

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 26-03

Distribution: All Providers

Issued: January 22, 2026

Subject: Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Code Updates

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services, MI Coordinated Health (MICH) Program

This bulletin is to notify providers of CPT and HCPCS code changes being implemented by the Michigan Department of Health and Human Services (MDHHS). Effective dates are identified for each topic area. Note that this notice is distributed to a broad range of providers and not all, or any, of the codes listed may apply to their scope of practice.

Refer to HCPCS code books and the Centers for Medicare & Medicaid Services (CMS) website (www.cms.hhs.gov) for full descriptions of codes. Information regarding fee screens is maintained on the appropriate database or professional fee schedule on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information. Additional pertinent coverage parameters, such as age restrictions, prior authorization (PA) requirements, and other billing indicators, are accessible via the Medicaid Code and Rate Reference tool within the Community Health Automated Medicaid Processing System (CHAMPS) at <https://sso.state.mi.us> >> External Links >> Medicaid Code and Rate Reference.

A. COVERAGE OF NEW CODES ESTABLISHED JANUARY 1, 2026

Listed below are HCPCS codes being adopted by MDHHS for dates of service (DOS) on and after January 1, 2026, and the provider groups allowed to bill these codes. Any new procedure code not listed will not be covered at this time, except for reporting codes. Coding information is based on the most recent file from CMS. If additional code revisions are released by CMS, a subsequent bulletin will be published notifying providers of this change.

The symbol * will appear with those codes requiring PA.

Reporting codes (Category II codes and other select HCPCS codes) will be allowed for submission to Medicaid where appropriate. The codes are optional but can be used to complement Category I codes for clarification purposes. Reporting codes will not appear on the MDHHS fee schedule; however, a full list of current codes can be found at www.ama-assn.org/go/cpt.

1. Physicians, Practitioners, and Medical Clinics

27458	27713	33882	35602	37254	37255	37256
37257	37258	37259	37260	37261	37262	37263
37264	37265	37266	37267	37268	37269	37270
37271	37272	37273	37274	37275	37276	37277
37278	37279	37280	37281	37282	37283	37284
37285	37286	37287	37288	37289	37290	37291
37292	37293	37294	37295	37296	37297	37298
37299	43889*	47384	52443	52597	55707	55708
55709	55710	55711	55712	55713	55714	55715
55868	55869	55877	62330	62331	63032	64567
64654	64655	64656	64657	64658	64659	64728
70471	70472	70473	75577	77436	77437	77438
77439	87494	87812	90482	90483	90484	91124
91125	92930	92945	93145	93146	98979	99445
99470	G0571	J0013*	J0162	J0654	J1073	J1737
J1837	J2516	J2596	J2711	J3291	J3376	J3379
J3387*	J3389*	J9184	J9256*	J9282	J9326	Q4398
Q4399	Q4400	Q4401	Q4402	Q4403	Q4404	Q4405
Q4406	Q4407	Q4408	Q4409	Q4410	Q4411	Q4412
Q4413	Q4414	Q4415	Q4416	Q4417	Q4420	Q5160

2. Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC)

MDHHS aligns with Medicare guidelines for procedure codes covered through the OPPS/APC as closely as possible. Certain procedures billed by Outpatient Hospitals, Comprehensive Outpatient Rehabilitation Facilities, Rehabilitation Agencies, and Freestanding Dialysis Centers may represent packaged/bundled service codes. The costs for these services are allocated to the APC but are not paid separately. For services not paid under OPPS, MDHHS will utilize a Medicare fee schedule with the MDHHS reduction factor applied.

a. Wrap Around Codes

Codes covered differently than Medicare or specific to Michigan Medicaid services will be identified on the January 2026 version of the OPSS Wrap-Around Code List on the MDHHS website: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Outpatient Hospitals

3. Ambulatory Surgical Centers (ASC)

MDHHS aligns with Medicare guidelines for Medicaid-covered procedure codes covered through the Outpatient Ambulatory Prospective Payment System (OAPPS) as closely as possible. Certain procedures billed by ASCs may represent packaged/bundled service codes. The costs for these services are not paid separately. For ASC services paid as Medicare-certified ASC facilities, MDHHS will utilize a Medicare fee schedule with the MDHHS reduction factor applied.

a. Wrap Around Codes

Codes covered differently than Medicare or specific to Michigan Medicaid services will be identified on the January 2026 version of the ASC Code List on the MDHHS website: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Ambulatory Surgical Centers.

4. Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers

87494	87812	90482	90483	90484	98979	98984
98985	99445	99470	J0162	J2516	Q4398	Q4399
Q4400	Q4401	Q4402	Q4403	Q4404	Q4405	Q4406
Q4407	Q4408	Q4409	Q4410	Q4411	Q4412	Q4413
Q4414	Q4415	Q4416	Q4417	Q4420		

5. Local Health Department and Child and Adolescent Health Center & Programs

87494	87812	90482	90483	90484	J0162
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6. Certified Nurse Midwives

87494	87812	90482	90483	90484	98979	99445
99470	J0162					

7. Family Planning Clinic

87494	90482	90483	90484	J0162
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8. Podiatry

J0162	J3376	Q4398	Q4399	Q4400	Q4401	Q4402
Q4403	Q4404	Q4405	Q4406	Q4407	Q4408	Q4409
Q4410	Q4411	Q4412	Q4413	Q4414	Q4415	Q4416
Q4417	Q4420					

9. Oral/Maxillofacial Surgeons

70471	J0162	J3291	Q4398	Q4399	Q4400	Q4401
Q4402	Q4403	Q4404	Q4405	Q4406	Q4407	Q4408
Q4409	Q4410	Q4411	Q4412	Q4413	Q4414	Q4415
Q4416	Q4417	Q4420				

10. Urgent Care Centers

87494	87812	90482	90483	90484	J0162	
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11. Independent Diagnostic Testing Facility (IDTF)

55707	55708	55709	55710	55711	70471	70472
70473	75577	91124	91125	99445	99470	J0162

12. Laboratory Services

87182	87183	87494	87627	87812		
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13. Certified Registered Nurse Anesthetist (CRNA)

J0162	J2711					
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14. School Services Program

87812	92641					
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15. Occupational Therapists, Physical Therapists and Speech Language Pathologists

98979	98984	98985				
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16. CORF/CARF/Rehab Agency and CAA-Accredited Univ Grad Ed Program

92628	92629	92631	92632	92638	92639	92641
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17. Audiologist

92628	92629	92631	92632	92636	92637	92638
92639	92641					

18. Medical Suppliers, Orthotists, and Prosthetists and DIS Contract

A4295	A4296	A4297
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19. Hearing Aid Dealer

92631	92632	92636	92637	92638	92639
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20. MiDPP

G9871

21. Nursing Facilities

98979	98984	98985
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B. NEW COVERAGE OF EXISTING CODES

1. Effective for DOS on and after January 1, 2026, existing HCPCS codes will be activated for coverage as identified in the following provider categories:

a. Physicians, Practitioners, and Medical Clinic

15011	15012	15013	15014	15015	15016	15017
15018	J0681					

b. Laboratory Services

0421U

c. Oral/Maxillofacial Surgeons and Podiatry

15011	15012	15013	15014	15015	15016	15017
15018						

C. MEDICAID COVERAGE OF STAND-ALONE VACCINE COUNSELING

Effective for services provided on and after January 1, 2026, non-pharmacy providers should report CPT codes 90482-90484 for stand-alone vaccine counseling services when vaccines are not administered on the same DOS. These codes apply to counseling provided in person or via telehealth and require documentation of at least three minutes of counseling time. Refer to the [MDHHS Medicaid Provider Manual](#), Telemedicine Chapter,

for additional information for program coverage of telemedicine services. Medicaid coverage of HCPCS G0310-G0315, which were previously reported for stand-alone vaccine counseling, ended on December 31, 2025.

Vaccine counseling is a covered preventive service for all Medicaid beneficiaries. This includes stand-alone vaccine counseling which may be reported when a beneficiary and/or caregiver receives counseling from a health care provider about a vaccine but a vaccine is not administered on the same DOS as the counseling.

D. HEARING AID PROFESSIONAL SERVICE REPORTING CHANGES

The American Medical Association (AMA) has released a set of new procedure codes to describe hearing aid-related professional services that reflect current practice patterns and technology. Medicaid will be adopting the new codes related to hearing aid candidacy determination, selection, follow-up, verification, and electroacoustic analysis. To prevent billing duplication, Medicaid is no longer covering existing HCPCS codes V5011 (Fitting/Checking of a Hearing Aid) and V5020 (Conformity Evaluation) after December 31, 2025.

Effective for DOS on and after January 1, 2026, all hearing aid providers must report follow-up hearing aid fitting and checking services under CPT 92636 (Hearing aid post-fitting follow-up services, first 30 minutes) and CPT 92637 (Hearing aid post-fitting follow-up services, each additional 15 minutes), and conformity evaluation services under CPT 92638 (Behavioral verification of amplification) and/or CPT 92639 (Hearing-aid measurement, verification with probe-microphone) as appropriate.

