The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.
# GYNECOLOGICAL AND REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES

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1 General Information

The information in this handbook is intended for gynecological and reproductive health services providers, Texas Medicaid Title XIX family planning providers, and DSHS Family Planning Program providers. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures that are applicable to these service providers.

**Important:** All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Refer to: The Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about providing services to Texas Medicaid/Texas Health Steps (THSteps) clients.

Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information)

“Medicaid Program Administration” in “Preliminary Information” (Vol. 1, General Information)

Department of State Health Services (DSHS) website at [www.dshs.state.tx.us/famplan/](http://www.dshs.state.tx.us/famplan/) for information about family planning and the locations of clinics receiving family planning funding from DSHS.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, providers can refer to the Medicaid Managed Care Handbook.

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in the Texas Medicaid Managed Care Handbook.

Refer to: Section 8, “Carve-Out Services” in the Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks).

1.1 Family Planning Overview

TMHP processes family planning claims and encounters for two different funding sources:

- The DSHS Family Planning program funding for DSHS-contracted providers
- The Title XIX family planning funding for Texas Medicaid providers

DSHS awards contracts to agencies across Texas to provide services to low-income individuals who may not qualify for Texas Medicaid services. These awards are granted through a competitive procurement process. DSHS contracts with a variety of providers, including local health departments, universities, medical schools, private nonprofit agencies, FQHCs, RHCs, and hospital districts. All DSHS-contracted providers must first be enrolled in Title XIX Texas Medicaid.

Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services may differ for each funding source. Family planning funding cannot be used for elective abortion services.
• Title XIX funds are available for family planning services provided to Texas Medicaid clients. TMHP processes Title XIX claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.

• DSHS Family Planning Program contracts annually with family planning providers. TMHP processes claims and reimburses providers for services to eligible clients according to the individually granted funds.

• Funds are also available for limited family planning services provided to Texas Women’s Health Program (TWHP) clients. TMHP processes TWHP claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.

1.1.1 Guidelines for Family Planning Providers
The following guidelines apply for all family planning services:

• Family planning services may be provided by a physician or under the direction of a physician, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physicians assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or certified nurse midwife (CNM).

• Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.

• Texas Medicaid clients, including limited care clients, are allowed to choose any enrolled family planning service provider.

• Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate.

• Family planning clients must be allowed the freedom to accept or reject services without coercion.

• Only family planning clients may consent to the provision of family planning services. Counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.

• Sterilization services cannot be provided to any person who is 20 years of age or younger. For more information, DSHS-contracted providers may refer to the DSHS website at www.dshs.state.tx.us/famplan/rules.shtm.

1.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission
According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

• The professional services are rendered in the inpatient hospital setting.

• The hospital and the physician office or other entity are both owned by a third party, such as a health system.

• The hospital is not the sole or 100-percent owner of the entity.
Refer to: Subsection 3.7.3.8, “* Payment Window Reimbursement Guidelines” of the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for additional information about the payment window reimbursement guidelines.

2 Medicaid Title XIX Family Planning Services

2.1 Title XIX Provider Enrollment

Physician, FQHC, and RHC providers may provide Title XIX family planning services for Texas Medicaid clients under the provider’s Texas Medicaid provider number. No additional enrollment is required to provide Title XIX family planning services.

Refer to: Subsection 7.1, “Provider Enrollment” in the Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks) for information about physician provider enrollment.

Section 4.1, "Enrollment" in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information about FQHC provider enrollment.

Section 7.1, "Enrollment" in the Clinics and Other Outpatient Facility Services Handbook (Vol. 2, Provider Handbooks) for information about RHC provider enrollment.

Family planning agencies must apply for enrollment with TMHP to receive an agency provider identifier. To be enrolled in Texas Medicaid, family planning agencies must meet the following requirements:

- Complete an agency enrollment application.
- Ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician in accordance with the Texas Medical Board or Texas BON.
- Have a medical director who is a physician currently licensed to practice medicine in Texas, and submit a current copy of the medical director’s physician license.
- Have an established record of performance in the provision of both medical and educational counseling of family planning services as verified through client records, established clinic hours, and clinic site locations.
- Provide family planning services in accordance with DSHS standards of client care for family planning agencies.
- Be approved for family planning services by the DSHS Family Planning Program.

Note: An RHC can also apply for enrollment as a family planning agency.

The effective date for participation is the date an approved provider agreement with Medicaid is established and the provider is assigned a Medicaid provider identifier.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 6.3.6, “Benefit Code” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about benefit codes.

2.2 Services, Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through Title XIX Medicaid.
Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Title XIX services include:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory services
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
- Sterilization and sterilization-related procedures (i.e., tubal implants, tubal ligation, vasectomy, and anesthesia for sterilization)

Providers must use one of the following diagnosis codes in conjunction with all family planning procedures and services:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z3041</td>
</tr>
<tr>
<td>Z309</td>
</tr>
</tbody>
</table>

One of the diagnosis codes in this table must be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

**Note:** Title XIX family planning services are exempt from the limited program and rules.

### 2.2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, which includes the following:

- Medical laboratory evaluations as indicated
- An assessment of the client’s problems and needs
- The implementation of an appropriate contraceptive management plan

Family planning providers must bill the most appropriate evaluation and management (E/M) visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a family planning diagnosis code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>

**Important:** Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.
The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patient:</strong> Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td><strong>Established patient:</strong> Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code</td>
<td>Once a year*</td>
</tr>
</tbody>
</table>

*The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit.

If another condition requiring an E/M office visit beyond the required components for the annual examination is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

### 2.2.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 2.2.1, “Family Planning Annual Exams” in this handbook.

The annual exam is allowed once per fiscal year, per client, per provider. Two additional family planning office or outpatient visits may be reimbursed to the FQHC within the same year for the same client.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

### 2.2.2 Other Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.

During any visit for a medical problem or follow-up visit, the following must occur:

- An update of the client’s relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated
Title XIX family planning providers must use one of the following procedure codes based on the complexity of the visit with a family planning diagnosis for other family planning office or outpatient visits:

### Procedure Codes

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>99201</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
<td>99211</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
</tbody>
</table>

**Important:** Family planning E/M office and outpatient visits should not be billed with modifier FP. Claims filed incorrectly may be denied.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for each type of visit:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Most appropriate E/M procedure code with a family planning diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>Established patient: Most appropriate E/M procedure code with a family planning diagnosis code</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.

Refer to: Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

#### 2.2.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per year, per client, regardless of the reason for the encounter. The three encounters may include any combination of general family planning, annual family planning exams, or services. Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

A family planning diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

Refer to: Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook, (Vol. 2, Provider Handbooks) for more information about FQHC services.

#### 2.2.3 Laboratory Procedures

All family planning laboratory services must be billed with a family planning diagnosis code.
2.2.3.1 Clinical Laboratory Improvement Amendments (CLIA) Requirement

All providers of laboratory services must comply with the rules and regulations of the CLIA. Providers who are not in compliance with CLIA will not be reimbursed for laboratory services. Only the office or lab that holds the appropriate CLIA certificate and that actually performs the laboratory test procedure may be reimbursed for the procedure.

Refer to: Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)

2.2.3.2 Medical Record Documentation

Medicaid family planning service providers must document in the client’s medical record the medical necessity of all ordered laboratory services. The medical record documentation must also reference an appropriate diagnosis.

2.2.3.3 Lab Specimen Handling and Testing

Any test specimen sent to a laboratory may be reimbursed to the laboratory that performs the test and not to the referring family planning provider.

If the provider that obtains the specimen does not perform the laboratory procedure, the provider that obtains the specimen may be reimbursed one lab handling fee per day, per client, using procedure code 99000 and a family planning diagnosis code for the handling or conveyance of the specimen from the provider’s office to a laboratory. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. The appropriate procedure code may be reimbursed for Pap smear interpretations when billed with modifier SU indicating that the screening and interpretation were actually performed in the office.

2.2.3.4 Providing Information to the Reference Laboratory

When sending any specimen, including Pap smears, to the reference laboratory, the family planning provider must provide the reference laboratory with the client’s name, address, Texas Medicaid number, and a family planning diagnosis so the laboratory may bill Texas Medicaid for its family planning lab services.

2.2.4 Radiology Services

Procedure codes 74000, 74010, and 76830 may be reimbursed for services performed for the purpose of localization of an intrauterine device (IUD).

2.2.5 Contraceptive Devices and Related Procedures

2.2.5.1 External Contraceptives

Procedure codes A4261 (cervical cap) and A4266 (diaphragm) may be reimbursed separately from the fitting and instruction (procedure code 57170).

Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z30431</td>
</tr>
</tbody>
</table>
2.2.5.2 Intrauterine Device

2.2.5.2.1 Insertion of the IUD

The IUD and the insertion of the IUD may be reimbursed using procedure code J7297, J7298, J7300, J7301, and 58300.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD insertion procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance, and
- The IUD insertion will be reimbursed at half the allowed amount.

Procedure codes J7297, J7298, J7300, and J7301 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z3041</td>
</tr>
<tr>
<td>Z309</td>
</tr>
</tbody>
</table>

2.2.5.2.2 Removal of the IUD

Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity. An office visit will not be reimbursed when billed on the same date of service as procedure code 58301.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

2.2.5.3 Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Procedure code 11981 may be reimbursed for the insertion of the implant device when it is billed with a family planning diagnosis code.

Procedure code 11983 may be reimbursed for the removal with reinsertion of the implant device when it is billed with a family planning diagnosis code. Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the Food and Drug Administration (FDA), the removal of the implanted contraceptive capsule may be considered for reimbursement with procedure code 11976 or 11982.

2.2.5.4 Immediate Postpartum Insertion of IUDs and Implantable Contraceptive Capsules

Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the hospital diagnosis related group (DRG) payment when insertion is performed immediately postpartum. “Immediately postpartum” refers to insertion within 10-15 minutes of placental delivery, after vaginal or cesarean delivery, for IUDs or insertion prior to discharge for implantable contraceptive capsules.

When seeking reimbursement for an IUD or implantable contraceptive capsule inserted immediately postpartum, hospital/facility providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for the delivery services.
2.2.6 Drugs and Supplies

The following procedure codes may be reimbursed for drugs and supplies:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4267</td>
</tr>
</tbody>
</table>

* Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client.

Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

Procedure code J1050 (no modifier) may be reimbursed for services rendered to male and female clients of any age for other indications as appropriate. Providers must bill the appropriate quantity based on the amount used in milligrams (mg).

For Texas Medicaid Title XIX services, procedure code J1050 is not diagnosis-restricted. For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z30431</td>
</tr>
</tbody>
</table>

Procedure code A9150 is not reimbursed through Title XIX Medicaid for the medication to treat a monilia infection. The drug is available through the Medicaid Vendor Drug Program with a prescription.

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Refer to: “Appendix B: Vendor Drug Program” (Vol. 1, General Information) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

2.2.6.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill accordingly.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP for Texas Medicaid fee-for-service clients. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a 1-year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Refer to: Subsection 2.2, “Services, Benefits, Limitations, and Prior Authorization” in this chapter.

Title XIX clients may have prescriptions filled at the clinic pharmacy or at another pharmacy. Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.
2.2.6.2 Long-Acting Reversible Contraception Products

Certain long-acting reversible contraception (LARC) products are available as a pharmacy benefit of Family Planning and are available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers can refer to the Texas Medicaid/CHIP Vendor Drug Program website at http://www.txvendordrug.com/formulary/larc.shtml for additional information, including a list of covered products and participating specialty pharmacies.

2.2.6.3 * Medroxyprogesterone Acetate (Depo-Provera)

Medroxyprogesterone acetate injectable suspension (Depo-Provera) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate given at 90-day intervals has been proven to be a long-term method of preventing pregnancy. Medroxyprogesterone acetate injectable suspension is reimbursed by Texas Medicaid to providers of family planning services. Medroxyprogesterone acetate must be billed using procedure code J1050 with modifier U1 and a valid family planning diagnosis codes.

2.2.6.4 Injection Administration

Injection administration billed by a provider is reimbursed separately from the medication. If billed without procedure code J1050 and modifier U1, procedure code 96372 must be billed with a family planning diagnosis and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for a list of family planning diagnosis codes.

