TEXAS INSIGHT
HEALTHCARE INTELLIGENCE

Health and Human Services

Proposed Medicaid Payment Rates for Healthcare Common Procedure Coding System (HCPCS) Reviews

March 3, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

Hearing. The Texas Health and Human Services Commission (HHSC) conducted a public hearing to receive public comments on proposed Medicaid payment rates for Healthcare Common Procedure Coding System (HCPCS) Updates.

HHSC held the hearing under state statutes/rules to receive public comment on proposed Medicaid fee-for-service payment rates; the hearing was available both online and in person and was recorded. Rate hearing packets were posted on the HHSC Provider Finance site (pfd.hhs.texas.gov/rate-packets); topics were announced in the Texas Register on Feb 6, 2026 and packets posted Feb 19, 2026 with a GovDelivery notice. Testimony was required to stay focused on reimbursement/payment rates in the posted packets; off-topic input was directed to be submitted by email for later consideration.

Background HHSC is responsible for the reimbursement determination functions for the Texas Medicaid Program. Proposed rates are calculated utilizing established methodologies that conform to the Social Security Act and related federal regulations, the federally approved Texas Medicaid State Plan, all applicable state statutes and rules, and other requirements. HHSC reviews the Medicaid reimbursement rates for all acute care services every two years. These biennial reviews result in rates that are increased, decreased, or remain the same. The reviews are conducted to ensure that rates continue to be based on established rate methodologies.

Rate Details: 1-1-2026-policy-hcpcs-att.zip. Proposed to be effective January 01, 2026: Annual HCPCS Updates

Physician Administered Drugs – Type of Service (TOS) 1 (Medical Services);

HCPCS Attachment A(1) - TOS 1 Drugs (Proposed to be effective January 1, 2026)

					CURRENT		1/1/2026		
TOS*	Procedure Code	Long Description	Age Range	Non-Facility (N)/ Facility (F)	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	Percent Change from Current Medicaid Fee
1	91323	**	0-999	N/F	$201.91	$201.91	$201.91	$201.91	0.00%

*Type of Service (TOS)	
1	Medical Services

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Non-Drugs – TOS 1;

HCPCS Attachment A(2) - TOS 1 Non-Drugs (Proposed to be effective January 1, 2026)

						CURRENT		1/1/2026		
TOS*	Procedure Code	Long Description	Modifier 1	Age Range	Non-Facility (N)/ Facility (F)	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	Percent Change from Current Medicaid Fee
1	91124	**		0-20	N/F	$646.39	$646.39	$646.39	$646.39	0.00%
1	91124	**		21-999	N/F	$615.60	$615.60	$615.60	$615.60	0.00%
1	91125	**		0-20	N/F	$292.18	$292.18	$292.18	$292.18	0.00%
1	91125	**		21-999	N/F	$278.26	$278.26	$278.26	$278.26	0.00%
1	92628	**		0-999	N/F	$21.68	$21.68	$21.68	$21.68	0.00%
1	92629	**		0-999	N/F	$10.84	$10.84	$10.84	$10.84	0.00%
1	92631	**		0-999	N/F	$21.68	$21.68	$21.68	$21.68	0.00%
1	92632	**		0-999	N/F	$10.84	$10.84	$10.84	$10.84	0.00%
1	92634	**		0-20	N	$122.37	$122.37	$122.37	$122.37	0.00%
1	92634	**		0-20	F	$80.55	$80.55	$80.55	$80.55	0.00%
1	92634	**		21-999	N	$116.54	$116.54	$116.54	$116.54	0.00%
1	92634	**		21-999	F	$76.72	$76.72	$76.72	$76.72	0.00%
1	92635	**		0-20	N	$30.59	$30.59	$30.59	$30.59	0.00%
1	92635	**		0-20	F	$20.14	$20.14	$20.14	$20.14	0.00%
1	92635	**		21-999	N	$29.14	$29.14	$29.14	$29.14	0.00%
1	92635	**		21-999	F	$19.18	$19.18	$19.18	$19.18	0.00%
1	92636	**		0-999	N/F	$11.97	$11.97	$11.97	$11.97	0.00%
1	92637	**		0-999	N/F	$5.99	$5.99	$5.99	$5.99	0.00%
1	92638	**		0-999	N/F	$23.94	$23.94	$23.94	$23.94	0.00%
1	92639	**		0-999	N/F	$23.94	$23.94	$23.94	$23.94	0.00%
1	92639	**	52	0-999	N/F	$11.97	$11.97	$11.97	$11.97	0.00%
1	92641	**		0-999	N/F	$27.45	$27.45	$27.45	$27.45	0.00%
1	92641	**	52	0-999	N/F	$13.73	$13.73	$13.73	$13.73	0.00%