Changes to the allowable procedure codes for hearing aid follow-up and conformity evaluation services will not impact the benefit maximums for these services. Medicaid will continue to allow up to two hearing aid follow-up visits (up to one hour each) and up to two conformity evaluation visits per year without PA when provided after the hearing aid's 90-day dispensing fee period. Each conformity evaluation can include a behavioral verification measure test, a hearing aid measurement test, or both, as medically necessary.

Providers will be reimbursed according to the rates published on the fee schedule available at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Hearing Services/Hearing Aid Dealers.

E. UPDATES TO MICHIGAN DIABETES PREVENTION PROGRAM REQUIREMENTS

The Michigan Diabetes Prevention Program (MiDPP) will align with recently added HCPCS code G9871 (Behavioral counseling for diabetes prevention, online, 60 min) for asynchronous online delivery.

MiDPP providers and lifestyle coaches are required to follow the Diabetes Prevention Recognition Program (DPRP) standards and operating procedures, as well as Michigan Medicaid telemedicine policy as outlined in the [MDHHS Medicaid Provider Manual](#).

F. UPDATE TO CLINIC BILLING FOR PSYCHIATRIC COLLABORATIVE CARE MODEL (CoCM) SERVICES

Psychiatric Collaborative Care Model (CoCM) services provided by a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tribal Health Center (THC), or Tribal Federally Qualified Health Center provider as defined in the policy (e.g., Medical Doctor/Doctor of Osteopathy [MD/DO], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Physician Assistant [PA]) may be reimbursed outside of the Prospective Payment System (PPS) or All-Inclusive Rate (AIR). HCPCS code G0512 was end-dated effective December 31, 2025. For DOS on and after January 1, 2026, FQHCs, RHCs, and THCs should use CPT codes 99492, 99493, and 99494 and HCPCS code G2214 to report CoCM services. Clinics are expected to adhere to AMA CPT coding guidelines for CoCM services as reported by CPT codes 99492, 99493, and 99494, as well as the Centers for Medicare and Medicaid Services (CMS) HCPCS coding requirements for CoCM services as reported by HCPCS code G2214. For more information on coverage and reimbursement, refer to the [MDHHS Medicaid Provider Manual](#), Practitioner chapter, Section 14.3 Psychiatric Collaborative Care Model (CoCM) Services or the applicable clinic provider database on the MDHHS website.

G. DISCONTINUED COVERAGE FOR ALL APPLICABLE PROVIDER TYPES

Coverage of the following HCPCS codes was discontinued effective December 31, 2025:

G0310 G0311 G0312 G0313 G0314 G3015 V5011 V5020

H. DISCONTINUED HCPCS PROCEDURE CODES FOR ALL APPLICABLE PROVIDER TYPES

The following HCPCS codes are discontinued effective December 31, 2025:

27445	27468	33884	33889	33891	37220	37221	37222
37223	37224	37225	37226	37227	37228	37229	37230
37231	37232	37233	37234	37235	37500	52647	55700
75842	75956	75957	75958	75959	77014	77385	77386
77401	91120	91122	92590	92591	92592	92593	92594
92595	92921	92925	92929	92934	92938	92944	92975
92977	94662	0033U	0042T	0131U	0132U	0135U	0266T
0267T	0268T	0269T	0270T	0271T	0272T	0273T	0275T
0361U	0394T	0421T	0508U	0509U	0544U	0550U	0551U
0619T	0623T	0624T	0625T	0626T	0631T	0662T	0663T
0720T	C5271	C5272	C5273	C5274	C5275	C5276	C5277
C5278	C9089	C9305	C9306	C9751	C9784	D1352	D1705
D1706	D1707	D1712	D9248	G0071	G0511	G0512	G6001
G6002	G6003	G6004	G6005	G6006	G6007	G6008	G6009
G6010	G6011	G6012	G6013	G6014	G6015	G6016	G6017
G9604	J0172	J0190	J0200	J0205	J0215	J0288	J0350
J0365	J0380	J0395	J0710	J0715	J0795	J0889	J1267

J1330	J1443	J1444	J1445	J1452	J1457	J1562	J1620
J1655	J1710	J1945	J2504	J2513	J2910	J2940	J2995
J3280	J3305	J3310	J3320	J3355	J3364	J3365	J3400
J7309	J7310	J7505	J7513	J8562	J8650	J9019	J9020
J9098	J9151	J9165	J9212	J9270	Q0174	Q2017	Q4100
Q4106	Q5109	Q9969	S0013	S0080	S0189		

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



Meghan E. Groen, Chief Deputy Director
Health Services