2.2.7 Medical Counseling and Education

Procedure code H1010 for the instruction in natural family planning methods may be reimbursed once per day, per person or per couple, when billed by any provider with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011 Z30018 Z3002 Z3009 Z302 Z3040 Z3041 Z3042</td>
</tr>
<tr>
<td>Z30430 Z30431 Z30432 Z30433 Z3049 Z308 Z309 Z9851</td>
</tr>
<tr>
<td>Z9852</td>
</tr>
</tbody>
</table>

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning. Two sessions (one per client) may be billed for separate, individual sessions, or one session may be billed for counseling and education if provided in a joint session. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

2.2.8 Sterilization and Sterilization-Related Procedures

For a complete list of Title XIX sterilization procedures, providers can refer to the Texas Medicaid fee schedules located on the TMHP website at http://public.tmhp.com/FeeSchedules/Default.aspx.

2.2.8.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.
Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.
Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.
2.2.8.2 Anesthesia for Sterilization
Procedure codes 00840, 00851, and 00940 may be reimbursed for anesthesia for sterilization services in accordance with standard anesthesia billing requirements. Providers must include a valid family planning diagnosis code on the claim.

Refer to: Subsection 6.2.5.2, “Anesthesia” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about anesthesia modifiers.

2.2.8.3 Occlusive Sterilization Device
Procedure code A4264 may be reimbursed for the occlusive sterilization system (micro-insert), and may be reimbursed separately from the surgery (procedure code 58565) to place the device.

Providers must bill procedure code A4264 on the same date of service by the same provider as the occlusive sterilization system (micro-insert).

Procedure code 58565 is considered bilateral and is limited to once per lifetime, any provider.

2.2.8.4 Tubal Ligation
Procedure code 58600, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

2.2.8.5 Vasectomy
Procedure code 55250 may be reimbursed for any sterilization procedure that is performed on a male by a family planning agency. This procedure code may be reimbursed as a global fee to include preoperative, intra-operative, and postoperative services by all parties involved. Vasectomies are considered to be permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the client, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

2.2.8.6 Facility Fees for Sterilization
Hospital-based and freestanding ambulatory surgical centers (HASCs/ASCs) may be reimbursed for procedure code 55250, 58565, 58600, 58615, 58670, or 58671. An appropriate family planning diagnosis code must be billed when reporting facility fees for procedure codes 58565 or 58670.

Refer to: Ambulatory Surgical Center on the TMHP website at www.tmhp.com for a claim form example.

2.2.9 Prior Authorization
Prior authorization is not required for family planning services, including sterilization and sterilization-related procedures.

2.2.10 Non-covered Services
2.2.10.1 Family Planning Services for Undocumented Aliens
Undocumented aliens are identified on the client eligibility card as having limited Medicaid eligibility by the classification of Type Program (TP) 30, 31, 34, and 35. Under Texas Medicaid, these clients are only eligible for emergency services, including emergency labor and delivery. Texas Medicaid emergency-only services do not cover Title XIX family planning services.

2.3 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services, and family planning services.

Gynecological and reproductive health services, and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.
2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Providers may use the following claim forms to submit claims to TMHP:

<table>
<thead>
<tr>
<th>Providers</th>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Fee-For-Service Claims Submitted to TMHP</td>
<td>2017 claim form or approved electronic format</td>
</tr>
<tr>
<td>All family planning services provided by physicians, PAs, NPs, CNSs, CNMs, and family planning agencies who also contract with DSHS</td>
<td>2017 claim form, CMS-1500 claim form, or approved electronic format of either form</td>
</tr>
<tr>
<td>Medicaid family planning providers who do not contract with DSHS</td>
<td>2017 claim form, CMS-1500 claim form, or approved electronic format of either form</td>
</tr>
<tr>
<td>Hospitals</td>
<td>UB-04 CMS-1450 claim form or approved electronic format</td>
</tr>
<tr>
<td>FQHCs not contracted with DSHS</td>
<td>UB-04 CMS-1450, 2017 claim form, or approved electronic format of either form</td>
</tr>
<tr>
<td>FQHC also contracts with DSHS</td>
<td>2017 claim form or approved electronic format</td>
</tr>
</tbody>
</table>

The following applies when filing claims:

- All claims and Sterilization Consent Forms submitted by family planning agencies must be submitted with benefit code FP3.

- Family planning services billed by RHCs must include modifier AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.

- When completing a 2017, CMS-1500, or UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

- All claims must be filed within approved filing deadlines.

- Denied claims may be appealed.

Providers may copy 2017 Claim Form on the TMHP website at www.tmhp.com.

Providers may purchase CMS-1500 and UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.
Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Section 6: Claims Filing (Vol. 1, General Information) for general information about claims filing.


Subsection 6.5.4, “CMS-1500 Instruction Table” in Section 6, “Claims Filing” (Vol. 1, General Information).


Section 7: Appeals (Vol. 1, General Information) for information about appealing claims.

Blocks that are not referenced are not required for processing by TMHP and may be left blank.

RHCs must use their National Provider Identifier (NPI), the appropriate benefit code as applicable, and the appropriate modifier and place of service as outlined in this section.

2.4.1.1 Family Planning and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client’s confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

2.4.2 Billing Procedures for Non-Family-Planning Services Provided During a Family Planning Visit (Title XIX Only)

When a non-family-planning service is provided during a family planning visit or the client is offered family planning services during a medical visit, the following billing process must be used:

- A family planning clinic must bill for non-family-planning services using the performing provider’s identifier. The clinic provider identifier is used to bill family planning services only.

- The performing provider must bill both family planning services and non-family-planning services, using the correct provider identifier.

- The FQHC must bill both family planning services and non-family-planning services, using the correct provider identifier.

- An RHC may bill a rural health encounter for a non-family-planning medical condition or use the physician’s or NP’s provider identifier to bill for family planning services. If the RHC also is enrolled as a family planning agency, the family planning services may be billed using the agency’s family planning provider identifier and the appropriate national place of service (72) for an RHC setting.

2.4.3 National Drug Code

2.4.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI webpage for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

3 * Obstetric Services

3.1 Services, Benefits, Limitations, and Prior Authorization

Antepartum care, antenatal surveillance, perinatal procedures, infant deliveries, and postpartum care are a benefit of Texas Medicaid.

The procedure codes listed in the tables below may be reimbursed by Texas Medicaid. Providers can refer to the Texas Medicaid Static Fee Schedules and the Online Fee Look-up for rate information about specific procedure codes.

3.1.1 Antepartum and Fetal Invasive Procedures

The following procedure codes may be submitted for antepartum and fetal invasive procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>36460</td>
</tr>
<tr>
<td>59070</td>
</tr>
</tbody>
</table>

3.1.2 Vaginal and Cesarean Deliveries

The following procedure codes submitted with the appropriate modifier may be a benefit for vaginal or Cesarean deliveries:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
</tr>
</tbody>
</table>

* Procedure code S8415 is for home delivery supplies

The following modifiers may be billed with the procedure codes indicated above for vaginal and cesarean deliveries:

<table>
<thead>
<tr>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
</tr>
<tr>
<td>U2</td>
</tr>
<tr>
<td>U3</td>
</tr>
</tbody>
</table>

3.1.3 Elective Deliveries Prior to 39 Weeks

Texas Medicaid restricts any Cesarean section, labor induction, or any delivery following labor induction to one of the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks

The following procedure codes may be submitted for elective deliveries prior to 39 weeks:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59070</td>
</tr>
</tbody>
</table>
• When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery

  **Note:** Records are subject to retrospective review. Payments made for Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria (as determined by review of medical documentation), are subject to recoupment. Recoupment may apply to all services related to the delivery, including additional physician fees, birthing center, and inpatient and outpatient hospital fees.

### 3.1.4 Other Vaginal and Cesarean Delivery Procedures

The following vaginal and Cesarean delivery procedures do not require vaginal and Cesarean delivery modifiers:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59414</td>
<td></td>
</tr>
<tr>
<td>59525</td>
<td></td>
</tr>
</tbody>
</table>

### 3.1.5 Abortion

The following procedure codes may be submitted for abortion services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59812</td>
<td></td>
</tr>
<tr>
<td>59820</td>
<td></td>
</tr>
<tr>
<td>59821</td>
<td></td>
</tr>
<tr>
<td>59830</td>
<td></td>
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<tr>
<td>59840</td>
<td></td>
</tr>
<tr>
<td>59841</td>
<td></td>
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<tr>
<td>59850</td>
<td></td>
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<tr>
<td>59851</td>
<td></td>
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<td>59852</td>
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<td>59855</td>
<td></td>
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<tr>
<td>59856</td>
<td></td>
</tr>
<tr>
<td>59857</td>
<td></td>
</tr>
</tbody>
</table>

Abortion services are benefits of Texas Medicaid if submitted with the following modifier:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G7</td>
<td>Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening</td>
</tr>
</tbody>
</table>

### 3.1.6 Other Maternity Care and Delivery Services

The following procedure codes may be submitted for other maternity care and delivery services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59100</td>
<td></td>
</tr>
<tr>
<td>59160</td>
<td></td>
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<tr>
<td>59200</td>
<td></td>
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<tr>
<td>59300</td>
<td></td>
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<tr>
<td>59320</td>
<td></td>
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<tr>
<td>59325</td>
<td></td>
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<tr>
<td>59350</td>
<td></td>
</tr>
<tr>
<td>59412</td>
<td></td>
</tr>
<tr>
<td>59870</td>
<td></td>
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<tr>
<td>59871</td>
<td></td>
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<tr>
<td>59897</td>
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<tr>
<td>59898</td>
<td></td>
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<tr>
<td>59899</td>
<td></td>
</tr>
</tbody>
</table>

### 3.1.7 Obstetric Ultrasound

The following procedure codes may be submitted for obstetric ultrasound services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76801</td>
<td></td>
</tr>
<tr>
<td>76802</td>
<td></td>
</tr>
<tr>
<td>76805</td>
<td></td>
</tr>
<tr>
<td>76810</td>
<td></td>
</tr>
<tr>
<td>76811</td>
<td></td>
</tr>
<tr>
<td>76812</td>
<td></td>
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<td>76813</td>
<td></td>
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<tr>
<td>76814</td>
<td></td>
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<tr>
<td>76815</td>
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<tr>
<td>76816</td>
<td></td>
</tr>
<tr>
<td>76817</td>
<td></td>
</tr>
</tbody>
</table>

### 3.1.8 Diagnostic Ultrasound and Ultrasonic Guidance

The following procedure codes may be submitted for diagnostic ultrasound and ultrasonic guidance services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76818</td>
<td></td>
</tr>
<tr>
<td>76819</td>
<td></td>
</tr>
<tr>
<td>76941</td>
<td></td>
</tr>
<tr>
<td>76946</td>
<td></td>
</tr>
</tbody>
</table>
3.1.9  **Doppler Studies**
The following procedure codes may be submitted for doppler study services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76820</td>
</tr>
<tr>
<td>76821</td>
</tr>
</tbody>
</table>

3.1.10  **Echocardiography**
The following procedure codes may be submitted for echocardiography services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76825</td>
</tr>
<tr>
<td>76826</td>
</tr>
<tr>
<td>76827</td>
</tr>
<tr>
<td>76828</td>
</tr>
</tbody>
</table>

3.1.11  **Hydroxyprogesterone Caproate**
The following procedure codes may be submitted for hydroxyprogesterone caproate:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1725 U1</td>
<td>Hydroxyprogesterone Caproate Compounded Version</td>
</tr>
<tr>
<td>J1725</td>
<td>Hydroxyprogesterone Caproate Trademarked Version</td>
</tr>
</tbody>
</table>

Procedure code J1725 with and without modifier U1 is restricted to the following payable diagnosis:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>O09211</td>
</tr>
<tr>
<td>O09212</td>
</tr>
<tr>
<td>O09213</td>
</tr>
<tr>
<td>O09219</td>
</tr>
</tbody>
</table>

Hydroxyprogesterone caproate is administered intramuscularly at a dose of 250mg once weekly (every 7 days).

3.1.12  **Fetal Surgery**
The following procedure codes may be submitted for fetal surgery:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59072</td>
</tr>
<tr>
<td>S2401</td>
</tr>
<tr>
<td>S2402</td>
</tr>
<tr>
<td>S2403</td>
</tr>
<tr>
<td>S2405</td>
</tr>
<tr>
<td>S2409</td>
</tr>
<tr>
<td>S2411</td>
</tr>
</tbody>
</table>

3.1.13  **Antenatal and Postnatal Care Visits**
The following procedure codes may be submitted for antenatal and postnatal care visits:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59430</td>
</tr>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99202</td>
</tr>
<tr>
<td>99203</td>
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<tr>
<td>99349</td>
</tr>
<tr>
<td>99350</td>
</tr>
</tbody>
</table>

*Note:*  Antenatal visits must be submitted with the appropriate level of evaluation and management (E/M) procedure code with the TH modifier.

