

Benefit Criteria for Pathology and Laboratory Services-Hematology and Coagulation to Change for Texas Medicaid

Effective for dates of service on or after February 1, 2016, benefit criteria for pathology and laboratory services-hematology and coagulation will change for Texas Medicaid.

The procedure codes in the table below will be a benefit only as a total component when provided by:

- Nurse practitioner, clinical nurse specialists, physician assistant, physician, certified nurse midwife, nephrology, and renal dialysis facility providers for services rendered in the office setting;
- Hospital providers for services rendered in the outpatient hospital setting; or
- Independent/privately-owned laboratory providers for services rendered in the independent laboratory setting.

Benefit changes will be applied to the following hematology and coagulation laboratory services procedure codes:

Procedure Codes									
85002	85004	85007	85008	85009	85013	85014*	85018*	85025	85027
85032	85041	85044	85045	85046	85048	85049	85055	85060	85097
85130	85170	85175	85210	85220	85230	85240	85244	85245	85246
85247	85250	85260	85270	85280	85290	85291	85292	85293	85300
85301	85302	85303	85305	85306	85307	85335	85337	85345	85347
85348	85360	85362	85366	85370	85378	85379	85380	85384	85385
85390	85396	85397	85400	85410	85415	85420	85421	85441	85445
85460	85461	85475	85520	85525	85530	85536	85540	85547	85549
85555	85557	85576*	85597	85598	85610*	85611	85612	85613	85635
85651	85652	85660	85670	85675	85705	85730	85732	85810	85999
G0306	G0307								
* CLIA Waived test									

Note: The procedure codes above do not require prior authorization for Fee-For-Service.

Procedure codes 85460 and 85461 may be reimbursed for female clients who are 10 through 55 years of age.

Procedure code 85004 will deny if billed on the same day by the same provider as procedure code 85007.

Procedure code 85536 will no longer be diagnosis restricted.

Procedure code 85660 will be limited to once per lifetime, any provider. An additional test may be considered on appeal with documentation indicating the provider was unaware the client was tested previously or was unable to obtain client's medical records.

Documentation Requirements

All services are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.