*Type of Service (TOS)	
1	Medical Services
Modifier	
52	Unilateral Procedure

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Surgery Services – TOS 2 (Surgery Services), and TOS 8 (Assistant Surgery);
Because of the file size, please follow the link above for rate details

Radiological Services – TOS 4 (Radiology), TOS I (Professional Component), and TOS T (Technical Component);

HCPCS A(4a) -TOS 4- Rural (Proposed to be effective January 1, 2026)

							CURRENT		1/1/2026		
TOS*	Procedure Code	Long Description	Modifier	Age Range	Non-Facility (N)/ Facility (F)	Provider Type/ Provider Specialty	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	Percent Change from Current Medicaid Fee
4	70471	**	RHMG	0-999	F	HOSP	$449.10	$449.10	$449.10	$449.10	0.00%
4	70472	**	RHMG	0-999	F	HOSP	$220.58	$220.58	$220.58	$220.58	0.00%
4	70473	**	RHMG	0-999	F	HOSP	$225.79	$225.79	$225.79	$225.79	0.00%

*Type of Service (TOS)	
4	Radiology
Modifier	
RHMG	Rural Hospital Modifier Group
Provider Type	
HOSP	Hospital

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HCPCS A(4b) -TOS 4- Non-Rural (Proposed to be effective January 1, 2026)

						CURRENT		1/1/2026		
TOS*	Procedure Code	Long Description	Age Range	Non-Facility (N)/ Facility (F)	Provider Type/ Provider Specialty	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	Percent Change from Current Medicaid Fee
4	70471	**	0-999	F	HOSP	$356.43	$356.43	$356.43	$356.43	0.00%
4	70472	**	0-999	F	HOSP	$152.36	$152.36	$152.36	$152.36	0.00%
4	70473	**	0-999	F	HOSP	$179.20	$179.20	$179.20	$179.20	0.00%

*Type of Service (TOS)	
4	Radiology
Provider Type	
HOSP	Hospital

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HCPCS A(5) -TOS 4-I-T (Proposed to be effective January 1, 2026)

