            |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 7/1/2025       | J3391 | INI, ATIDARSAGENE AUTOTEMCEL, PER TREATMENT                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 8/27/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2025       | J3392 | EXAGAMGLOGENE AUTOTEMCEL (CASGEVY)                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 7/1/2024       | J3393 | BETIBEGLOGENE AUTOTEMCEL (ZYNTEGLO)                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |



| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                                                            | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                               | Notes                                                                                                                                                  | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 7/1/2024          | J3394 | LOVOTIBEGLOGENE AUTOTEMCEL (LYFGENIA)                                                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual       | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                  | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | J3398 | INJECTION VORETIGENE NEPARVOVEC-RZYL 1 B VEC G (Luxturna)                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual       | Limited to one injection per eye per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 2/1/2023          | J3399 | INJECTION, ONASEMNOGENE ABEPARVOVEC, PER TX, UP TO 5x10*15 VECTOR GENOMES (ZOLGENSMA) | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual       | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                  | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2024          | J3401 | INJECTION, BEREMAGENE GEPERPAVEC-SVDT (VYJUVEK)                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual       | Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                                      | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2025         | J3402 | Injection, remestemcel-I-rknd (Ryoncil), per therapeutic dose                         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy<br>Ryoncil (remestemcel) | Please fax requests for prior authorization to the Transplant department fax number <b>877-813-1206</b> .                                              | 8/27/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                           | Notes                                                                                                                                 | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2025         | J3403 | Revakinagene taroretccl-lwey (Encelto), per implant                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy<br>Encelto (revakinagene taroretccl) | Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                     | 8/27/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2024          | J9029 | INJECTION, NADOFARAGENE FIRADENOVEC-VNCG, PER THERAPEUTIC DOSE (ADSTILADRIN) | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                   | Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                     | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | Q2041 | KTE-C19 TO 200 M A ANTI-CD19 CAR POS T CE P TD (YESCARTA)                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                   | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 5/21/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | Q2042 | TISAGENLECEUCEL TO 600 M CAR-POS VI T CE PER TD (KYMRIAH)                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                   | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 5/21/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | Q2043 | SIPULEUCEL-T AUTO CD54 PLUS (PROVENGE)                                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Provenge (Sipuleucel-T)          |                                                                                                                                       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date | Code  | Definition                                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                   | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 7/1/2021       | Q2053 | BREXUCABTAGENE CAR POST (TECARTUS)                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                                                                                   | 5/21/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2022       | Q2054 | LM GT OR EQUAL TO 110 MIL AUTOL ANTI-CD19 CAR-POS VIABL T (BREYANZI) | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                                                                                   | 5/21/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 1/1/2023       | Q2056 | CILTACABTAGENE AUTOLEUCEL TO 100 M BCMA PER TX D (CARVYKTI)          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                                                                                   | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 4/1/2025       | Q2057 | AFAMITRESGENE AUTOLEUCEL (TECELRA)                                   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> .                                                                                                   | 5/21/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | 10/1/2025      | Q2058 | OBECABTAGENE CAR POS T (AUCATZYL)                                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Limited to once per lifetime<br>Administered in two doses: the first dose on day one and a second dose on day ten (+/- 2 days)<br><br>Please fax requests for prior authorization to the UM department fax number <b>866-420-3639</b> . | 8/27/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                              | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2054 | TRANSPLANTATION OF MULTIVISCERAL ORGANS              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Small Bowel Multivisceral Transplantation                           |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2053 | TRANSPLANTATION SMALL INTESTINE AND LIVER ALLOGRAFTS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Liver Transplantation;<br>Small Bowel Multivisceral Transplantation |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2055 | HARVEST DONOR MX-VISCERAL ORGAN; CADVER DONOR        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Small Bowel Multivisceral Transplantation                           |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2060 | LOBAR LUNG TRANSPLANTATION                           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Lung Transplantation                                                |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2061 | DONOR LOBECTOMY FOR TRANSPLANTATION LIVING DONOR     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Lung Transplantation                                                |       | 2/19/2025             |