3.1.14  **Birthing Centers - Professional Services**
The following procedures may be performed by professionals in the birthing center setting:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
</tr>
<tr>
<td>59410***</td>
</tr>
<tr>
<td>99218</td>
</tr>
<tr>
<td>99219</td>
</tr>
<tr>
<td>99220</td>
</tr>
</tbody>
</table>

***Licensed Midwives may not use code 59410.***
The following table includes procedure codes that may be benefits for Licensed Midwives services rendered in the Birthing Center setting.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
</tr>
</tbody>
</table>

**Note:** Licensed Midwives may not use code 59410.

### 3.1.15 Birthing Centers - Facility Services
The following procedures may be performed by birthing center facilities:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
</tr>
</tbody>
</table>

### 3.1.16 Tobacco Use Cessation
Counseling for cessation of the habit of using tobacco products by pregnant women is a benefit of Texas Medicaid.

The following procedure codes listed may be billed for tobacco use cessation counseling using an applicable diagnosis code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406</td>
</tr>
</tbody>
</table>

One of the following diagnosis codes must be submitted for tobacco use cessation with the appropriate procedure code:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>O99330</td>
</tr>
</tbody>
</table>

### 3.2 Documentation Requirements

#### 3.2.1 Diagnostic Studies
Medical record documentation must include assessment findings that substantiate the medical necessity for each diagnostic test performed.

#### 3.2.2 Obstetric Ultrasound
Texas Medicaid requires providers to follow the documentation requirements as set forth in the Diagnostic Ultrasound section of the Current Procedural Terminology (CPT) manual for the diagnostic studies of the fetus, including when ultrasound is used to guide a procedure.

Documentation requirements set forth in the CPT manual include, but are not limited to:

- Permanently recorded images with measurements, when measurements are clinically indicated
- Final written report included in the client’s medical record (includes written interpretation)
- Report must include description of elements that comprised a “complete” or “limited” exam and the reasons an element could not be visualized
- Permanently recorded images are also required for ultrasound guidance procedures of the site to be localized. In addition, description of the localization process, either separately or within the report of the procedure when the guidance is utilized.

Permanently recorded images must be available on request by the Texas Health and Human Services Commission (HHSC).
3.2.3 Hydroxyprogesterone Caproate

The following documentation supporting medical necessity for administration of a hydroxyprogesterone caproate injection must be maintained in the client’s medical record:

- The client’s treatment is initiated between 16 weeks, 0 days and 20 weeks, 6 days gestation
- The client’s treatment continues, as medically indicated, through 36 weeks, 6 days gestation or delivery, whichever occurs first
- The client has a singleton pregnancy
- The client has had a prior, singleton spontaneous preterm delivery before 37 weeks gestation

Hydroxyprogesterone caproate is limited to a maximum of 21 doses per pregnancy

3.3 Authorization Requirements

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients’ responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures. For additional information about electronic signatures, please refer to the ‘Electronic Signatures in Prior Authorizations’ medical policy.

3.3.1 Hydroxyprogesterone Caproate

Prior authorization is not required for either the compounded or trademarked versions of hydroxyprogesterone caproate for injection (procedure codes J1725 and J1725 U1).

Requests for initiation of the client’s treatment after 20 weeks, 6 days gestation but not beyond 24 weeks gestation will be considered on a case-by-case basis. A prior authorization request must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department with documentation to support the medical necessity of starting treatment at this stage of gestation, and must be approved by the Medical Director.

3.3.2 Obstetric Ultrasound

Prior authorization is required for greater than three obstetrical ultrasounds per pregnancy. Requests for additional obstetric ultrasounds may be considered when submitted with documentation of medical necessity on the Obstetric Ultrasound Prior Authorization Request Form.

Authorization is not required for obstetric ultrasounds performed in the emergency department, outpatient observation, or inpatient hospital setting.

Texas Medicaid follows the American Congress of Obstetricians and Gynecologists (ACOG) indications for sonography.

First trimester ultrasounds may be medically necessary for, but not limited to, the following conditions:

- Confirm the presence of an intrauterine pregnancy
- Evaluation of a suspected ectopic pregnancy
- Evaluation of vaginal bleeding
- Evaluation of pelvic pain
- Estimation of gestational age
- Diagnosis or evaluation of multiple gestations
- Confirmation of cardiac activity
- Adjunct to chorionic villus sampling or localization and removal of an intrauterine device
- Assessment of certain fetal anomalies, such as anencephaly, in clients at high risk
- Evaluation of maternal pelvic or adnexal masses or uterine abnormalities
- Screening for fetal aneuploidy
- Evaluation of suspected hydatidiform mole

Second- and third-trimester ultrasounds may be medically necessary for the following conditions:

- Estimation of fetal age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal and pelvic pain
- Determination of fetal presentation
- Adjunct to amniocentesis or other procedure
- Evaluation of suspected multiple gestation
- Evaluation of a significant discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Evaluation of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of a suspected ectopic pregnancy
- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation for fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Adjunct to external cephalic version
- Evaluation for premature rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa
- Evaluation for clients with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment of findings that may increase the risk of aneuploidy
- Screening for fetal anomalies

A request for retroactive authorization must be submitted no later than 14 calendar days, beginning the day after the study is completed.

Requests for prior authorization or retroactive authorization may be submitted by phone, mail, or an approved electronic method.
The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, dated, and maintained in the client’s medical record by the provider requesting the test. The form must include information related to medical necessity of the test including all of the following:

- Procedure requested (CPT code) and quantity requested
- The trimester(s) during which the requested ultrasounds will be performed
- The date range during which the procedure(s) will be performed
- Client’s estimated date of confinement (EDC) at the time the request is submitted
- Diagnosis

Additional documentation to support medical necessity may include any of the following:

- Treatment history
- Treatment plan
- Medications
- Previous imaging results

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, and dated by the ordering provider (physician, nurse practitioner/clinical nurse specialist, certified nurse midwife [CNM], or physician assistant) when requesting prior authorization for obstetric ultrasounds, regardless of the method of request for authorization.

Residents may order obstetric ultrasounds; however, the attending physician must sign the authorization form and provide the group or supervising provider’s provider identifier.

Providers may be requested to provide additional documentation.

### 3.3.3 Home Deliveries

Home deliveries and the home supplies for the delivery (S8415) require submitting a written prior authorization request during the client’s third trimester of pregnancy. Home deliveries will not be prior authorized to a licensed midwife.

Documentation must include:

- A statement signed by a licensed physician who examined the client during the third trimester and determined at the time of examination the client is not at high risk for complications and is suitable for a home delivery
- A plan for access to emergency transport for mother and neonate, if needed

### 3.3.4 Fetal Surgeries

Fetal surgery procedures require prior authorization.

Prior authorization requests must be submitted on a Special Medical Prior Authorization (SMPA) Request Form to the SMPA department.

Procedure codes S2401, S2402, S2403, S2405 and S2409 may be authorized for Texas Medicaid only when the hospital is a member of the North American Fetal Therapy Network (NAFTNet).

The pediatric surgeon for procedure codes S2401, S2402, S2403, S2405, or S2409 must submit documentation which includes:

- A clear description of the fetal malformation(s). The malformation(s) must interfere with the intrauterine organ development and fetal survival and have potential fatal consequences before or after birth
• Evidence that in utero correction of the fetal congenital malformation(s) results in a clinical outcome that is better than that which would be seen in expectant management

Note: Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.

Umbilical cord occlusion (procedure code 59072) may be considered when all the following is documented:

• Diagnosis of monoamniotic-monochorionic twins is present
• Spontaneous fetal death of one of the twins with the presence of hydrops
• The ratio of the acardia twin weight to the pump twin weight is greater than 50%
• The abdominal circumference of the twin with reversed arterial perfusion fetus is greater than or equal to the abdominal circumference of the pump twin

Note: Elective abortions are not benefits of Texas Medicaid

Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome (procedure code S2411) may be considered when all the following are documented:

• Fetal gestational age of less than 26 weeks
• Evidence of polyhydramnios in the recipient fetus
• Donor fetus is oligohydramnios
• Evidence of abnormal blood flow documented by Doppler studies in one or both fetuses

3.4 Reimbursement

Not all procedures are benefits for all age groups. Providers are advised to check the fee schedule for coverage information.

3.4.1 Antepartum and Fetal Invasive Services

Antenatal surveillance includes fetal contraction stress test (procedure code 59020), fetal nonstress test (procedure code 59025), and fetal biophysical profile with or without nonstress testing (procedure code 76818 or 76819).

The American Congress of Obstetricians and Gynecologists (ACOG) states “because antepartum fetal surveillance results have not been definitively demonstrated to improve perinatal outcome, all indications for antepartum testing must be considered somewhat relative. In general, antepartum fetal surveillance has been employed in pregnancies in which the risk of antepartum fetal demise is increased.” Accordingly, some of the conditions under which testing may be appropriate, include but are not limited to the following:

• Maternal conditions:
  • Antiphospholipid syndrome
  • Hyperthyroidism (poorly controlled)
  • Hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
  • Cyanotic heart disease
  • Systemic lupus erythematosus
  • Chronic renal disease
  • Type I diabetes mellitus
  • Hypertensive disorders
• Pregnancy-related conditions:
  • Pregnancy-induced hypertension
  • Decreased fetal movement
  • Oligohydramnios
  • Polyhydramnios
  • Intrauterine growth restriction
  • Postterm pregnancy
  • Isoimmunization (moderate to severe)
  • Previous fetal demise (unexplained or recurrent risk)
  • Multiple gestation (with significant growth discrepancy)

Procedure codes 59020 and 59025 billed with revenue code 729 for outpatient facilities may be reimbursed on the same day by a different provider without appeal; however, if billed more than once per day by the same provider, it will be denied. The provider may appeal with documentation supporting the performance of the test more than once on the same day by the same provider.

3.4.2 Fetal Fibronectin Enzyme Immunoassay
A fetal fibronectin (fFN) enzyme immunoassay (procedure code 82731) may be considered for reimbursement through Texas Medicaid when performed between 22 0/7 and 34 6/7 weeks for women with risk factors for preterm labor with or without symptoms of preterm labor.

3.4.3 Fetal Intrauterine Transfusion (FIUT)
Fetal intrauterine transfusion (procedure code 36460), cordocentesis (procedure code 59012), and ultrasonic guidance (procedure code 76941) are restricted to the diagnoses listed in the following table:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>O353XX0</td>
</tr>
<tr>
<td>O360110</td>
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<tr>
<td>O360121</td>
</tr>
<tr>
<td>O360132</td>
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<tr>
<td>O360193</td>
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<tr>
<td>O360914</td>
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<td>O360925</td>
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<tr>
<td>O360939</td>
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<tr>
<td>O361110</td>
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<tr>
<td>O361121</td>
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<td>O361132</td>
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<td>O361193</td>
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<td>O361914</td>
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<td>O361925</td>
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<tr>
<td>O361939</td>
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<tr>
<td>O368210</td>
</tr>
<tr>
<td>O368221</td>
</tr>
<tr>
<td>O368232</td>
</tr>
</tbody>
</table>
FIUT (procedure code 36460) is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis (procedure code 59012).

Appeals for cordocentesis performed for a diagnosis other than the ones listed in the appropriate table in the policy will be reviewed on a case by case basis.

In addition to the physician performing the FIUT (procedure code 36460), another physician may assist with echography control. Ultrasonic guidance for intrauterine fetal transfusion (procedure code 76941) will be reimbursed separately when billed by a different physician.

### 3.4.4 Therapeutic Amniocentesis

Therapeutic amniocentesis (procedure code 59001) is restricted to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>O360110</td>
</tr>
<tr>
<td>O360112</td>
</tr>
<tr>
<td>O360114</td>
</tr>
<tr>
<td>O360116</td>
</tr>
<tr>
<td>O360118</td>
</tr>
</tbody>
</table>

### 3.4.5 Transabdominal Amnioinfusion

Transabdominal amnioinfusion (procedure code 59070), fetal fluid drainage (e.g., vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance (procedure code 59074), and fetal shunt placement, including ultrasound guidance (procedure code 59076) are restricted to one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>O361110</td>
</tr>
<tr>
<td>O361112</td>
</tr>
<tr>
<td>O361114</td>
</tr>
<tr>
<td>O361116</td>
</tr>
<tr>
<td>O361118</td>
</tr>
</tbody>
</table>
3.4.6 Vaginal and Cesarean Deliveries

Vaginal and Cesarean deliveries must be billed with the appropriate modifier:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Prior to 39 weeks and medically necessary</td>
</tr>
<tr>
<td>U2</td>
<td>39 weeks or later</td>
</tr>
<tr>
<td>U3</td>
<td>Prior to 39 weeks and not medically necessary</td>
</tr>
</tbody>
</table>

Claims will deny if submitted for a delivery prior to 39 weeks of gestation and not medically necessary, or for a delivery service with no modifier.

