

MANDATED BENEFITS DATA CALL CODE LIST

Mandated Benefit	Description	ICD-9	CPT Codes
<p>ACQUIRED BRAIN INJURY (ABI): TIC §§1352.003 and 1352.0035; 28 TAC §§21.3101 – 21.3105</p>	<p>Health benefit plans other than small employer health benefit plans: A health benefit plan must include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an ABI. A health benefit plan must include the same payment limitations, deductibles, copayments, and coinsurance factors for coverage as applicable to other similar coverage provided under the health benefit plan.</p> <p>Small employer health benefit plans: A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an ABI. Coverage may be subject to deductibles, copayments, and annual or maximum payment limits that are consistent with other similar coverage under the EOC or policy.</p>	<p>Diagnosis codes for ABI include a large number of codes associated with both physical and psychological illnesses and injuries. Identification and reporting of claims related to the ABI mandate will generally require a variety of data elements in order to accurately limit claim reporting to only those claims subject to the ABI mandated benefit requirement.</p> <p>Please note that the mandate only addresses coverage of specific therapy and intervention services and does not include medical services for treatment of the actual head injury. Do not report all costs for claims associated with these diagnosis codes, but only those costs related to the required therapy, testing, and treatment, as the mandated benefit description in the first column provides.</p> <p>A list of ICD-9 diagnosis codes that may be associated with the ABI mandate follows, but it is not necessarily complete.</p> <p>191's: brain neoplasm 310.2: post-concussive syndrome 320-326: inflammatory diseases 343.9: acquired cerebral palsy 348: brain lesions, other conditions of the brain 430-438: cerebrovascular disease 436: stroke, CVA 519.8: airway obstruction 780.0: altered consciousness 780.39: seizures 799.0: hypoxia 800-804: skull fracture injuries 847.10: cervical trauma syndrome 850-854: intercranial injury, concussions 873.8 open head injury</p>	<p>CPT codes for ABI include a large number of codes associated with various forms of treatment that are provided to patients other than those with ABI. As such, identify only claims provided to insureds diagnosed with ABI. Identification and reporting of claims related to the ABI mandate will generally require a variety of data elements in order to accurately limit claim reporting to only those claims subject to the ABI mandated benefit requirement.</p> <p>A list of CPT codes follows that may potentially identify ABI services. However, do not include reported claims costs for any of these services unless they were provided as a result of an ABI.</p> <p>90901 90911 90875 90801-90899 92507 92585 95925-95930 95961-95962 95812, 95819 96100-96117 97001-97799 97530 97532 97533 97535 97537 99301-99380</p>

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ACQUIRED BRAIN INJURY (ABI): CONTINUED		905.0, 907.0, 907.1: late effects of injuries to the nervous system 924.9: contusion 950.9: post traumatic vision syndrome 959.01: head injury, traumatic brain injury, mild closed head injury 977.9: toxic drug ingestion 980.9: toxic ETOH ingestion 989.9: toxic chemical ingestion 994.1: near drowning 995.55: shaken baby syndrome V57: rehab procedures	
CHEMICAL DEPENDENCY – INPATIENT AND OUTPATIENT: TIC Chapter 1368; 28 TAC §§3.8001 - 3.8030, and 11.509(3)	<p>A group health benefit plan must provide benefits for the necessary care and treatment of chemical dependency on the same basis as other physical illnesses generally. The treatments must be in accordance with the standards adopted under 28 TAC §§3.8001 - 3.8030.</p> <p>A group health benefit plan must cover treatment of chemical dependency in a chemical dependency treatment facility as favorably as any other physical illness and on the same basis as treatment in a hospital.</p>	303.90: alcohol dependence 304.40: amphetamine dependence 304.30: cannabis dependence 304.20: cocaine dependence 304.50: hallucinogen dependence 304.60: inhalant dependence 304.00: opioid dependence 304.90: phencyclidine dependence 304.10: sedative, hypnotic, or anxiolytic dependence 304.80: polysubstance abuse dependence	
CHILDREN – HEARING SCREENING: TIC Chapter 1367, Subchapter C	<p>Health benefit plans that provide benefits for a family member of the enrollee/insured must provide coverage for each covered child for:</p> <p>(1) a screening test for hearing loss from birth through the date the child is 30 days old, as provided by Chapter 47, Health and Safety Code; and</p> <p>(2) necessary follow-up care related to the screening test from birth through the date the child is 24 months old.</p> <p>A health benefit plan may subject benefits to copayment/coinsurance requirements, but may not subject them to a deductible requirement or dollar limits. These limitations and requirements must be stated in the EOC or policy.</p>	<p>NOTE: Age Specific - birth-24 months.</p> <p>V20.2: Routine infant or child health check, which includes routine vision and hearing testing.</p> <p>NOTE: Necessary follow-up care related to screening test is treatment.</p> <p>389.0x: conductive hearing loss 389.1x: sensorineural hearing loss 389.2: mixed conductive and sensorineural hearing loss 389.7: deaf mutism, not elsewhere classified 389.8: other specified forms of hearing loss 389.9: unspecified hearing loss</p>	