					CURRENT		1/1/2026		Percent Change from Current Medicaid Fee
TOS*	Procedure Code	Long Description	Age Range	Non-Facility (N)/ Facility (F)	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	
4	70471	**	0-20	N/F	$316.60	$316.60	$316.60	$316.60	0.00%
4	70471	**	21-999	N/F	$301.52	$301.52	$301.52	$301.52	0.00%
I	70471	**	0-20	N/F	$99.36	$99.36	$99.36	$99.36	0.00%
I	70471	**	21-999	N/F	$94.63	$94.63	$94.63	$94.63	0.00%
T	70471	**	0-20	N/F	$217.24	$217.24	$217.24	$217.24	0.00%
T	70471	**	21-999	N/F	$206.89	$206.89	$206.89	$206.89	0.00%
4	70472	**	0-20	N/F	$131.35	$131.35	$131.35	$131.35	0.00%
4	70472	**	21-999	N/F	$125.10	$125.10	$125.10	$125.10	0.00%
I	70472	**	0-20	N/F	$30.59	$30.59	$30.59	$30.59	0.00%
I	70472	**	21-999	N/F	$29.14	$29.14	$29.14	$29.14	0.00%
T	70472	**	0-20	N/F	$100.76	$100.76	$100.76	$100.76	0.00%
T	70472	**	21-999	N/F	$95.96	$95.96	$95.96	$95.96	0.00%
4	70473	**	0-20	N/F	$202.65	$202.65	$202.65	$202.65	0.00%
4	70473	**	21-999	N/F	$192.99	$192.99	$192.99	$192.99	0.00%
I	70473	**	0-20	N/F	$39.86	$39.86	$39.86	$39.86	0.00%
I	70473	**	21-999	N/F	$37.96	$37.96	$37.96	$37.96	0.00%
T	70473	**	0-20	N/F	$162.79	$162.79	$162.79	$162.79	0.00%
T	70473	**	21-999	N/F	$155.03	$155.03	$155.03	$155.03	0.00%
4	75577	**	0-20	N/F	$850.44	$850.44	$850.44	$850.44	0.00%
4	75577	**	21-999	N/F	$809.93	$809.93	$809.93	$809.93	0.00%
I	75577	**	0-20	N/F	$34.80	$34.80	$34.80	$34.80	0.00%
I	75577	**	21-999	N/F	$33.15	$33.15	$33.15	$33.15	0.00%
T	75577	**	0-20	N/F	$815.63	$815.63	$815.63	$815.63	0.00%
T	75577	**	21-999	N/F	$776.78	$776.78	$776.78	$776.78	0.00%

*Type of Service (TOS)	
4	Radiology
I	Professional Component
T	Technical Component

Clinical Diagnostic Laboratory Services – TOS 5 (Laboratory);

HCPCS Attachment A(6) - TOS 5 (Proposed to be effective January 1, 2026)

				CURRENT				1/1/2026							
TOS*	Procedure Code	Age Range	Non-Facility (N)/Facility (F)	Current Non-State Clinical Lab Fee	Current Sole Community Lab Fee	Current DSHS Clinical Lab Fee	Current Rural Hospital Rural Sole Community Fee	Proposed Non-State Clinical Lab Fee	Proposed Sole Community Lab Fee	Proposed DSHS Clinical Lab Fee	Proposed Rural Hospital and Sole Community Fee	Percent Change from Current - Adjusted Non-State Clinical Lab Fee	Percent Change from Current - Adjusted Sole Community Lab Fee	Percent Change from Current - DSHS Clinical Lab Fee	Percent Change from Current - Rural Hospital and Sole Community Fee
5	87182	0-999	N/F	$3.99	$6.51	$5.13	$6.51	$3.99	$6.51	$5.13	$6.51	0.00%	0.00%	0.00%	0.00%
5	87494	0-999	N/F	$58.97	$96.17	$75.82	$96.17	$58.97	$96.17	$75.82	$96.17	0.00%	0.00%	0.00%	0.00%
5	87627	0-999	N/F	$350.10	$570.99	$450.12	$570.99	$350.10	$570.99	$450.12	$570.99	0.00%	0.00%	0.00%	0.00%
5	87812	0-999	N/F	$34.76	$56.69	$44.69	$56.69	$34.76	$56.69	$44.69	$56.69	0.00%	0.00%	0.00%	0.00%

*Type of Service (TOS)	
5	Laboratory

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Radiation Therapy – TOS 6 (Radiation Therapy), TOS I (Professional Component), TOS T (Technical Component);

HCPCS Attachment A(7) - TOS 6-I-T (Proposed to be effective January 1, 2026)