Claims will deny or recoupment will occur for associated claims for deliveries that are performed prior to 39 weeks and are determined to be not medically necessary including:

- Claims for the provider performing the vaginal or Cesarean delivery
- Inpatient and outpatient hospital claims inclusive of the delivery, planned Cesarean section, induction with vaginal delivery or failed induction with subsequent Cesarean section
- Birthing center claims inclusive of induction with vaginal delivery
- Claims for medical or surgical admission, including ICU, due to the complications of the delivery for the mother

Home deliveries must be billed with procedure code 59409 or 59410; including postpartum care.

Licensed midwives will not be reimbursed for home deliveries.

3.4.7 Abortion Services

In accordance with federal directives, abortions may be reimbursed when performed to save the life of the mother or for pregnancies resulting from rape or incest.

In accordance with federal law, providers are required to use specific language regarding the reason the mother’s condition is life-threatening. An abortion for a life-threatening condition must be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed.

Reimbursement of an abortion is based on the physician’s certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest.

One of the following statements, signed by the physician is mandatory for any abortion performed. Substitute wording will not be accepted. One of these statements must accompany any claim for abortion in order for reimbursement to be made:

- Signature

  “I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client’s full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place her in danger of death unless an abortion is performed.”
• Signature

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.”

• Signature

“I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.”

• Signature

A stamped or typed physician signature on the original certification statement is not acceptable. The physician signature must be an original signature. A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time. The physician must maintain the original certification statement in the client’s file.

Abortion services must be billed with the following modifier:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G7</td>
<td>Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening</td>
</tr>
</tbody>
</table>

### 3.4.8 Obstetric Ultrasound

Obstetric ultrasounds provided in the emergency department or outpatient observation must be submitted with Modifier U6 when submitted on the professional claim form in order to be considered for reimbursement.

Obstetric ultrasounds provided in the emergency department or hospital observation must be submitted with the appropriate corresponding emergency services or hospital observation revenue code in order to be considered for reimbursement.

**Note:** Any obstetric ultrasound performed in the emergency department or hospital observation will **not count toward the limit of three per pregnancy**.

The initial three claims reimbursed for obstetric ultrasounds do not require prior authorization. Any obstetric ultrasound claims submitted with or without prior authorization for the initial three will count toward the limit of three per pregnancy.

For transvaginal obstetric ultrasound performed in addition to one of the transabdominal examinations, documentation is required to substantiate the need to perform both tests on the same day.

Reimbursement for obstetric ultrasounds may be considered on appeal when submitted with documentation of any one of the following:

• Ultrasound was performed for a different pregnancy
• The provider was unable to obtain the previous ultrasound records from a different provider
• The provider was new to treating the client and was not aware the client had received three obstetric ultrasounds

Only one appeal will be considered per client for the same provider. Providers must obtain prior authorization for additional obstetric ultrasounds performed after the appealed service.
Add-on procedure codes (76802, 76810, 76812, and 76814) when billed with the primary procedure code for obstetric ultrasounds do not count toward the limit of three per pregnancy.

Claims for add-on codes for multiple fetuses should be billed with Modifier 76 if greater than one additional fetus. Claims for multiple fetuses greater than two will be considered on appeal with documentation indicating number of fetuses.

Three dimensional (3-D) rendering of obstetric ultrasound (procedure code 76376 or 76377) is not a benefit of Texas Medicaid.

Procedure code 76810 must be billed in conjunction with primary procedure code 76805, any provider.

Procedure code 76812 must be billed in conjunction with primary procedure code 76811, any provider.

Procedure code 76814 must be billed in conjunction with primary procedure code 76813, any provider.

3.4.9 Diagnostic Ultrasound and Ultrasonic Guidance

Fetal biophysical profile (procedure code 76818 or 76819), when billed with 76805, 76810, 76811, 76812, 76813, 76814, 76815, or 76816, will be reimbursed separately.

3.4.10 Doppler Studies

As supported by ACOG, umbilical artery doppler (procedure code 76820) is limited to suspected intrauterine growth restriction (IUGR), post-term gestation, diabetes mellitus, systemic lupus erythematosus, or antiphospholipid antibody syndrome.

Middle cerebral artery doppler (procedure code 76821) is indicated, but not limited to fetuses who are alloimmunized.

3.4.11 Echocardiography

Fetal echocardiography (procedure codes 76825, 76826, 76827, and 76828) may be reimbursed for the following factors/syndromes:

- Fetal Risk Factors
  - Extracardiac anomalies
    - Chromosomal
    - Anatomic
  - Fetal cardiac dysrhythmia
    - Irregular rhythm
    - Tachycardia
    - Bradycardia
  - Nonimmune hydrops fetalis
- Suspected cardiac anomaly on ultrasound
- Abnormal fetal situs
- Maternal Risk Factors
  - Congenital heart disease
  - Cardiac teratogen exposure
    - Lithium
    - Alcohol
    - Phenytoin
• Trimethadione
• Isoretinoin
• Maternal Metabolic Disorders
  • Diabetes mellitus
  • Phenylketonuria
• Familial Risk Factors for congenital heart disease
  • Previous sibling
  • Paternal
• Syndromes
  • Marfan's
  • Noonan's
  • Tuberous sclerosis

### 3.4.12 Hydroxyprogesterone Caproate

Claims for compounded hydroxyprogesterone caproate for injection must be submitted with:
• Procedure code J1725
• Diagnosis codes O09211, O09212, O09213, or O09219
• Modifier U1
• NDC

Claims for trademarked hydroxyprogesterone caproate must be billed with:
• Procedure code J1725
• Diagnosis codes O09211, O09212, O09213, or O09219
• NDC

Claims for procedure code J1725 with and without modifier U1 must be billed using the payable diagnosis code O09211, O09212, O09213, or O09219.

### 3.4.13 Antenatal and Postnatal Visits

Texas Medicaid reimburses antepartum care, deliveries, and postpartum care as individual procedures. Antepartum and postpartum care visits billed in place of service (POS) 3 (inpatient), will be denied as part of another procedure when billed within the three days prior to delivery or the six weeks after delivery.

Physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 outpatient antepartum care visits per pregnancy. Licensed midwives (LMs) are limited to 20 outpatient antepartum care visits per pregnancy to be performed in a birthing center; postpartum visits are not separately reimbursed. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client's medical record documentation should reflect the need for increased visits and is subject to retrospective review.
Providers should bill the most appropriate new or established antenatal visit code or postnatal visit code. New patient codes may be used when the client has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years (36 months). Refer to Table Q for antenatal and postnatal care procedure codes.

Antenatal visits must be billed to the highest level of specificity with the appropriate level evaluation and management (E/M) procedure code with the TH modifier.

**Note:** Failure to use the TH modifier may result in recoupment of payment rendered.

Postpartum care (procedure code 59430 (postpartum care only, separate procedure) is limited to one claim per pregnancy.

Licensed midwives are not reimbursed for postpartum visits.

Postpartum care only (procedure code 59430) will be denied if any delivery procedure that includes postpartum care (procedure codes 59410, 59515, 59614, and 59622) was billed within the prior 45 days by any provider.

Any other E/M office visit will not be reimbursed when billed on the same day, by the same provider, as any antenatal or postpartum office visit. Modifier 25 may be used to identify a significant separately identifiable E/M service by the same physician on the same day of the procedure or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

### 3.4.14 Certified Nurse Midwife (CNM) and Licensed Midwife (LM)

All limitations applied to the physician for payable services also apply to the CNM and LM.

CNMs must use procedure code 59409, 59410, 59612, or 59614 when billing for delivery.

LMs must use procedure code 59409. No other delivery codes will be reimbursed to LMs.

### 3.4.15 Birthing Center

Refer to Subsection 9.2.44, “*Newborn Services*” in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) for information related to the care of the newborn.

### 3.4.16 Professional Services for Physicians and CNMs

All antenatal services must be billed by the professional in the office setting. Antenatal services will not be reimbursed when billed in the birthing center setting.

If the client is discharged prior to delivery, procedure codes 99218, 99219, and 99220 may be billed by the professional for labor services only.

Professional claims for delivery services in a birthing center must be billed with procedure codes 59409 or 59410.

### 3.4.17 Professional Services for LMs

Antenatal services provided by LMs will be reimbursed when billed in the birthing center setting with codes 99201, 99202, 99211, or 99212, using TH modifier.

If the client is discharged prior to delivery, procedure codes 99218, 99219, or 99220 may be billed by the professional for labor services only. Clinical documentation that clearly demonstrates level of medical decision making (i.e., moderate or complex) must be included in the client's medical record. All medical documentation is subject to retrospective review. Those services not supported by the documentation in the client's medical record are subject to recoupment.

Professional claims for delivery services in a birthing center must be billed with procedure code 59409.
3.4.18 Facility Services
Deliveries at a facility licensed as a birthing center by the Department of State Health Services (DSHS) must be billed with procedure code 59409.

If the client is discharged prior to delivery, procedure code S4005 may be billed by the facility for labor services only.

3.4.19 Maternity Service Clinic (MSC)
MSCs are limited provider clinics, unrelated to a hospital, that only provide maternity services. An MSC will be reimbursed for antepartum and/or postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied.

3.4.20 Tobacco Use Cessation
Procedure codes for tobacco use cessation counseling (99406 and 99407) may only be reimbursed when an appropriate diagnosis code (O99330, O99331, O99332, O99333, O99334 or O99335) is billed.

Procedure codes 99406 and 99407 are limited to once per day, same or different procedure code, any provider.

Procedure codes 99406 and 99407 may be billed in any combination by the same or different provider, and are limited to eight services per rolling year.

4 Noninvasive Prenatal Testing (NIPT)
Noninvasive prenatal testing (NIPT) is a benefit of Texas Medicaid when medically necessary for the advanced screening of fetal chromosomal abnormalities in pregnant women who meet specific screening criteria. Genetic screening results, when informative, may influence clinical management decisions.

NIPT may be performed as early as ten weeks gestation for specific fetal aneuploidy screening, restricted to Trisomy 13, Trisomy 18, Trisomy 21, and fetal sex chromosome aneuploidy (SCA). To determine NIPT appropriateness, a baseline ultrasound, if not previously performed, is strongly recommended to confirm viability, the number of fetuses, and gestational dating.

If NIPT provides an abnormal screening result, invasive prenatal confirmatory diagnostic testing is strongly encouraged due to the potential risk of a false-positive result from NIPT. Confirmatory diagnostic tests include chorionic villus sampling (CVS) or amniocentesis.

It is recommended that clients who receive an indeterminate result be offered further genetic counseling, comprehensive evaluation with ultrasound, and diagnostic testing due to the increased risk of aneuploidy. Higher body mass index (BMI) may affect NIPT results. Clients weighing more than 250 pounds are at risk of having an inconclusive result from NIPT.

NIPT does not assess the risk for fetal anomalies such as neural tube defects or ventral wall defects. Ultrasound evaluation and maternal serum alpha-fetoprotein screening should be offered for these risk assessments.

NIPT must be ordered by the medical provider rendering direct care to the client. The provider must order the most appropriate test based on the client’s medical history and the results of previous screenings, if available. The provider must clarify for the client the option to decline, and the provider must document that the option to decline was clearly provided in the client’s medical record.

Note: Some noninvasive prenatal tests include an extended panel that screens for microdeletions and additional trisomies, such as T16 and T22. However, this use has not been validated, and the “opt-out” box on the requisition form should be checked.
4.1 Screening for Fetal Sex Chromosome Aneuploidy

In addition to trisomy (e.g., T13, T18, T21), NIPT procedure code 81420 may also screen for fetal SCA (e.g., 45, X; 47, XXX; 47, XXY; 47, XYY). It is recommended that diagnostic testing be offered rather than NIPT if a fetal structural anomaly (e.g., hydrops, cystic hygroma, cardiac malformations, abdominal wall defects, or skeletal abnormalities) is identified upon ultrasound examination.

Sex chromosome aneuploidy of maternal origin should be considered when NIPT results suggest fetal sex chromosome aneuploidy (e.g., 45, X; 47, XXX, 47, XXY; 47, XYY). Other considerations include the risk for incidental findings with NIPT. Appropriate client counseling is encouraged.