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<p>CHILDREN – IMMUNIZATIONS: TIC §1367.053; 28 TAC §11.508(a)(1)(H)</p>	<p>Any health benefit plan that provides benefits for a family member of the enrollee must provide coverage for each covered child from birth through the date the child is six years old for:</p> <p>(1) immunization against diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; and rotovirus; and</p> <p>(2) any other immunization that is required by law for the child.</p> <p>Immunizations may not be subject to a deductible or copayment requirement.</p> <p>NOTE: Immunizations required by law will be different throughout the state and each school district may have different requirements.</p>		<p>90471 90472 (use in conjunction with 90471) 90473 90474 (use in conjunction with 90473) 90645-90648 90700-90703 90704-90710 90712-90713 90716 90719 90720 90721 90723 90744 90748 90680</p> <p>NOTE: Codes 90471-90474 must be reported in addition to code(s) 90476-90749.</p>
<p>CHILDREN – RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES IN A CHILD: TIC §1367.153</p>	<p>Any health benefit plan that provides benefits for a child who is younger than 18 years of age must define “reconstructive surgery for craniofacial abnormalities” in the EOC or policy to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.</p> <p>NOTE: Age specific to a child less than 18 years of age.</p>		<p>21076-21088 21089 21100 21110 21120-21123 21125-21127 21137-21139 21141-21147 21150-21151 21554-21560 21172 21175 21179-21180 21181 21182-21184 21188 21193-21196 21198-21199 21206 21208-21209 21210 + 21215 21230 + 21235 21244</p>

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CHILDREN – RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES IN A CHILD: CONTINUED			21245-21246 21247 21248-21249 21255 21256 21260-21263 21267-21268 21270 21275 21280 21282 21295-21296 21299 62115-62117 62140-62141 62142-62143 62145 62146-62147 67950
COLORECTAL CANCER TESTING: TIC Chapter 1363	<p>A health benefit plan that provides benefits for screening medical procedures must provide coverage, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. An insured must have the choice of at least one of the following:</p> <p>(1) a fecal occult blood test preformed annually and a flexible sigmoidoscopy performed every five years, or</p> <p>(2) a colonoscopy performed every 10 years.</p> <p>Note: Age specific to an enrollee 50 years of age or older.</p>	V10.0: personal history of malignant neoplasm, gastrointestinal tract V12.72: personal history of colonic polyps V16.0: family history of malignant neoplasm, gastrointestinal tract V76.5: special screening for malignant neoplasms, intestine V76.41: special screening for malignant neoplasms, rectum	45378 45380 45330 45331 82270