					CURRENT		1/1/2026		
TOS*	Procedure Code	Long Description	Age Range	Non-Facility (N)/ Facility (F)	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	Percent Change from Current Medicaid Fee
6	77436	**	0-20	N/F	$65.96	$65.96	$65.96	$65.96	0.00%
6	77436	**	21-999	N/F	$62.82	$62.82	$62.82	$62.82	0.00%
I	77436	**	0-20	N/F	$35.08	$35.08	$35.08	$35.08	0.00%
I	77436	**	21-999	N/F	$33.41	$33.41	$33.41	$33.41	0.00%
T	77436	**	0-20	N/F	$30.88	$30.88	$30.88	$30.88	0.00%
T	77436	**	21-999	N/F	$29.41	$29.41	$29.41	$29.41	0.00%
6	77437	**	0-20	N/F	$92.06	$92.06	$92.06	$92.06	0.00%
6	77437	**	21-999	N/F	$87.68	$87.68	$87.68	$87.68	0.00%
6	77438	**	0-20	N/F	$92.90	$92.90	$92.90	$92.90	0.00%
6	77438	**	21-999	N/F	$88.48	$88.48	$88.48	$88.48	0.00%
6	77439	**	0-20	N/F	$13.47	$13.47	$13.47	$13.47	0.00%
6	77439	**	21-999	N/F	$12.83	$12.83	$12.83	$12.83	0.00%
I	77439	**	0-20	N/F	$13.47	$13.47	$13.47	$13.47	0.00%
I	77439	**	21-999	N/F	$12.83	$12.83	$12.83	$12.83	0.00%

*Type of Service (TOS)	
6	Radiation Therapy
I	Professional Component
T	Technical Component

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Durable Medical Equipment, Prosthetics, Orthotics, and Supplies –

TOS 9 (Other Medical Items or Services), TOS J (DME Purchase-New), and TOS L (DME Rental-Monthly)

HCPCS Attachment A(8) - TOS 9-J-L (Proposed to be effective January 1, 2026)

					CURRENT		1/1/2026		
TOS*	Procedure Code	Long Description	Age Range	Non-Facility (N)/ Facility (F)	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	Percent Change from Current Medicaid Fee
9	A4295	**	0-999	2	$1.81	$1.81	$1.81	$1.81	0.00%
9	A4296	**	0-999	2	$5.07	$5.07	$5.07	$5.07	0.00%
J	C1607	**	0-999	2	$14,096.73	$14,096.73	$14,096.73	$14,096.73	0.00%
9	C1742	**	0-999	2	$7,480.40	$7,480.40	$7,480.40	$7,480.40	0.00%

*Type of Service (TOS)	
9	Other Medical items or services
J	DME Purchase-New

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Ambulatory Surgical Center-TOS F (Ambulatory Surgical Center); and

HCPCS A(9) -TOS F (Proposed to be effective January 1, 2026)