4.1.1 Screening Criteria

NIPT is a benefit for singleton pregnancies. At least one of the following criteria must be met for a client to be eligible for NIPT:

- Fetal ultrasound indicates risk of aneuploidy
- Fetal ultrasound indicates structural anomalies associated with aneuploidy, and the mother wishes to postpone invasive diagnostic testing
- History of pregnancy with aneuploidy
- Maternal age of 35 years or older at time of delivery
- Parental balanced Robertsonian translocation of chromosome 13 or 21
- Abnormal serum screening results for the current pregnancy:
  - First trimester screen
  - Sequential screen
  - Integrated screen
  - Quadruple screen

4.2 Genetic Counseling Requirement

Genetic counseling must be provided by a trained genetic counselor, nurse specialist in genetics, maternal-fetal medicine specialist, or other medical provider (e.g. obstetrician) possessing expertise in genetic counseling who is not affiliated with the genetic testing laboratory. Both pre- and post-test counseling must provide the depth of content and time for the client to make an informed testing decision.

The client must be provided with information about the purpose and nature of the tests. Documentation in the medical record must reflect that the client has been given information on the benefits, risks, and limitations of advanced screening; as well as the nature, inheritance, and implications of genetic disorders. Documentation requirements include all of the following:

- Pre-testing genetic counseling:
  - The date that formal pre-test counseling was provided, with the name and qualifications of the counseling professional
  - The explanation of risks, benefits, and limitations that was discussed with the client
  - The client’s ability to understand the risks, benefits, and limitations and the client’s informed choice to proceed with NIPT as evidenced by the client’s signature on a consent form specific to the NIPT to be performed
  - The client's other prenatal screenings or test results, if available, to support medical necessity of NIPT
The client’s NIPT results

Post-testing genetic counseling:
- The date that formal post-test counseling was provided, with the name and qualifications of the counseling professional
- The clear, non-directive explanation provided to the client concerning the findings and implications of the NIPT results
- The client’s ability to understand the results and explanation provided

The genetic counseling must be nondirective. The purpose of the provider’s information is not to direct the client, but to allow the client to make informed medical and personal decisions.

Clients should be informed that a negative NIPT result does not ensure an unaffected pregnancy.

4.3 Prior Authorization

Prior authorization is required for NIPT procedure codes 81420 and 81507. The prior authorization request must be submitted on the Special Medical Prior Authorization (SMPA) Request Form completed, signed, and dated by the provider rendering direct care to the client, and include the performing laboratory’s TPI in section D of the form. The requesting provider must share the authorization number with the laboratory provider submitting the claim. Requests from laboratories will not be processed.

The expected dates of service requested in Section B of the Special Medical Prior Authorization (SMPA) Request Form must not exceed 45 days. Prior authorizations will only be approved for 45 days, during which time the client must obtain testing.

Note: For prior authorization requests submitted before the client’s 10th week of gestation, the expected dates of service must begin no sooner than the 10th week of gestation. Approved prior authorizations will expire 45 days from the start of service date indicated on the SMPA form.

The provider must indicate on the prior authorization request form that the client meets required criteria (as noted above in Screening Criteria) for NIPT.

Prior authorization requests for sequencing analysis of fetal sex chromosome aneuploidy (procedure code 81420) must include a description of the medical need for the service on the prior authorization request form. Inadequate documentation for the addition of fetal sex chromosome aneuploidy screening may result in the denial of procedure code 81420. Providers may resubmit a request for procedure code 81420 without SCA screening, or may submit a request for procedure code 81507.

The request for prior authorization should document that the client was provided counseling regarding potential outcomes of aneuploidy screening, as well as potential outcomes of fetal sex chromosome aneuploidy screening when elected, and that she understands the implications associated with each possible aneuploidy result.

Prior authorization requests may be submitted to the TMHP Special Medical Prior Authorization Department via mail, fax, or the electronic portal. Providers may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Medical documentation submitted by the provider must verify any indications the provider included on the form, such as the client’s age, history of affected pregnancy or family history, anomalous ultrasound findings, or abnormal maternal serum results. Requisition forms from the laboratory are not sufficient for verification of genetic history.

A no-call or inconclusive result is possible and further diagnostic testing is strongly recommended in these cases.
NIPT procedure codes 81420 and 81507 are limited to once per pregnancy. Additional tests will not be authorized.

**Note**: Providers may appeal denied claims with documentation of a new pregnancy.

### 4.3.1 Additional Documentation Requirements

In addition to the documentation of pre and post genetic counseling, and the option to decline NIPT provided to the client, the following NIPT documentation must also be maintained in the client’s medical record and is subject to retrospective review:

- The appropriateness and benefit of NIPT specific to the client
- The client’s specific high-risk criteria

### 4.4 NIPT Limitations

Procedure codes 81507 and 81420 are restricted to female clients only who are 10 through 55 years of age. Procedure code 81420 will be denied when billed during the same pregnancy as procedure code 81507, by any provider. Claims that have been paid for procedure code 81420 are subject to recoupment if procedure code 81507 is submitted later for the same pregnancy.

### 4.5 Non-Covered Services

The following NIPT services are not a benefit of Texas Medicaid:

- NIPT as part of a routine prenatal laboratory assessment
- NIPT if performed without informed patient choice and pre- and post-test genetic counseling from a qualified professional
- NIPT for women who do not meet the criteria outlined above
- NIPT for women with multiple gestations (e.g., twins, triplets, etc.)
- NIPT for screening of chromosomal microdeletion syndromes
- NIPT for screening of trisomy other than T13, T18, or T21
- NIPT for sex determination, paternity determination, or non-medical reasons
- NIPT is not reimbursed with procedure code 81599

### 5 Texas Women’s Health Program

#### 5.1 Texas Women’s Health Program (TWHP) TWHP Overview

The goal of TWHP is to expand access to family planning services to reduce unintended pregnancies in the eligible population.

TWHP is established to achieve the following objectives:

- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions.
- Ensure the efficient and effective use of state funds in support of these objectives and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly-funded healthcare (including federally-funded healthcare) by providing low-income Texans access to safe, effective services that are consistent with these objectives.
• Enforce Human Resources Code, §32.024(c-1) and any other state law that regulates delivery of non-federally funded family planning services.

Refer to: Subsection 1.1, “Family Planning Overview” in this handbook for an overview of family planning funding sources.

The TMHP TWHP web page at www.tmhp.com/Pages/TWHP/TWHP_Home.aspx, for more information about provider certification.

5.1.1 Guidelines for TWHP Providers

TWHP provides an annual family planning exam, family planning services, contraception, and treatment for certain sexually transmitted infections (STIs) for women who meet the following qualifications:

• Must be 18 through 44 years of age
• Must be a United States citizen or eligible immigrant
• Must be a resident of Texas
• Does not currently receive full Medicaid benefits including Medicaid for pregnant women, Children’s Health Insurance Program (CHIP), or Medicare Part A or B.
• Does not have other insurance that covers family planning services, or has insurance that covers family planning services, but filing a claim on the health insurance would cause physical, emotional, or other harm from a spouse, parent, or other person
• Has a household income at or below 185 percent of the federal poverty level
• Is not pregnant
• Is not sterile, infertile, or unable to get pregnant because of medical reasons

Note: Women who have received a sterilization procedure, but have not been confirmed to be sterile, may be eligible for sterilization follow-up services.

TWHP services are provided by a physician or under physician direction, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by an RN, PA, NP, or CNS. TWHP participants may receive services from any provider that participates in TWHP.

TWHP clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate. They must also be allowed the freedom to accept or reject services without coercion. All TWHP-covered methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference. Only TWHP clients, not their parents, spouses, or any other individuals may consent to the provision of family planning services.

Providers may use the client’s Your Texas Benefits Card to verify the client’s TWHP eligibility on the HHSC website at www.yourtexasbenefitscard.com.

Client eligibility may also be verified using the following sources:

• The TMHP website at www.tmhp.com
• The Automated Inquiry System (AIS)
• TexMedConnect

Refer to: Subsection 4.5.3, “Client Eligibility Verification” in Section 4, “Client Eligibility” (Vol. 1, General Information).
TWHP clients will have the following identifiers on the feedback received from the stated source:

- Medicaid Coverage: W - MA - TWHP
- Program Type: 68 - MEDICAL ASSISTANCE - WOMEN’S HEALTH PR
- Program: 100 - MEDICAID
- Benefit Plan: 100 - Traditional Medicaid

A TWHP client can be disenrolled from the program before the 12-month term ends only in the following cases:

- The client dies
- The client voluntarily withdraws from TWHP
- The client no longer satisfies the TWHP eligibility criteria
- The client becomes eligible for full Medicaid, the Children’s Health Insurance Program (CHIP), or another publicly-funded health coverage program that is more comprehensive than TWHP
- HHSC discovers the client gave fraudulent information on the application
- The client moves out of Texas

If it is discovered during the visit that the client has received a surgical or nonsurgical sterilization procedure before enrolling with TWHP, but the client did not indicate that information on the TWHP application (e.g., because she filled out the TWHP application incorrectly, she misunderstood the question), the provider should:

- Inform the client that she is no longer eligible to receive TWHP services and that she is responsible for all of the fees for services rendered.
- Encourage the client to call 1-866-993-9972 to voluntarily withdraw from TWHP.

If a provider suspects that a TWHP client has committed fraud on the application, the provider should report the client to the HHSC Office of Inspector General (OIG) at 1-800-436-6184.

5.1.2 Referrals

If a provider identifies a health problem such as diabetes or high blood pressure, the provider must refer the TWHP client to another doctor or clinic that can treat her. As mandated by Texas Human Resources Code, Section 32.024(c-1), TWHP does not reimburse for office visits where TWHP clients are referred for elective abortions.

HHSC prefers that clients be referred to local indigent care services. However, the toll-free Information and Referral hotline 2-1-1, can assist clients and providers with locating low-cost health services for clients in need.

5.1.2.1 Referrals for Breast and Cervical Cancer Screening, Diagnostics, and Treatment

The Breast and Cervical Cancer Services program (BCCS) offers breast and cervical cancer screening and diagnostic services, and cervical dysplasia treatment throughout Texas at no or low-cost to eligible women.

5.1.2.2 Referrals for Clients Diagnosed with Breast or Cervical Cancer

Medicaid for Breast and Cervical Cancer (MBCC) provides access to cancer treatment through full Medicaid benefits for qualified women diagnosed with breast or cervical cancer. Health facilities that contract with BCCS are responsible for assisting women with the MBCC application.

To find a BCCS provider, call 2-1-1. For questions about the BCCS program, contact the state office at (512)-458-7796, or visit www.dshs.state.tx.us/bcccs/.
5.1.3 Abortions

Elective and non-elective abortions are not benefits of TWHP.

Texas Human Resources Code, Section 32.024(c-1) and Title 25 Texas Administrative Code, §39.38 prohibit the participation of a provider that performs or promotes elective abortion or affiliates with an entity that performs or promotes elective abortions.

A provider that performs elective abortions (through either surgical or medical methods) or that is affiliated with an entity that performs or promotes elective abortions for any patient is ineligible to serve TWHP clients and cannot be reimbursed for any services rendered to a TWHP client. This prohibition only applies to providers delivering services to TWHP clients. The prohibition does not impact services delivered to Medicaid clients who are not enrolled in TWHP.

“Elective abortion” means the intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means: (A) to terminate a pregnancy that resulted from an act of rape or incest; (B) in a case in which a woman suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the woman in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or (C) in a case in which a fetus has a severe fetal abnormality, meaning a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

Certain providers that want to participate in TWHP must certify that they do not perform or promote elective abortions and do not affiliate with any entity that does, as directed by HHSC.

Refer to: Subsection 5.2, “TWHP Provider Enrollment” in this handbook for more information about certification regarding elective abortions.

5.2 TWHP Provider Enrollment

Certain providers who deliver family planning services, have completed the Medicaid-enrollment process through TMHP, and have certified that they do not perform elective abortions or affiliate with providers that perform elective abortion are eligible to participate.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.1, “Title XIX Provider Enrollment” in this handbook.

Certain providers that want to participate in TWHP must certify that they do not perform or promote elective abortions and do not affiliate with any entity that does, as directed by HHSC. Providers may complete the Texas Women’s Health Program (TWHP) Provider Certification Form and disclose the required information as part of the Medicaid enrollment process, or at any time after completing the Medicaid enrollment process. New providers may use the TMHP website to submit the Texas Women’s Health Program (TWHP) Provider Certification Form through the Provider Enrollment Portal (PEP). Medicaid-only providers may use the TMHP website to submit the Texas Women’s Health Program (TWHP) Provider Certification Form through the Provider Information Management System (PIMS).