| Service Category Notes                                                                                                                 | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                                                                                    | Notes | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2065 | SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Pancreas Transplantation Procedures                                                                                                                                                                                                                                       |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2107 | ADOPTIVE IMMUNOTHERAPY PER COURSE OF TREATMENT       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria                                                                                                                                                                                                                                                                     |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2140 | CORD BLOOD HARVESTING TRANSPLANTATION ALLOGENEIC     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2142 | CORD BLD-DERIVED STEM-CELL TPLNT ALLOGENEIC          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                            |       | 2/19/2025             |
| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization. | Prior to 9/1/2019 | S2150 | BN MARROW BLD DERIVD STEM CELLS HARV TPLNT AND COMP; | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Hematopoietic Stem Cell Transplantation for Hematologic Cancers;<br>Hematopoietic Stem Cell Transplantation for Hematologic Disorders;<br>Hematopoietic Stem Cell Transplantation for Non-Cancerous Diseases;<br>Hematopoietic Stem Cell Transplantation for Solid Tumors |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                              | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                                                                           | Notes                                                                                                                                                                                                                                 | Date of Annual Review |
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| <b>Transplants/Gene Therapy:</b><br>(Including Solid Organ and Bone Marrow)<br>Corneal Transplants Do Not Require Prior Authorization.                                                                              | Prior to 9/1/2019 | S2152 | SOLID ORGAN; TRANSPLANTATION AND RELATED COMP        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>Heart Transplantation;<br>Kidney Transplantation;<br>Liver Transplantation;<br>Lung Transplantation;<br>Pancreas Transplantation Procedures;<br>Pancreatic Cellular Replacement Therapy Lantidra (donislecel-jujn);<br>Small Bowel Multivisceral Transplantation |                                                                                                                                                                                                                                       | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0382 | BLS ROUTINE DISPOSABLE SUPPLIES                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                   | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0398 | ALS ROUTINE DISPOSABLE SUPPLIES                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                   | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0420 | AMBULANCE WAITING TIME ONE-HALF HOUR INCREMENTS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                   | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0422 | AMB OXYGEN AND O2 SUPPLIES LIFE SUSTAINING SITUATION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                                                                                                                                                                                                                                   | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                  | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                 | Date of Annual Review |
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| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0424 | EXTRA AMBULANCE ATTENDANT GROUND OR AIR        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0425 | GROUND MILEAGE PER STATUTE MILE                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | Prior to 9/1/2019 | A0426 | AMB SERVICE ALS NONEMERGENCY TRANSPORT LEVEL 1 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0427 | MB SERVICE ALS EMERGENCY TRANSPORT LEVEL 1     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | Prior to 9/1/2019 | A0428 | AMBULANCE SERVICE BLS NONEMERGENCY TRANSPORT   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                                                                                   | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                 | Date of Annual Review |
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| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier.                                                                                                  | 4/10/2023         | A0429 | AMBULANCE SERVICE BLS EMERGENCY TRANSPORT      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier.                                                                                                  | Prior to 9/1/2019 | A0430 | AMB SERVICE CONVNTION AIR SRVC TRANSPORT 1 WAY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | Prior to 9/1/2019 | A0431 | AMB SERVICE CONVNTION AIR SRVC TRANSPORT 1 WAY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0433 | ADVANCED LIFE SUPPORT LEVEL 2                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br><br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br><br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0434 | SPECIALTY CARE TRANSPORT                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |



| Service Category Notes                                                                                                                                                                                                                                                                                           | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                         | Notes                                                                                                                                                                                                                                 | Date of Annual Review |
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| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0435 | FIXED WING AIR MILEAGE PER STATUTE MILE         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | A0436 | ROTARY WING AIR MILEAGE PER STATUTE MILE        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 4/10/2023         | G2022 | MDL PRTCP BENEFICIARY REFUSES SRVC COVR UND MDL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | Prior to 9/1/2019 | S9960 | AMB SERVICE AIR NONEMERGENCY 1 WAY FIXED WING   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                       | 2/19/2025             |
| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | Prior to 9/1/2019 | S9961 | AMB SERVICE AIR NONEMERGENCY 1 WAY ROTARY WING  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Third Party Proprietary Criteria          |                                                                                                                                                                                                                                       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                                                                           | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes                                                     | Date of Annual Review |