						CURRENT		1/1/2026		Percent Change from Current Medicaid Fee
TOS*	Procedure Code	Long Description	Age Range	Non-Facility (N)/ Facility (F)	Provider Type/ Provider Specialty	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	
F	27458	**	0-20	F	51,52	$3,745.83	$3,745.83	$3,745.83	$3,745.83	0.00%
F	27458	**	21-999	F	51,52	$3,745.83	$3,745.83	$3,745.83	$3,745.83	0.00%
F	27713	**	0-20	F	51,52	$3,745.83	$3,745.83	$3,745.83	$3,745.83	0.00%
F	27713	**	21-999	F	51,52	$3,745.83	$3,745.83	$3,745.83	$3,745.83	0.00%
F	37254	**	0-999	F	51,52	$2,869.66	$2,869.66	$2,869.66	$2,869.66	0.00%
F	37256	**	0-999	F	51,52	$2,869.66	$2,869.66	$2,869.66	$2,869.66	0.00%
F	37258	**	0-999	F	51,52	$6,132.14	$6,132.14	$6,132.14	$6,132.14	0.00%
F	37260	**	0-999	F	51,52	$6,132.14	$6,132.14	$6,132.14	$6,132.14	0.00%
F	37263	**	0-999	F	51,52	$3,036.54	$3,036.54	$3,036.54	$3,036.54	0.00%
F	37265	**	0-999	F	51,52	$3,036.54	$3,036.54	$3,036.54	$3,036.54	0.00%
F	37267	**	0-999	F	51,52	$6,452.54	$6,452.54	$6,452.54	$6,452.54	0.00%
F	37269	**	0-999	F	51,52	$6,452.54	$6,452.54	$6,452.54	$6,452.54	0.00%
F	37271	**	0-999	F	51,52	$10,479.62	$10,479.62	$10,479.62	$10,479.62	0.00%
F	37273	**	0-999	F	51,52	$10,479.62	$10,479.62	$10,479.62	$10,479.62	0.00%
F	37275	**	0-999	F	51,52	$10,564.28	$10,564.28	$10,564.28	$10,564.28	0.00%
F	37277	**	0-999	F	51,52	$10,564.28	$10,564.28	$10,564.28	$10,564.28	0.00%
F	37280	**	0-999	F	51,52	$5,662.36	$5,662.36	$5,662.36	$5,662.36	0.00%
F	37282	**	0-999	F	51,52	$5,662.36	$5,662.36	$5,662.36	$5,662.36	0.00%
F	37284	**	0-999	F	51,52	$9,765.66	$9,765.66	$9,765.66	$9,765.66	0.00%
F	37286	**	0-999	F	51,52	$9,765.66	$9,765.66	$9,765.66	$9,765.66	0.00%
F	37288	**	0-999	F	51,52	$9,898.27	$9,898.27	$9,898.27	$9,898.27	0.00%
F	37290	**	0-999	F	51,52	$9,898.27	$9,898.27	$9,898.27	$9,898.27	0.00%
F	37292	**	0-999	F	51,52	$10,320.97	$10,320.97	$10,320.97	$10,320.97	0.00%
F	37294	**	0-999	F	51,52	$10,320.97	$10,320.97	$10,320.97	$10,320.97	0.00%
F	37296	**	0-999	F	51,52	$5,662.36	$5,662.36	$5,662.36	$5,662.36	0.00%
F	37298	**	0-999	F	51,52	$5,662.36	$5,662.36	$5,662.36	$5,662.36	0.00%
F	52597	**	0-999	F	51,52	$5,559.85	$5,559.85	$5,559.85	$5,559.85	0.00%
F	55707	**	0-999	F	51,52	$1,378.42	$1,378.42	$1,378.42	$1,378.42	0.00%
F	55708	**	0-999	F	51,52	$44,566.40	$44,566.40	$44,566.40	$44,566.40	0.00%
F	55709	**	0-999	F	51,52	$1,378.42	$1,378.42	$1,378.42	$1,378.42	0.00%
F	55710	**	0-999	F	51,52	$1,378.42	$1,378.42	$1,378.42	$1,378.42	0.00%
F	55711	**	0-999	F	51,52	$1,378.42	$1,378.42	$1,378.42	$1,378.42	0.00%
F	55712	**	0-999	F	51,52	$1,378.42	$1,378.42	$1,378.42	$1,378.42	0.00%
F	55713	**	0-999	F	51,52	$2,183.73	$2,183.73	$2,183.73	$2,183.73	0.00%
F	55714	**	0-999	F	51,52	$2,183.73	$2,183.73	$2,183.73	$2,183.73	0.00%
F	64728	**	0-999	F	51,52	$961.57	$961.57	$961.57	$961.57	0.00%
F	92930	**	0-20	F	51,52	$10,273.60	$10,273.60	$10,273.60	$10,273.60	0.00%
F	92930	**	21-999	F	51,52	$10,273.60	$10,273.60	$10,273.60	$10,273.60	0.00%
F	92945	**	0-20	F	51,52	$5,950.65	$5,950.65	$5,950.65	$5,950.65	0.00%
F	92945	**	21-999	F	51,52	$5,950.65	$5,950.65	$5,950.65	$5,950.65	0.00%