The following provider types are required to certify:

- Physician or physician group with a general surgery, family practice/general practice, gynecology, OB/GYN, internal medicine, or pediatric specialty, or a clinic/group practice
- Federally Qualified Health Center (FQHC)
- Physician Assistant
- Nurse practitioner/clinical nurse specialist
• Certified nurse midwife/registered nurse/licensed midwife
• Maternity Services Clinic
• Family Planning Agency
• Rural Health Clinic - Freestanding/Independent
• Rural Health Clinic - Hospital Based
• Ambulatory Surgical Center - Freestanding/Independent

Information that providers submit through PIMS can be searched by clients who use the Find a Doctor Today feature on the TWHP website at www.texaswomenshealth.org.

5.3 Services, Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through TWHP. TWHP benefits include:

• Annual family planning exam and Pap test
• Other family planning office or outpatient visits
• Laboratory procedures
• Radiology services
• Contraceptive methods and follow-up visits related to the client’s chosen contraceptive method
• Counseling for specific methods and use of contraception (as part of evaluation and management services), including natural family planning and excluding emergency contraception
• Drugs and supplies
• Medical counseling and education
• Female sterilization and sterilization-related procedures and follow-up visits, including procedures to confirm sterilization
• Pregnancy tests and STI screenings during a family planning exam
• Treatments for certain sexually transmitted infections (STIs)

For TWHP family planning claims to process correctly, providers must use one of the following diagnosis codes in conjunction with all TWHP family planning procedures and services:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A5400</td>
</tr>
<tr>
<td>Z302</td>
</tr>
<tr>
<td>Z3049</td>
</tr>
</tbody>
</table>

The choice of diagnosis code must be based on the type of family planning service performed.
5.3.1 Family Planning Annual Exams

Family planning providers must bill the most appropriate E/M visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a TWHP diagnosis code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99243</td>
</tr>
</tbody>
</table>

**Important:** Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Most appropriate E/M procedure code with modifier FP and a TWHP diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>Established patient: Most appropriate E/M procedure code with modifier FP and a TWHP diagnosis code</td>
<td>Once a year*</td>
</tr>
</tbody>
</table>

Refer to: Subsection 5.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of TWHP diagnosis codes.

**Note:** TWHP does not reimburse for follow-up visits after an abnormal Pap test.

5.3.2 Other Family Planning Office or Outpatient Visits

TWHP only covers office or other outpatient family planning visits if the primary purpose of the visit is related to contraceptive management, as indicated by the allowable diagnosis codes previously listed. TWHP does not cover office or other outpatient family planning visits when the primary purpose of the visit is not related to contraceptive management, such as visits for the purpose of pregnancy testing only, STI testing, or a repeat Pap test after an abnormal result.

A provider is allowed to bill clients for services that are not a benefit of TWHP.

Refer to: Subsection 1.6.9.1, “Client Acknowledgment Statement” in Section 1, “Provider Enrollment and Responsibilities” (Vol. 1. General Information) for the requirements for billing clients.
For office or other outpatient family planning E/M visits, providers must bill one of the following procedure codes based on the complexity of the visit with a TWHP family planning diagnosis code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99253</td>
</tr>
</tbody>
</table>

**Important:** Family planning E/M office and outpatient visits should not be billed with modifier FP. Claims filed incorrectly may be denied.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for each type of visit:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Most appropriate E/M procedure code with a TWHP diagnosis code</td>
<td>One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>Established patient: Most appropriate E/M procedure code with a TWHP diagnosis code</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.

**Refer to:** Subsection 5.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of TWHP diagnosis codes.

Family planning services provided during a TWHP visit in which only family planning services were provided must be submitted with these procedure codes and the most appropriate informational procedure codes for services that were rendered.

The procedure codes in the previous table are allowed for routine contraceptive surveillance, family planning counseling and education, and contraceptive problems. Depending on the extent of the services provided during the office visit, providers may bill for the maximum allowable fees.

During any visit for a medical problem or follow-up visit the following must occur:

- An update of the client’s relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

### 5.3.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per client, per year regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters or an annual family planning examination. Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.
A TWHP diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

Refer to: Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook, (Volume 2, Provider Handbooks) for more information about FQHC services.

5.3.3 Laboratory Procedures

If the provider who obtains the specimen does not perform the laboratory procedure, the provider who obtains the specimen may be reimbursed one lab handling fee per day, per client. The fee for the handling or conveyance of the specimen for transfer from the provider’s office to a laboratory may be reimbursed using procedure code 99000 and a family planning diagnosis code. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office by using the modifier SU, procedure performed in physician’s office.

Providers must forward the client’s name, address, member ID, and a family planning diagnosis with any specimen, including Pap smears, to the reference laboratory so the laboratory may bill TWHP for its family planning lab services.

When family planning test specimens, such as Pap smears, are collected, providers must direct the laboratory to indicate that the claim for the test is to be billed as a family planning service (i.e., procedure must be billed with a TWHP qualifying diagnosis code).

Refer to: Subsection 2.2.3, “Laboratory Procedures” in this handbook for more information about family planning laboratory services.

Subsection 5.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of TWHP diagnosis codes.


TWHP laboratory services may be submitted using the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061 81000 81001 81002 81003 81015 81015 81025 82947 82948 84443</td>
</tr>
<tr>
<td>84702 84703 85013 85014 85018 85025 85027 86318 86518 86592</td>
</tr>
<tr>
<td>86689 86695 86696 86701 86703 86703 86762 86803 86600 86901 87070</td>
</tr>
<tr>
<td>87086 87088 87092 87110 87205 87210 87220 87252 87340 87389</td>
</tr>
<tr>
<td>87480 87490 87491 87510 87590 87591 87592 87593 87623 87624 87625 87660</td>
</tr>
<tr>
<td>87797 87800 87801 87810 87850 88142 88150 88164 88175 99000</td>
</tr>
<tr>
<td>99001</td>
</tr>
</tbody>
</table>

Appropriate documentation must be kept in the client’s record.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If more than one of procedure codes 87480, 87510, 87660, or 87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes will be denied.

TWHP follows the Medicare categorization of tests for CLIA certificate holders.

5.3.4 Radiology
The following procedure codes may be reimbursed for radiology services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>74000</td>
</tr>
</tbody>
</table>

5.3.5 Contraceptive Devices and Related Procedures
The following procedure codes may be reimbursed for contraceptive devices and related procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11976</td>
</tr>
<tr>
<td>J7300</td>
</tr>
</tbody>
</table>

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program. Procedure code 11981 may be reimbursed when it is submitted with the most appropriate family planning diagnosis code.

Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z30432</td>
</tr>
</tbody>
</table>

Procedure code J7297, J7298, J7300, and J7301 may be reimbursed when it is billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z30430</td>
</tr>
</tbody>
</table>

An E/M procedure code will not be reimbursed when it is billed with the same date of service as procedure code 58301, unless the E/M visit is a significant, separately identifiable service from the removal of the IUD. If the E/M visit occurs on the same date of service as the removal of the IUD, modifier 25 may be used to indicate that the E/M visit was a significant, separately identifiable service from the procedure, and documentation must be included in the client’s medical record that indicates either the key components (history, physical examination, and medical decision making) or time spent counseling.

Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Note: TWHP does not reimburse for counseling for, or provision of, emergency contraception.

5.3.6 Drugs and Supplies
Procedure codes A4267, A4268, A4269, J1050 and modifier U1, J7303, J7304, and S4993 may be reimbursed for drugs and supplies.

Refer to: Subsection 5.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for a list of TWHP family planning diagnosis codes.
Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

For TWHP services, procedure code J1050 is not diagnosis restricted.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z30018</td>
</tr>
<tr>
<td>Z3009</td>
</tr>
<tr>
<td>Z302</td>
</tr>
<tr>
<td>Z3040</td>
</tr>
<tr>
<td>Z3041</td>
</tr>
<tr>
<td>Z3042</td>
</tr>
<tr>
<td>Z30431</td>
</tr>
</tbody>
</table>

Note: TWHP does not reimburse providers for counseling about emergency contraception or the provision of emergency contraception.

5.3.6.1 Prescriptions and Dispensing Medication

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP. Family planning clinics may be reimbursed for dispensing up to a one year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

Refer to: “Appendix B: Vendor Drug Program” (Vol. 1, General Information) for information about outpatient prescription drugs and the Vendor Drug Program.

5.3.6.1.1 Long-Acting Reversible Contraception Products

Certain long-acting reversible contraception (LARC) products are available as a pharmacy benefit of TWHP and are available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers can refer to the Texas Medicaid/CHIP Vendor Drug Program website at http://www.txvendordrug.com/formulary/larc.shtml for additional information, including a list of covered products and participating specialty pharmacies.

5.3.6.2 Injection Administration

Injection administration may be reimbursed separately from the medication. Administration procedure code 96372 must be billed with a family planning diagnosis code and the National Drug Code (NDC) of the medication that was administered.

Claims for procedure code 96372 may not be submitted by outpatient hospitals.

5.3.7 Instruction in Natural Family Planning Methods

Procedure code H1010 is a benefit of TWHP and is limited to one service per day when billed by any provider with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z30018</td>
</tr>
<tr>
<td>Z3002</td>
</tr>
<tr>
<td>Z3009</td>
</tr>
<tr>
<td>Z302</td>
</tr>
<tr>
<td>Z3040</td>
</tr>
<tr>
<td>Z3041</td>
</tr>
<tr>
<td>Z3042</td>
</tr>
<tr>
<td>Z30430</td>
</tr>
<tr>
<td>Z30431</td>
</tr>
<tr>
<td>Z30432</td>
</tr>
<tr>
<td>Z30433</td>
</tr>
<tr>
<td>Z3049</td>
</tr>
<tr>
<td>Z308</td>
</tr>
<tr>
<td>Z309</td>
</tr>
<tr>
<td>Z9851</td>
</tr>
</tbody>
</table>

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning and may consist of two sessions. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.
5.3.8 Sterilization and Sterilization-Related Procedures

Sterilizations are considered to be permanent, once per lifetime procedures. Denied claims may be appealed with documentation that supports the medical necessity for a repeat sterilization.

The sterilization services that are available to TWHP clients include surgical or nonsurgical sterilization, follow-up office visits related to confirming the sterilization, and any necessary short-term contraception. No other services are covered for TWHP clients who have been sterilized.

TWHP covers sterilization as a form of birth control. To be eligible for a sterilization procedure through TWHP, the client must be 21 years of age or older and must complete and sign a Sterilization Consent Form within at least 30 days of the date of the surgery but no more than 180 days. In the case of an emergency, there must be at least 72 hours between the date on which the consent form is signed and the date of the surgery. Operative reports that detail the need for emergency surgery are required.

TWHP may reimburse providers for a follow-up visit that includes a hysterosalpingogram to ensure tubal occlusion, which is recommended three months after a hysteroscopic sterilization procedure. TWHP may also reimburse providers for short-term contraceptives dispensed following the insertion of an occlusive sterilization system.

5.3.8.1 Sterilization Consent

Per federal regulation 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.
Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.
Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

5.3.8.2 Tubal Ligation

Procedure code 58600, 58611, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

5.3.8.3 Anesthesia for Sterilization

Procedure code 00851 must be used when reporting anesthesia services for a tubal ligation sterilization procedure.

5.3.8.4 Facility Fees for Sterilization

Hospital-based and freestanding ASCs may be reimbursed for procedure code 58565, 58600, 58615, 58670, 58671, or A4264. An appropriate TWHP diagnosis code must be billed when reporting facility fees related to tubal ligation.

Refer to: Section 5, “Ambulatory Surgical Center and Hospital Ambulatory Surgical Center” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for more information about ASC billing procedures.

5.3.8.5 Hysteroscopic Sterilization

Procedure code 58340 or 58565 may be reimbursed for the fallopian tube occlusion sterilization when submitted with diagnosis code Z302. Procedure code 58565 is considered bilateral.

The occlusive sterilization system (micro-insert) is a benefit when billed with procedure code A4264. Procedure code A4264 may be reimbursed for females 10 years through 55 years of age.
5.3.8.6   **TWHP Services After Sterilization**

A hysterosalpingogram is recommended three months after a hysteroscopic sterilization procedure to ensure tubal occlusion. Procedure code 74740 is considered for reimbursement in this circumstance when submitted with diagnosis code Z302. Procedure code 58340 may be billed for introduction of saline or contrast material for hysterosalpingography.