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<p>DIABETES CARE, SUPPLIES, AND SERVICES: TIC Chapter 1358; 28 TAC §§11.508(b)(3) and 21.2601 - 21.2606</p>	<p>In accordance with TIC Chapter 1358, health benefit plans must provide coverage for:</p> <p><u>Diabetes equipment</u> – blood glucose monitors, insulin pumps and associated appurtenances, insulin infusion devices, and podiatric appliances for the prevention of diabetes complications.</p> <p><u>Diabetes supplies</u> – test strips for glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescription and nonprescription oral agents for controlling blood sugar levels, and glucagon emergency kits.</p> <p><u>Diabetes self-management training</u> – provided by a licensed health care provider as described in TIC §1358.055.</p> <p><u>New or improved equipment and supplies</u> – improved diabetes equipment or supplies, including improved insulin or another prescription drug, approved by the U.S. Food and Drug Administration if the equipment or supplies are determined by a physician or other health care practitioner to be medically necessary and appropriate.</p> <p>Coverage must be provided in accordance with the standards adopted under 28 TAC §§21.2601 - 21.2607.</p>	<p>250.xx: diabetes mellitus (excluding 250.3x: diabetic coma)</p>	<p>99078 99071</p> <p>NOTE: Glucose monitors, test strips, needles, syringes, and other diabetic equipment may not be captured on claims forms. Rather, these expenses may be calculated through a PBM or retail pharmacy.</p>
<p>HIV OR AIDS RELATED ILLNESSES: TIC §§1202.052, 1364.001 - 1364.053, 1364.101, 1551.205, and 1601.109</p>	<p>A health benefit plan may not exclude, deny, or cancel coverage for HIV, AIDS, or HIV-related illnesses.</p>	<p>042: HIV infection type 1 (including AIDS) 079.53: HIV type 2 V08: asymptomatic HIV infection status 136.3: pneumocystosis 795.71: nonspecific serologic evidence of HIV</p>	
<p>IN VITRO FERTILIZATION: TIC §§1366.003 – 1366.004; 28 TAC §11.510(1)</p>	<p>A health benefit plan that provides coverage for pregnancy-related procedures must offer and, unless rejected in writing by the group contract holder, make available coverage for outpatient expenses that may arise from in vitro fertilization procedures.</p>	<p>628.x: infertility, female</p>	<p>89250</p>

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LOSS OR IMPAIRMENT OF SPEECH OR HEARING: TIC Chapter 1365; 28 TAC §11.510(2)	A health benefit plan shall offer, and the group contract holder shall have the right to reject, coverage for the necessary care and treatment of loss or impairment of speech or hearing that is not less favorable than for physical illness generally. The group contract holder may select an alternative level of coverage if the plan offers such coverage.	V72.1: examination of ears and hearing	92507-92510 69930 69710 Audiologic Function Tests with Medical Diagnostic Evaluation (All descriptors refer to testing both ears. Modifier -52 can be used if a test is applied to one ear only.) 92551-92553 92555-92557 92559-92565 92567-92569 92571-92573 92575-92577 92579 92582-92599
LOW DOSE MAMMOGRAPHY CANCER SCREENING: TIC §1356.005; 28 TAC §11.508(a)(1)(H)	A health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer. Required under basic care/well woman exam.	V76.11: screening mammogram for high-risk patient V76.12: other screening mammogram	76092
OSTEOPOROSIS – DETECTION AND PREVENTION: TIC Chapter 1361; 28 TAC §11.509(4)	Any health benefit plan that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness must provide coverage to qualified enrollees for medically accepted bone mass measurement to determine the enrollee’s risk of osteoporosis and fractures associated with osteoporosis. (Group coverage only; requires strict qualifications).	V82.81: osteoporosis screening	
PKU FORMULAS: TIC Chapter 1359	Any health benefit plan that provides benefits for prescription drugs must include formulas for treatment of phenylketonuria (PKU) or other heritable diseases. NOTE: Only report claims paid for the cost of nutritional formulas required by those with PKU or other heritable diseases that require special nutritional formulas. Do not include claims for the evaluation and treatment of patients as a cost related to this mandated benefit.	270.1: PKU	

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PRESCRIPTION CONTRACEPTIVE DRUGS AND DEVICES AND RELATED SERVICES: TIC §1369.104; 28 TAC §21.404	A health benefit plan must provide benefits for oral contraceptives when all other prescription drugs are provided.		
PROSTATE CANCER TESTING: TIC §1362.003	Any health benefit plan that provides benefits for diagnostic medical procedures must provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer. Minimum benefits must include: (1) a physical examination for the detection of prostate cancer; and (2) a prostate specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is at least 50 years of age and asymptomatic; or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.		84152-84154 NOTE: The TIC has age specifications of 50 for all males and 40 for males with a family history.
PSYCHIATRIC DAY TREATMENT: TIC Chapter 1355, Subchapter C; 28 TAC §§11.509(5) and §11.510(3)	A health benefit plan that provides benefits for treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Determination of benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or in-patient program. On rejection of mandated benefits, the plan must offer and the enrollee can select an alternative level of benefits; however, any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in hospital facilities.	This benefit refers to either intensive outpatient (IOP) or partial hospitalization in either a free standing psychiatric facility or an acute care hospital with a day psychiatric program. Treatment would be rendered in two to eight hours, so note the admission and discharge fields on the claims forms in order to gather this data. Further, treatment for mental, emotional, or nervous disorders that may be covered in this setting could include a vast list of diagnosis codes, including all codes for serious mental illness.	