*Type of Service (TOS)	
F	Ambulatory Surgical Center
Provider Type	
51	Ambulatory Surgical Center - Freestanding/Independent
52	Ambulatory Surgical Center - Hospital Based

Texas Healthy Steps Dental/Orthodontia-TOS W (Dental/Orthodontia)

HCPCS Attachment A(10) - TOS W (Proposed to be effective January 1, 2026)

					CURRENT		1/1/2026		Percent Change from Current Medicaid Fee
TOS*	Procedure Code	Long Description	Age Range	Non-Facility (N)/ Facility (F)	Current Medicaid Fee	Current Adjusted Medicaid Fee	Proposed Medicaid Fee	Proposed Adjusted Medicaid Fee	
W	D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	0-999	N/F	$6.69	$6.69	$6.69	$6.69	0.00%
W	D9224	Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	0-999	N/F	$58.50	$58.50	$58.50	$58.50	0.00%
W	D9225	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	0-999	N/F	$43.88	$43.88	$43.88	$43.88	0.00%
W	D9244	In-office administration of minimal sedation – single drug – enteral	0-999	N	$128.52	$128.52	$128.52	$128.52	0.00%
W	D9245	Administration of moderate sedation – enteral	0-999	N	$128.52	$128.52	$128.52	$128.52	0.00%
W	D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	0-999	N/F	$57.04	$57.04	$57.04	$57.04	0.00%
W	D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	0-999	N	$45.11	$45.11	$45.11	$45.11	0.00%

*Type of Service (TOS)	
W	THSTEPS Dental/ Orthodontia

** Required Notice: The five-character code included in this notice is obtained from the Current Procedural Terminology (CPT®), copyright 2026 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of this notice is with HHSC and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this notice. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained.

Discussion/Testimony

Jerome Heaton, Texas Society of Dentist Anesthesiologists TXDSA | Texas Dental Society of Anesthesiology. requested HHSC apply the existing UZ modifier policy for dentist-anesthesiologist delivered general anesthesia to new CDT codes for general anesthesia with advanced airway. Heaton cited a prior (spring 2025) HHSC Provider Finance analysis indicating ~$135/unit was appropriate, versus a current proposal of ~$43/unit (described as a 67% reduction), and argued the lower rate is not sustainable (staffing, equipment, insurance, and travel for mobile anesthesia—sometimes 10 hours and a week away). Heaton emphasized dentist anesthesiologists provide hospital-level anesthesia in community dental offices for children with severe infections/early childhood caries and patients with intellectual/developmental disabilities, reducing hospital utilization and avoiding hospital facility fees (~$1,377.94 per case), describing savings of ~$1,400+ per case. Heaton also compared other states' payment levels (examples given: South Carolina $263/unit; Michigan $150/unit; Oregon $800 flat per case; California $122.50; Montana ~$1,200 per case for travel) to support a higher Texas rate.

General Anesthesiology with Advanced Airway
In general anesthesiology, advanced airway management is crucial for ensuring patient safety and effective anesthesia delivery. It involves the use of various tools and techniques to maintain a clear airway, which is essential for the patient's safety and the success of the anesthetic procedure. Here are some key points regarding advanced airway management in general anesthesiology:

Intubation: An endotracheal tube (ET tube) is inserted into the trachea to maintain a direct route for oxygen and anesthetic gases. This procedure is performed after the patient is rendered unconscious and is guided by a laryngoscope to visualize the airway.

Supraglottic Airway (SGA): The SGA is a device placed above the vocal cords to facilitate airway management. It is used in certain situations where intubation may be challenging or not feasible.

Mask Ventilation: Facemask ventilation is used to provide oxygen and anesthetics to the patient. It is a critical part of airway management and is used alongside intubation or SGA.