FQHC and professionals who render family planning services in the RHC setting may bill procedure codes 99201 and 99211 with an appropriate TWHP diagnosis code to receive their encounter reimbursement for follow-up services to confirm the sterilization of TWHP clients. FQHC providers may be reimbursed up to three family planning encounters per calendar year, per client. Professionals who render family planning services in the RHC setting may be reimbursed one encounter rate per calendar year, per TWHP client for family planning visits provided through TWHP.

5.3.8.6.1   **Clients Who Have Received Sterilization Services**

After the sterilization and all related services have been completed, the client is no longer eligible for TWHP services. Clients who have been sterilized cannot enroll in TWHP unless they are seeking to have the sterilization confirmed. After sterilization has been confirmed, a client is not eligible for TWHP coverage.

After an occlusive sterilization procedure, if the client’s 12-month TWHP coverage lapses before the sterilization is confirmed, the client may reapply for coverage in order to access short-term contraceptives and the hysterosalpingography necessary to confirm that the fallopian tubes are blocked. If it has not been confirmed that the occlusive sterilization system is blocking the fallopian tubes, the client is not considered to have been sterilized.

Providers must inform TWHP clients who seek sterilization that, after the sterilization procedure, TWHP covers only the follow-up visit to confirm the sterilization and the short-term contraceptives that are dispensed for the 12-week period following the insertion of an occlusive sterilization system.

5.3.9   **Treatment for Sexually Transmitted Infections (STIs)**

TWHP reimbursement for treatment of STIs is available only if the condition was discovered during a visit where the primary purpose was the client’s family planning needs, i.e., contraception or contraceptive counseling.

TWHP covers treatment for the following conditions:

- Gardnerella
- Trichomoniasis
- Candida
- Chlamydia
- Gonorrhea
- Herpes

Reimbursement for the treatment of STIs is available through the Texas Vendor Drug Program (VDP). Clients can access their prescribed drugs through pharmacies that are enrolled in the VDP.

**Refer to:** The Texas VDP website at [www.txvendordrug.com/formulary](http://www.txvendordrug.com/formulary) for more information.

**Note:** *TWHP does not reimburse for the treatment of any non-STD conditions that are diagnosed during a TWHP visit.*
5.3.9.1 Gonorrhea Treatment

Procedure code J0696 may be reimbursed for gonorrhea treatment services rendered to TWHP clients. Procedure code J0696 may be reimbursed when it is submitted with diagnosis code A5400, A5409, A545, or A546 as the referenced diagnosis code.

*Note:* Other TWHP services will not be reimbursed if they are submitted with diagnosis codes A5400, A5409, A545, or A546 as referenced diagnoses.

5.3.10 Prior Authorization

Prior authorization is not required for TWHP services.

5.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including TWHP services.

TWHP services are subject to retrospective review and recoupment if documentation does not support the service billed.

5.5 TWHP Claims Filing and Reimbursement

5.5.1 Claims Information

Providers must use the appropriate claim form to submit TWHP claims to TMHP.

*Refer to:* Subsection 2.4, “Claims Filing and Reimbursement” in this handbook for more information about filing family planning claims.

5.5.1.1 TWHP and Third Party Liability

Federal and state regulations mandate that family planning client information be kept confidential.

Because seeking information from third party insurance may jeopardize the client’s confidentiality, third party billing for TWHP is not allowed.

5.5.2 Reimbursement

Services provided under TWHP are reimbursed according to Medicaid rules at standard Medicaid rates.

5.5.3 National Drug Code


5.5.4 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.
6 Department of State Health Services (DSHS) Family Planning Program Services

6.1 Provider Enrollment for DSHS Family Planning Program Contractors

Agencies that submit claims for DSHS Family Planning Program Services must have a contract with DSHS. The DSHS Community Health Services Section determines client eligibility and services policy. Refer to the DSHS Family Planning Policy Manual for specific eligibility and policy information at www.dshs.state.tx.us/famplan.

Refer to: Section 1: Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.

Subsection 2.1, “Title XIX Provider Enrollment” in this handbook.

Subsection 1.1, “Family Planning Overview” in this handbook for more information about family planning funding sources, guidelines for family planning providers, and family planning services for undocumented aliens and legalized aliens.

6.2 Services, Benefits, Limitations, and Prior Authorization

This section contains information about family planning services funded through the DSHS Family Planning Program funding source including:

- Family planning annual exams
- Other family planning office or outpatient visits
- Laboratory procedures
- Radiology services
- Contraceptive devices and related procedures
- Drugs and supplies
- Medical counseling and education
- Sterilization and sterilization-related procedures (i.e., tubal ligation, vasectomy, and anesthesia for sterilization)

Providers are encouraged to include one of the following family planning diagnosis codes on the claim in conjunction with all family planning procedures and services:

<table>
<thead>
<tr>
<th>Diagnosis Codes (Submitted as stand-alone diagnosis codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30011</td>
</tr>
<tr>
<td>Z3041</td>
</tr>
<tr>
<td>Z309</td>
</tr>
</tbody>
</table>

One of the diagnosis codes in this table may be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

6.2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client’s problems and needs, and the implementation of an appropriate contraceptive management plan.
DSHS family planning providers must bill the most appropriate E/M visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>


The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for the annual examination:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patient: Appropriate E/M procedure code with modifier FP</strong></td>
<td>One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td><strong>Established patient: Appropriate E/M procedure code with modifier FP</strong></td>
<td>Once per state fiscal year*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: Subsection 6.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using Modifier 25 to indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

6.2.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive the encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 6.2.1, “Family Planning Annual Exams” in this handbook and must use modifier FP.

The annual exam is allowed once per fiscal year, per client, per provider. Other family planning office or outpatient visits may be billed within the same year.

A new patient visit for the annual exam may be reimbursed once every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

6.2.2 Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, genitourinary infections, and evaluation of other reproductive system symptoms.
During any visit for a medical problem or follow-up visit, the following must occur:

- An update of the client’s relevant history
- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

For general family planning visits, DSHS Family Planning Program Providers must bill one of the following, most appropriate E/M procedure code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
</tbody>
</table>

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for general family planning office or outpatient visits:

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Appropriate E/M procedure code</td>
<td>One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>Established patient: Appropriate E/M procedure code</td>
<td>As needed*</td>
</tr>
</tbody>
</table>

* The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.

For appropriate claims processing, providers are encouraged to use a family planning diagnosis code to bill the annual family planning exam.

Refer to: Subsection 6.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

6.2.2.1 FQHC Reimbursement for Family Planning Office or Outpatient Visits

To receive the encounter rate for a general family planning visit, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated previously in the tables in subsection 5.5.3, “National Drug Code” in this handbook.

FQHCs may be reimbursed for three family planning encounters per client, per year regardless of the reason for the encounter. The three encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7297, J7298, J7300, J7301, J7303, J7304, J7307, or S4993.

The new patient procedure codes will be limited to one new patient E/M procedure code three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using Modifier 25 to
indicate that the client’s condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

Refer to: Section 4, “Federally Qualified Health Center (FQHC)” in the Clinics and Other Outpatient Facility Services Handbook, (Volume 2, Provider Handbooks) for more information about FQHC services.

6.2.3 Laboratory Procedures

6.2.3.1 DSHS Family Planning Program

The following procedure codes may be reimbursed for DSHS Family Planning Program family planning laboratory services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061</td>
</tr>
<tr>
<td>84702</td>
</tr>
<tr>
<td>86695</td>
</tr>
<tr>
<td>87086</td>
</tr>
<tr>
<td>87480</td>
</tr>
<tr>
<td>87800</td>
</tr>
</tbody>
</table>

Appropriate documentation must be maintained in the client’s record.

Refer to: Subsection 5.3.3, “Laboratory Procedures” in this handbook for more information about family planning laboratory services requirements. Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in the Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks).

Texas Medicaid follows the Medicare categorization of tests for CLIA certificate holders.

Refer to: The CMS website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

6.2.4 Immunization Administration

Procedure codes 90460 and 90471 may be reimbursed when billed for vaccine administration.

Procedure code 90460 will be denied if billed on the same date of service as procedure codes 90630, 90632, or 90636.

6.2.4.1 Human Papilloma Virus (HPV) Vaccine

Procedure codes 90649 and 90650 may be reimbursed for the Human papilloma virus (HPV) vaccine.

6.2.5 Radiology

The following radiology services may be reimbursed for services performed for the purpose of localization of an IUD:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>73060</td>
</tr>
</tbody>
</table>

Procedure codes 76881 and 76882:

- Must be submitted with the most appropriate family planning diagnosis code
- Will be denied if they are submitted with the same date of service as procedure codes 55250 or 58600
6.2.6 Contraceptive Devices and Related Procedures

6.2.6.1 External Contraceptives

The following procedure codes may be reimbursed separately from the fitting and instruction (procedure code 57170):

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>57170</td>
<td>A4261 (cervical cap)</td>
</tr>
</tbody>
</table>

6.2.6.2 IUD

IUD services may be reimbursed using the following:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>58300</td>
</tr>
<tr>
<td>58301</td>
</tr>
<tr>
<td>J7297</td>
</tr>
<tr>
<td>J7298</td>
</tr>
<tr>
<td>J7300</td>
</tr>
<tr>
<td>J7301</td>
</tr>
</tbody>
</table>

6.2.6.2.1 Insertion of an IUD

The IUD and the insertion of the IUD may be reimbursed using procedure code J7297, J7298, J7300, J7301, and 58300.

The following reimbursement may apply:
- Procedure codes J7297, J7298, J7300, or J7301 may be reimbursed at full allowance.
- Procedure code 58300 may be reimbursed at full allowance.

When a vaginal, cervical, or uterine surgery (e.g., cervical cauterization) is billed for the same date of service as the insertion of the IUD, the following reimbursement will apply:
- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- Procedure code 58300 (IUD insertion) may be reimbursed at half the allowed amount.

6.2.6.2.2 Removal of the IUD

Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity.

When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:
- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

6.2.6.3 Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307 and procedure code 11981 (implantation). Procedure code 11981 may be reimbursed when billed with an appropriate family planning diagnosis code.

Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the FDA, the removal of the implanted contraceptive capsule may be considered for reimbursement with procedure code 11976 (removal).
6.2.6.4 Medroxyprogesterone Acetate/Estradiol Cypionate

Medroxyprogesterone acetate/estradiol cypionate has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate/estradiol cypionate given at 28- to 30-day intervals has been proven to be a short-term method to prevent pregnancy and will be limited to no more frequently than every 28 days.

6.2.7 Drugs and Supplies

The following drug and supply procedure codes may be reimbursed as:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4267</td>
</tr>
<tr>
<td>A4268</td>
</tr>
<tr>
<td>A4269</td>
</tr>
<tr>
<td>A9150</td>
</tr>
<tr>
<td>J1050/U1</td>
</tr>
<tr>
<td>J3490</td>
</tr>
<tr>
<td>J7303</td>
</tr>
<tr>
<td>J7304</td>
</tr>
<tr>
<td>S4993</td>
</tr>
</tbody>
</table>

Procedure code J1050 with modifier U1 may be reimbursed for services rendered to female clients as medically appropriate for the purpose of contraception. A quantity of 1 must be billed.

For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client. Procedure code A9150 may be reimbursed when a nonprescription medication to treat a monilia infection is provided to the client.

6.2.7.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill TMHP.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a one-year supply of contraceptives in a 12-month period using procedure code J7303, J7304, or S4993.

DSHS Family Planning Program clients may have their prescriptions filled at the clinic pharmacy.

DSHS Family Planning Providers can refer to the DSHS Family Planning Policy and Procedure Manual for additional guidance on dispensing medication.

**Note:** Pharmacies under the Medicaid Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three-prescriptions-per-month rule for up to a six-month supply.

**Refer to:** “Appendix B: Vendor Drug Program” (Vol. 1, General Information) for information about outpatient prescription drugs and the Medicaid Vendor Drug Program.

6.2.7.2 Oral Medication Reimbursement

Procedure code S5000 is a benefit of the DSHS Family Planning Program for oral medication reimbursement.

**Note:** This benefit is for the DSHS Family Planning Program only. This benefit does not apply for Title XIX family planning or TWHP.

6.2.8 Family Planning Education

Medical counseling and education may be reimbursed using procedure code H1010.
6.2.8.1 Medical Nutrition Therapy

For clients requiring intensive nutritional guidance, medical nutritional therapy can be provided as an allowable and billable service using procedure code 97802. Medical nutritional therapy, however, must be provided by a registered dietician in order to be reimbursed. Procedure code 97802 may only be billed up to four times per state fiscal year for the same client by the same provider.