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RECONSTRUCTIVE SURGERY INCIDENT TO A MASTECTOMY: TIC §§1357.003 and 1357.004; 28 TAC §11.508(b)(1)	<p>Any EOC or policy that provides benefits for mastectomy must provide coverage for:</p> <p>(1) reconstruction of the breast on which the mastectomy has been performed;</p> <p>(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and</p> <p>(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.</p> <p>The coverage may be subject to copayments that are consistent with other benefits under the EOC or policy.</p>	174.x: malignant neoplasm of female breast 175.x: malignant neoplasm of male breast V10.3: personal history of malignant neoplasm of breast	19318 19324-19325 19340 19342 19350 19357 19361 19364 19366 19367-19368 19369 19380 19396
SERIOUS MENTAL ILLNESS: 45/60 (SMALL EMPLOYER) OR FULL PARITY (LARGE EMPLOYER) TIC §§1355.004, 1355.151, 1551.205, and 1601.109; 28 TAC §11.509(5)	<p>A group health benefit plan:</p> <p>(a) must provide coverage for 45 days of inpatient treatment and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year;</p> <p>(b) may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and</p> <p>(c) must include the same amount limits and deductibles for serious mental illness as for physical illness.</p> <p>Small employer carriers must offer coverage for serious mental illness to small employers.</p> <p>Large employers (more than 50 employees) must provide coverage for serious mental illness, and are subject to federal parity requirements, which may require treatment coverage in excess of the 45/60 requirement.</p>	293.81-293.83: organic delusional, hallucinosis, and affective syndromes 295.xx: schizophrenic disorders (xx=modifiers defining specific types of schizophrenia) 296.xx: depressive & bipolar disorders 297.xx: paranoid states (delusional disorders) 298.xx: other non-organic psychoses 299.xx: pervasive developmental disorders 300.4: neurotic depression 301.13: cyclothymic disorder 311: depressive disorder not elsewhere classified	

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<p>TELEMEDICINE / TELEHEALTH: TIC §1455.004; 28 TAC §11.1607</p>	<p>A health benefit plan may not exclude a telemedicine medical service or a telehealth service from coverage solely because the service is not provided through a face-to-face consultation. Telemedicine medical services and telehealth services may be subject to a deductible or copayment requirement; however, the deductible or copayment may not exceed the amount that is required for a comparable medical service when provided through a face-to-face consultation.</p> <p>NOTE: Telemedicine/telehealth services could be used to diagnose/treat almost any diagnosis.</p>		<p>Commercial plans must develop a method for specifically identifying claims for telemedicine/telehealth services. This may involve a review of multiple claim data fields.</p> <p>The following information describes how telemedicine services are reimbursed for Texas Medicaid providers and may be helpful for identifying commercial claims:</p> <p>All codes with a prefix modifier of GT (for General Telemedicine or live telemedicine) or GS for store forward (taping a telemedicine encounter and sending it at a later date).</p> <p>Hub site providers may only be reimbursed for consultations via interactive video using procedure codes 3-99241 through 3-99275 billed with the GT modifier.</p> <p>A health benefit plan may reimburse remote site providers for an office visit (POS1) using codes 1-99201 through 1-99215 or encounter codes in POS1 or 5 as applicable, 1-Z9813 (Federally Qualified Health Center), 1-Z9202 (Rural Health Clinic), 1-Z9100 (Rural Health Clinic), 9-Y0011 (Rural Health Clinic), and B-W0004 (Rural Health Clinic).</p> <p>If prolonged physician services 1-99354 and 1-99355 or special services 1-99050, 1-99052, and 1-99054 are provided in addition to a telemedicine office visit (1-99201 through 1-99215), these services should also be billed with the GT modifier.</p>

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TMJ TREATMENT: TIC §1360.004; 28 TAC §11.509(6)	Any health benefit plan that provides benefits for diagnostic or surgical treatment of skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint that is necessary due to: <ul style="list-style-type: none"> (1) an accident; (2) a trauma; (3) a congenital defect; (4) a developmental defect; or (5) a pathology. 	524.6x: temporomandibular joint disorders 830.0-830.1: dislocation of jaw including temporomandibular joint 848.1: other and ill-defined sprains and strains jaw, temporomandibular (joint)	21010 21050 21060 21116 + 70332 21240 21242 21243 21480 + 21285 21490 + 21497 21141-21147 21150-21151 21154-21160