Difficult Airway Management: Patients with difficult airways may require additional supplies, manpower, or even "awake" intubation techniques. These strategies are developed based on preoperative assessments and patient predictors of airway difficulty.

Advanced airway management is a specialized skill set that anesthesiologists must master to provide safe and effective anesthesia care. Continuous education and training are essential for maintaining proficiency in this critical area of anesthesiology.

Dr. William Steinhouer, Pediatric Dentist, Texas Academy of Pediatric Dentistry. supported adoption of new anesthesia/sedation codes but stated proposed rates are inadequate and that the services are not new—older codes are being replaced by more specific codes. Steinhauer reported pediatric dentists' supply/labor costs are ~20% higher than five years ago and cited a member survey showing Medicaid pediatric dental patients wait ~3.5 months for OR access statewide. He requested increases for D9224 and D9225 to at least $134 (what was paid March 1 of the prior year) and D9245 to at least $154, arguing that splitting an old code into minimal vs moderate sedation should not pay the same rate given higher complexity, monitoring, drugs, training, and permitting needs for multi-drug moderate sedation. Steinhauer also asked HHSC to increase D9244 and D9247 to better reflect other states' reimbursement and warned specialists are considering leaving Medicaid. Home - Texas Academy of Pediatric Dentistry

Landon Groth, Maxwell Medical Services. Home - Maxwell Medical asked HHSC to preserve the 2015 distinction between coated and non-coated catheters established via the SC modifier on A4351, and to conserve the $3.65 rate tied to coated catheters. Groff stated A4295/96/97 were created by PDAC/Medicare to distinguish hydrophilic vs non-coated catheters and do not replace A4351/A4352/A4353; he requested a hearing on A4297 (hydrophilic closed system catheter) and review of A4296 for an increase. Groff noted A4352/A4353 rates were set in 1997 with no inflation adjustment; he estimated inflation-adjusted rates of $10.25 for A4296 and $13.45 for A4297, and described the independence/UTI-prevention benefits of newer hydrophilic catheters, especially for users with limited dexterity.

Roseanne Gonzales, (inaudible) stressed urological catheters are critical for independence and health for children and adults with spina bifida; she argued more innovative (more costly) catheters improve compliance and reduce kidney/bladder infections. Gonzalez shared that catheter "fit" and discretion (not looking overly medical for school use) affect adherence; poor fit/reluctance can lead to infections.

Peyton Stevens Texas Speech Language and Hearing Association ceded her time to her colleague.

Paul Kennedy, Pediatric Dentist, Texas Dental Association Texas Dental Association | American Dental Association urged HHSC to increase rates for dental sedation / anesthesia, stressing these services are medically necessary for many children (age, trauma history, special healthcare needs, extent of disease). Kennedy referenced the elimination of D9248 and HHSC's role in setting new rates for D9244–D9247 and D9224–D9225, stating rates should reflect clinical complexity, regulatory burden, staffing/equipment costs, and inflation; he warned inadequate rates would lead to dentists limiting/discontinuing Medicaid sedation services and increased ER use/costs.

Victoria Peterson catheter service provider requested HHSC crosswalk the historical SC-modifier coated catheter rate ($3.65) to A4295 to preserve the long-standing coated vs standard distinction (she cited $3.65 coated vs $1.81 standard). Peterson requested A4296 be set higher than A4295 to reflect both hydrophilic coating and design complexity; she cited A4352's current rate ($5.07) as unchanged since 1997. Peterson warned inadequate reimbursement forces dispensing at a loss and contributes to providers exiting the market; she cited significant supplier contraction (about 44% of providers going out of business) and noted rural access risk.

A hydrophilic catheter is a step up from standard uncoated catheter technology. This type of urinary catheter features hydrophilic technology, meaning it attracts water molecules. In other words, this technology binds with water to create its own catheter lubrication.

Unlike standard straight catheters, which have to be manually lubricated with separate gel lubrication from a tube or packet, hydrophilic catheters become slippery and smooth throughout insertion and withdrawal.