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| <b>Transportation Services:</b><br>Prior Authorization is required for Non-Emergent Ambulance transportation services.<br>Accessory codes not listed require approval of base BLS/ALS transport for claims payment.<br>Emergency transport does not require prior authorization when submitted with ET modifier. | 1/1/2022          | T2002 | NON EMERGENCY TRANSPORTATION; PER DIEM           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                      | Prescribed Pediatric Extended Care Center (PPECC) Benefit | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein.                                                  | 1/1/2022          | 0708T | INTRADERMAL CANCER IMMNTX PREP and 1ST INJECTION | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                           | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein.                                                  | 1/1/2022          | 0709T | INTRADERMAL CANCER IMMNTX EACH ADDL INJECTION    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                           | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein.                                                  | Prior to 9/1/2019 | 17999 | UNLISTED PX SKIN MUC MEMBRANE AND SUBQ TISSUE    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                           | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein.                                                  | Prior to 9/1/2019 | 19499 | UNLISTED PROCEDURE BREAST                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                           | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 21089 | UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 21299 | UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 22899 | UNLISTED PROCEDURE SPINE                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 22999 | UNLISTED PX ABDOMEN MUSCULOSKELETAL SYSTEM        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 23929 | UNLISTED PROCEDURE SHOULDER                       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 26989 | UNLISTED PROCEDURE HANDS FINGERS    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 27299 | UNLISTED PROCEDURE PELVIS HIP JOINT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 29999 | UNLISTED PROCEDURE ARTHROSCOPY      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 30999 | UNLISTED PROCEDURE NOSE             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 37799 | UNLISTED PROCEDURE VASCULAR SURGERY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 38129 | UNLISTED LAPAROSCOPY PROCEDURE SPLEEN        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 38589 | UNLISTED LAPAROSCOPY PX LYMPHATIC SYSTEM     | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 38999 | UNLISTED PROCEDURE HEMIC OR LYMPHATIC SYSTEM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 39499 | UNLISTED PROCEDURE MEDIASTINUM               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 39599 | UNLISTED PROCEDURE DIAPHRAGM                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 40799 | UNLISTED PROCEDURE LIPS                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 41599 | UNLISTED PROCEDURE TONGUE FLOOR MOUTH   | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 42299 | UNLISTED PROCEDURE PALATE UVULA         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 43499 | UNLISTED PROCEDURE ESOPHAGUS            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 43659 | UNLISTED LAPAROSCOPIC PROCEDURE STOMACH | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 43999 | UNLISTED PROCEDURE STOMACH                        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 45399 | UNLISTED PROCEDURE COLON                          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 47579 | UNLISTED LAPAROSCOPY PROCEDURE BILIARY TRACT      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 47999 | UNLISTED PROCEDURE BILIARY TRACT                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 49999 | UNLISTED PROCEDURE ABDOMEN PERITONEUM AND OMENTUM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                   | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 54699 | UNLISTED LAPAROSCOPY PROCEDURE TESTIS        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 55559 | UNLISTED LAPROSCOPY PROCEDURE SPERMATIC CORD | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 55899 | UNLISTED PROCEDURE MALE GENITAL SYSTEM       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 58578 | UNLISTED LAPAROSCOPY PROCEDURE UTERUS        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 58679 | UNLISTED LAPAROSCOPY PROCEDURE OVIDUCT OVARY | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |



| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                                                                                                                                                                  | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 58999 | UNLISTED PX FEMALE GENITAL SYSTEM NONOBSTETRICAL | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.                                                                                                                                                     |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 60699 | UNLISTED PROCEDURE ENDOCRINE SYSTEM              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.                                                                                                                                                     |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 64999 | UNLISTED PROCEDURE NERVOUS SYSTEM                | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.<br><br>Molina Clinical<br>Policy:<br>Injections and Nerve Blocks for Neck and Back Pain<br><br>Radiofrequency Nerve Ablation for Neck and Back Pain |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 67299 | UNLISTED PROCEDURE POSTERIOR SEGMENT             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.                                                                                                                                                     |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 68899 | UNLISTED PROCEDURE LACRIMAL SYSTEM               | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.                                                                                                                                                     |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                 | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes                                   | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 77799 | UNLISTED PROCEDURE CLINICAL BRACHYTHERAPY  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                         | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 87797 | IADNA NOS DIRECT PROBE TQ EACH ORGANISM    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                         | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 87798 | IADNA NOS AMPLIFIED PROBE TQ EACH ORGANISM | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. | No prior auth required up to 3 per day. | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 88299 | UNLISTED CYTOGENETIC STUDY                 | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                         | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 88399 | UNLISTED SURGICAL PATHOLOGY PROCEDURE      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                         | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                         | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes                                        | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 93799 | UNLISTED CARDIOVASCULAR SERVICE PROCEDURE          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                              | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 95999 | UNLIS NEUROLOGICAL NEUROMUSCULAR DX PX             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                              | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 96549 | UNLISTED CHEMOTHERAPY PROCEDURE                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                              | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 7/1/2023          | 97039 | UNLIST MODALITY SPEC TYPE AND TIME CONSTANT ATTEND | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. | Prior auth required after initial evaluation | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 7/1/2023          | 97139 | UNLISTED THERAPEUTIC PROCEDURE SPECIFY             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. | Prior auth required after initial evaluation | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                    | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes                                                                                                                                                                                                                                 | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 97799 | UNLISTED PHYSICAL MEDICINE REHAB SERVICE PROC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                                                                                                                                                                                       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 99499 | UNLISTED EVALUATION AND MANAGEMENT SERVICE    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                                                                                                                                                                                       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | 99600 | UNLISTED HOME VISIT SERVICE PROCEDURE         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                                                                                                                                                                                       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | A0999 | UNLISTED AMBULANCE SERVICE                    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. | Prior Authorization is not required for emergency transport when submitted with Emergency Transport (ET) modifier.<br><br>Prior Authorization is required for non-emergency transport and requests submitted without the ET modifier. | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | A4421 | OSTOMY SUPPLY; MISCELLANEOUS                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                                                                                                                                                                                       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                     | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | A6262 | WOUND FILLER DRY FORM PER G NOT OTHERWISE SPEC | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 7/1/2022          | A9291 | PRESCRIPTION DIGITAL BT FDA CLEARED PER CRS TX | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | A9699 | RADIOPHARMACEUTICAL THERAPEUTIC NOC            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 5/20/2020         | A9900 | DME SUP ACCESS SRV-COMPON OTH HCPCS            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | A9999 | MISCELLANEOUS DME SUPPLY OR ACCESSORY NOS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                           | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | B9998 | NOC FOR ENTERAL SUPPLIES                             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                      |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | E0769 | ESTIM ELECTROMAGNETIC WOUND TREATMENT DEVC NOC       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | E0770 | FES TRANSQ STIM NERV AND MUSC GRP CMPL SYS NOS       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | E1399 | DURABLE MEDICAL EQUIPMENT MISCELLANEOUS              | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 1/1/2025          | G2082 | OFF/OTH OP E and M EST PT PROV 56 MG ESKETAMINE N SA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                              | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes                                                                                                          | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 1/1/2025          | G2083 | OFF/OTH OP E and M EST PT PROV GT 56 MG ESKETAMINE N SA | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                                                                | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | J3490 | UNCLASSIFIED DRUGS                                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. | Please fax requests for gene therapy prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | J3590 | UNCLASSIFIED DRUGS                                      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. | Please fax requests for gene therapy prior authorization to the UM department fax number <b>866-420-3639</b> . | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | J7599 | IMMUNOSUPPRESSIVE DRUG NOT OTHERWISE CLASSIFIED         | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                                                                | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | J7699 | NOC DRUGS INHALATION SOLUTION ADMINED THRU DME          | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                                                                | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes                                                                   | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | J7799 | NOC RX OTH THAN INHALATION RX ADMINED THRU DME  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                         | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | J7999 | COMPOUNDED DRUG NOT OTHERWISE CLASSIFIED        | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. | Bevacizumab when billed for intraocular injection does not require a PA | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | J8597 | ANTIEMETIC DRUG ORAL NOT OTHERWISE SPECIFIED    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                         | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | K0812 | POWER OPERATED VEHICLE NOT OTHERWISE CLASSIFIED | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                         | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | K0898 | POWER WHEELCHAIR NOT OTHERWISE CLASSIFIED       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |                                                                         | 2/19/2025             |



| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                        | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | K0899 | PWR MOBILITY DVC NOT CODED DME PDAC NOT MEET CRIT | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L0999 | ADD TO SPINAL ORTHOTIC NOT OTHERWISE SPECIFIED    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L1499 | SPINAL ORTHOTIC NOT OTHERWISE SPECIFIED           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L2999 | LOWER EXTREMITY ORTHOSES NOT OTHERWISE SPECIFIED  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L3999 | UPPER LIMB ORTHOSIS NOT OTHERWISE SPECIFIED       | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                      | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                                | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L5999 | LOWER EXTREMITY PROSTHESIS NOS                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.   |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L7499 | UPPER EXTREMITY PROSTHESIS NOS                  | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.   |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L8499 | UNLISTED PROC MISCELLANEOUS PROSTHETIC SERVICES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Texas Medicaid Provider Procedures Manual                                        |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L8699 | PROSTHETIC IMPLANT NOT OTHERWISE SPECIFIED      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria.   |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L8701 | PWR UE ROM AST DVC ELB WR HAND 1 DBL UP CUS FAB | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Molina Clinical Policy:<br>MyoPro Orthosis / Myelectric Upper Extremity Orthosis |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                       | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria Utilized                                                               | Notes                                                                               | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | L8702 | PWR UE ROM AST DVC ELBO WR H FINGER 1 DBL UP CUS | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>MyoPro Orthosis / Mylectric Upper Extremity Orthosis |                                                                                     | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | Q0508 | MISC SUPPLY OR ACCESSORY USE WITH IMPLANTED VAD  | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Additional information is required to define this code and determine criteria.  |                                                                                     | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 4/1/2023          | Q3014 | TELEHEALTH ORIGINATING SITE FACI                 | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Additional information is required to define this code and determine criteria.  |                                                                                     | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | Q4082 | DRUG OR BIOLOGICAL NOC PART B DRUG CAP           | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Additional information is required to define this code and determine criteria.  |                                                                                     | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 10/1/2022         | Q4100 | SKIN SUBSTITUTE NOT OTHERWISE SPECIFIED          | Information generally required to support authorization decision making includes, but not limited to: <ul style="list-style-type: none"><li>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;</li><li>•History of the presenting problem</li><li>•Clinical exam;</li><li>•Pertinent diagnostic testing results, operative and/or pathological reports;</li><li>•Treatment plan and progress notes;</li><li>•Pertinent psychosocial history;</li><li>•Information and consultations with the treating practitioner;</li><li>•Pertinent evaluations from other health care practitioners and providers;</li><li>•Pertinent charts, graphs or photographic information, as appropriate;</li><li>•Rehabilitation evaluations;</li><li>•Information regarding the local delivery system; and</li><li>•Patient characteristics and information.</li></ul> | Molina Clinical Policy:<br>Skin and Soft Tissue Substitutes                     | Refer to Texas Medicaid Provider Procedures Manual for skin substitute limitations. | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                          | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | S0590 | INTEGRAL LENS SERVICE MISC SERVICES REPORTED SEP    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 1/1/2022          | S9432 | MEDICAL FOODS FOR NONINBORN ERRORS OF METABOLISM    | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 5/20/2020         | T1999 | MISC TX ITEMS AND SPL RETAIL PURCHASE NOC           | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | T2025 | WAIVER SERVICES; NOT OTHERWISE SPECIFIED            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 1/1/2021          | T2047 | HABILITATION, PREVOCATIONAL, WAIVER; PER 15 MINUTES | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |

| Service Category Notes                                                                                                                                                                                                                                              | Effective Date    | Code  | Definition                                | Documentation Requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Criteria Utilized                                                              | Notes | Date of Annual Review |
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| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | TS999 | SUPPLY NOT OTHERWISE SPECIFIED            | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | 1/1/2021          | V2524 | CONTACT LENS HPI SPH PC ADDITIVE PER LENS | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | V2799 | VISION ITEM OR SERVICE MISCELLANEOUS      | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |
| <b>Unlisted/Miscellaneous codes:</b><br><br>Molina requires Prior Authorization, as well as medical necessity documentation and rationale be submitted with the prior authorization request for all Unlisted/Miscellaneous codes including those not listed herein. | Prior to 9/1/2019 | V5299 | HEARING SERVICE MISCELLANEOUS             | Information generally required to support authorization decision making includes, but not limited to:<br>•Current (up to 6 months), adequate patient history related to the requested services such as: office and hospital records;<br>•History of the presenting problem<br>•Clinical exam;<br>•Pertinent diagnostic testing results, operative and/or pathological reports;<br>•Treatment plan and progress notes;<br>•Pertinent psychosocial history;<br>•Information and consultations with the treating practitioner;<br>•Pertinent evaluations from other health care practitioners and providers;<br>•Pertinent charts, graphs or photographic information, as appropriate;<br>•Rehabilitation evaluations;<br>•Information regarding the local delivery system; and<br>•Patient characteristics and information. | Additional information is required to define this code and determine criteria. |       | 2/19/2025             |