Sarah McAlexander, Texas Academy of Pediatric Audiology

Audiology Excellence & Education | Texas Academy of Audiology | Denton, TX. . objected to the proposed reimbursement for CPT 92636 (post-fitting hearing aid follow-up), stating $11.97 for a 30-minute visit is inadequate (implied <$24/hour) and does not cover professional time or clinic overhead. McAlexander also criticized the policy limiting post-fitting follow-up services (codes 92636/92637) to two visits per calendar year, stating it is not clinically appropriate for pediatric patients who need more frequent monitoring due to growth and changing acoustics.

Paul Effner, Simply Thick Easy to Mix Welcome to the store requested an increase for HCPCS B4100 (gel thickener) and/or using a U1 modifier approach similar to Arkansas; he stated infants and individuals under 21 with aspiration need thickener and that weight-based reimbursement can favor ineffective heavier products; he said supporting information was submitted electronically.

Jssica Speiro, Texas Hearing Institute addressed code 92636 and the new rate changes the rates and rules. The new 92636 rate ($11.97) is lower than prior hearing aid check codes (she cited prior bilateral 92593 at $23.94 and prior unilateral 92592 at $15.83) and raised concerns about time-based limits; her testimony was interrupted due to apparent technical disruption. It limits the patients to two visits of 30 minutes per year. For children, this is not enough and the reimbursement does not cover the costs. Texas Hearing Institute | Center for Hearing & Speech | Pediatric Audiologists

There were technical issues interrupting the meeting. Texas Insight rejoined the meeting after the technical issues were resolved. One speaker was not covered as a result.

Katy Strang, Texas Speech Language and Hearing Association TxSLHA addressed the newly developed codes modernizing evaluation. She commented on 12 newly created CPT codes (92628–92641) for hearing device-related professional services, appreciating modernization/time-based structure but urging higher reimbursement to reflect labor costs, regulatory/documentation requirements, and equipment (real ear verification systems estimated at $15k–$18k). They appreciate the new structure but feel the 12 codes/rates should be an increase that addresses the actual hourly rates. The rates do not cover the base rates for audiology. Strang specifically urged increasing 92636 (just under $12 for a 30-minute increment),

recommending at least double the previous payment assigned to V5014 (15-minute increment) or alignment with historical 92592/92593, and warned inadequate rates may harm access and Medicaid network adequacy.

Allissa Wilson, Sedadent Anesthesia Services. SedaDent Anesthesia**.** requested adding a UZ modifier to D9224 and D9225 for dentist anesthesiologists providing in-office general anesthesia, with reimbursement of $215 for D9224 and $185 per unit for D9225. Wilson contrasted surgery center costs (CPT 00170 ~ $273 plus facility payment ~$1,378 under G0330, totaling ~$1,650 per case) with proposed in-office reimbursement for a typical 75-minute case (~$234), arguing it would be unsustainable and would shift cases to higher-cost facilities. She proposed limiting UZ to residency-trained dentist anesthesiologists and only when not billed alongside G0330 in facility/hospital settings, stating Texas would still save ~ $700 per case compared to surgery center care.

Mark Gowen, Angle Medical commented on catheter codes A4295 and A4296 and supported previous testimony on these codes. He suggested the panel try the different catheters to compare them.

Angela Reese, 180 medical . Catheter Brands & Free Samples | Award-Winning Supplier. spoke on codes A4295 and A4296 and the hydrophilic catheter technology. She commented that the reimbursement does not reflect typical HHSC reimbursement methodology. Hydrophilic catheters are not interchangeable with standard catheters. She requested rate adjustment to address the costs of the different and new technology. She supported implementing new codes A4295 and A4296 but warned aligning them to the lower A4351 rate would be a de facto rate reduction and could reduce access for medically fragile beneficiaries; she urged maintaining the higher hydrophilic reimbursement differential