6.2.8.2 Instruction in Natural Family Planning Methods

Counseling with the intent to instruct a couple or an individual in methods of natural family planning may be reimbursed twice a year using procedure code H1010.

6.2.9 Sterilization and Sterilization-Related Procedures

6.2.9.1 Sterilization Consent

Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Note: The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not sterilization consent.

Refer to: Sterilization Consent Form (English) on the TMHP website at www.tmhp.com.
Sterilization Consent Form (Spanish) on the TMHP website at www.tmhp.com.
Sterilization Consent Form Instructions on the TMHP website at www.tmhp.com.

6.2.9.2 Incomplete Sterilizations

Sterilizations are considered to be permanent, once per lifetime procedures. If the claim is denied indicating a sterilization procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

6.2.9.3 Tubal Ligation and Hysteroscopic Occlusion

Procedure codes 58600 and 58565 may be reimbursed for sterilization procedures performed on a female client. Reimbursement for procedure codes 58600 and 58565 include all preoperative, intra-operative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, and so on).

6.2.9.4 Vasectomy

Procedure code 55250 may be reimbursed for any sterilization procedure performed on a male. Reimbursement for procedure code 55250 includes preoperative, intra-operative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, and so on).

Vasectomies are considered to be permanent, once-per-lifetime procedures. If the claim is denied indicating a vasectomy procedure has already been reimbursed for the client, the provider may appeal with documentation that supports the medical necessity for the repeat sterilization.

6.2.10 Prior Authorization

Prior authorization is not required for sterilization and sterilization-related procedures.

6.2.11 Reimbursement for TWHP Wrap-Around Services

FQHC providers and family planning clinic providers contracted through DSHS may receive DSHS Family Planning Program reimbursement for TWHP wrap-around services during a visit. To receive reimbursement, the primary purpose of the visit must not be related to contraception or be reimbursed by TWHP.
FQHC providers and family planning clinic providers may receive reimbursement for the following services that are rendered to TWHP clients when the primary diagnosis is not related to contraception:

- **Follow-up Pap tests** - To receive reimbursement, DSHS contractors must file a separate claim with diagnosis code N889. DSHS contractors may be reimbursed for the Pap test, an appropriate counseling code, and the appropriate visit code.

- **Follow-up visits for sexually transmitted disease/sexually transmitted infection (STD/STI) testing** - To receive reimbursement for a visit that is strictly for the purposes of STD/STI testing for a TWHP client, DSHS contractors must file a separate claim with a diagnosis code of Z202. DSHS contractors may be reimbursed for STD/STI tests and STD/STI related services.

- **Pregnancy test-only visits** - To receive reimbursement for a visit that is for a pregnancy test only, DSHS contractors must file a separate claim with diagnosis code Z3200.

Claims that are submitted by FQHC providers for wrap-around services, but are considered part of a TWHP encounter, will be subject to retrospective review, as these claims are not eligible for reimbursement. Any wrap-around services that are determined to have been paid in error may be recouped.

### 6.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological and reproductive health services and family planning services.

Gynecological and reproductive health services and family planning services are subject to retrospective review and recoupment if documentation does not support the service billed.

### 6.4 Claims Filing and Reimbursement

**6.4.1 Claims Information**

Providers must use the appropriate claim form to submit DSHS Family Planning Program claims to TMHP. Claims for dates of service that span multiple contract periods must be submitted on separate claims for services performed within each contract period.

*Note:* To submit DSHS Family Planning Program claims using TexMedConnect, providers must choose Family Planning Program “Title X-DFPP” on the electronic version of the 2017 claim form.

*Refer to:* Subsection 2.4, “Claims Filing and Reimbursement” in this handbook for more information about filing family planning claims.

**6.4.1.1 Filing Deadlines**

The following table summarizes the filing deadlines for DSHS Family Planning Program claims:

<table>
<thead>
<tr>
<th>Deadline</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>95 days from the date of service on the claim or date of any third party insurance explanation of benefits (EOB)</td>
<td>120 days from the date of the Remittance and Status (R&amp;S) Report on which the claim reached a finalized status</td>
</tr>
<tr>
<td>If the filing deadline falls on a weekend or TMHP-recognized holiday, the filing deadline is extended until the next business day.</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* As stated in the DSHS Family Planning Policy and Procedure Manual, all claims and appeals must be submitted and processed within 60 days after the end of the contract period.
6.4.1.2 Third Party Liability
Federal and state regulations mandate that family planning client information be kept confidential. Because seeking information from third party insurance may jeopardize the client’s confidentiality, prior insurance billing is not a requirement for billing family planning for any title program.

6.4.2 Reimbursement
Reimbursement for family planning procedures is available in the TMHP Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com and on the DSHS website at www.dshs.state.tx.us/famplan.

6.4.2.1 Funds Gone
DSHS family planning providers are contracted to provide services for a specific time period, either the state fiscal year or a contract period within the fiscal year. The providers receive a specific budget amount for their contract period. When their claims payments have reached their budget allowance, providers must continue to submit claims. The amount of funds that they would have received had the funds been available will be tracked as “funds gone.”

Providers may receive additional funds for a contract period at a later time. Claims identified as “funds gone” may be reimbursed at that time.

On the R&S Report, “Claims Paid” is the dollar amount of claims paid during this financial transaction period. “Approved to Pay/Not Funds Gone” is the dollar amount that has been processed and approved to pay, but the payment has not been issued yet. “Funds Gone” is the dollar amount that has been submitted after the provider’s budget allowance has been reached. The amount in “Approved to Pay/Not Funds Gone” added to the amount in “Funds Gone” will equal the amount in the “Approved to Pay - New Claims” section.

6.4.3 NCCI and MUE Guidelines
The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

6.4.4 National Drug Code

7 Gynecological Health Services

7.1 Services, Benefits, Limitations, and Prior Authorization
Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

The following gynecological procedures and services may be benefits of Texas Medicaid:

- Gynecological and family planning examinations
- Contraceptives
- Diagnostic tests
- Surgical procedures
- Gynecological treatments
Refer to: Section 2, “Medicaid Title XIX Family Planning Services” in this handbook for information about contraception, sterilizations, and family planning annual examinations.

7.2 Surgical and Laparoscopic Treatment of Ectopic Pregnancy
Surgical and laparoscopic treatment of ectopic pregnancy (procedure codes 59120, 59121, 59130, 59135, 59136, 59140, 59150, and 59151) is a benefit of Texas Medicaid.

7.3 Laparoscopic Procedures
Laparoscopic procedures (procedure codes 58545, 58546, and 58578) are a benefit of Texas Medicaid.

7.4 Endometrial Cryoablation
Endometrial cryoablation (procedure codes 58353 and 58356) is a benefit of Texas Medicaid.

7.5 Uterine Suspension
Uterine suspension (procedure codes 58400 and 58410) is a benefit of Texas Medicaid.

7.6 Vulvectomy
Vulvectomy (procedure code 55620) is a benefit of Texas Medicaid.

7.6.1 Prior Authorization for Vulvectomy
Prior Authorization is required for vulvectomy.
The prior authorization request must include documentation of one of the following conditions:

- Vulvar intraepithelial neoplasia (VIN)
- Labial enlargement that results in abrasion, irritation, or intractable skin infection

Note: A vulvectomy will not be considered for cosmetic reasons.

7.7 Salpingostomy
Salpingostomy (procedure codes 58673 and 58770) is a benefit of Texas Medicaid.

7.7.1 Prior Authorization for Salpingostomy
Prior authorization is required for salpingostomy.
The prior authorization request must include documentation of one or more of the following conditions:

- Ectopic pregnancy
- Hydrosalpinx unrelated to infertility
- Salpingitis unrelated to infertility
- Torsion of the fallopian tube
- Abscess of the fallopian tube
- Peritubal adhesions unrelated to infertility
- Cyst or tumor of the fallopian tube unrelated to infertility
- Hematosalpinx
7.8 **Ovarian Wedge Resection**

Ovarian wedge resection (procedure code 58920) is a benefit of Texas Medicaid.

7.8.1 **Prior Authorization for Ovarian Wedge Resection**

Prior Authorization is required for ovarian wedge resection.

The prior authorization request must include documentation of polycystic ovarian syndrome (PCOS).

**Note:** Ovarian wedge resection will not be considered to improve chances of conceiving if the PCOS lead to infertility.

7.9 **Assays for the Diagnosis of Vaginitis**

Vaginitis assay procedure codes 87480, 87510, 87660, 87661, 87797, and 87800 are benefits of Texas Medicaid.

If more than one of procedure code 87480, 87510, 87660, 87661, or 87800 is submitted by the same provider for the same client with the same date of service, all of the procedure codes are denied. Only one procedure code (87480, 87510, 87660, 87661, or 87800) may be submitted for reimbursement, and providers must submit the most appropriate procedure code for the test provided:

- **Single organism test.** A single test must be submitted for reimbursement using the appropriate procedure code (87480, 87510, 87660, or 87661) that describes the organism being isolated.
- **Multiple organism test.** When testing for multiple vaginal pathogens, providers must submit procedure code 87800 for reimbursement. Procedure code 87800 is inclusive of procedure codes 87480, 87510, 87660, and 87661 and is the most appropriate code to request reimbursement for multiple tests.

If the claim is denied because more than one procedure code was submitted with the same date of service, the provider must appeal the denied claim with a statement indicating which procedure code is most appropriate and should be considered for reimbursement. Procedure codes 87800, 87480, 87510, 87660, and 87661 should not be submitted for reimbursement by the same provider with the same date of service for the same client on the same claim form or on separate claim forms.

Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797.

Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If a positive test result was not treated, documentation must be present indicating why treatment was not rendered.

7.10 **Hysteroscopy**

Hysteroscopy (procedure codes 58555, 58558, 58559, 58560, 58561, 58562, 58563, and 58579) is a benefit of Texas Medicaid.

7.11 ** Abortions**

According to a revision of the Hyde Amendment, under Public Law 103–112, HHSC implemented the federal directive pertaining to Medicaid reimbursement for abortions. Federal funding is available for a non-elective abortion to save the life of the mother and to terminate pregnancies resulting from rape or incest. Reimbursement is based on the physician’s certification that the abortion was performed to save the mother’s life, to terminate a pregnancy resulting from rape, or to terminate a pregnancy resulting from incest.
The following procedure codes may be used to submit claims for non-elective abortion procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>59830</td>
</tr>
</tbody>
</table>

In accordance with federal law, providers are required to use specific language regarding the reason the mother’s condition is life-threatening. An abortion for a life-threatening condition must be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed.

Reimbursement of an abortion is based on the physician’s certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest.

One of the following statements signed by the physician is mandatory for any abortion performed. Substitute wording will not be accepted. One of these statements must accompany any claim for an abortion to be considered for reimbursement:

- “I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client’s full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.” (A signature is required.)

- “I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities.” (A signature is required.)

- “I, (physician’s name), certify that on the basis of my professional judgment, an abortion procedure for (client’s full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities.” (A signature is required.)

Refer to: Abortion Certification Statements Form on the TMHP website at www.tmhp.com.

A stamped or typed physician signature is not acceptable on the original certification statement. The physician’s signature must be an original signature. A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes and electronic billing are not acceptable or available at this time. The physician must maintain the original certification statement in the client’s files.

Abortion services must be billed with modifier G7.

Performing physicians, facilities, anesthesiologists, and certified respiratory nurse anesthetist (CRNA) providers must submit modifier G7 with the appropriate procedure code when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid. Modifier G7 must be entered next to the procedure code that identifies the abortion services.

Important: To bill a Texas Medicaid client for a service that TMHP denies as not medically necessary, the billing provider must ensure that the client or client’s guardian has signed an acknowledgment statement obtained by the physician who has contact with the client.
7.11.1 Services Related to Abortion Procedures
An anesthesia service that is provided for an abortion procedure may be reimbursed if the abortion procedure meets medical necessity and complies with the Texas Medicaid guidelines in the section above.

All other services that are related to an abortion procedure are also subject to medical necessity review. Services that are related to a non-covered abortion procedure are denied or recouped.

7.12 Examination Under Anesthesia
Pelvic examination under anesthesia (procedure code 57410) is considered part of another gynecological surgery performed the same day.

If the examination is performed as an independent procedure or at the time of a nongynecological surgery, the procedure may be reimbursed.

7.13 Laminaria Insertion
Insertion of a laminaria or dilatation (procedure code 59200) is a benefit of Texas Medicaid.

7.14 Hysterectomy Services
Texas Medicaid reimburses hysterectomies when they are medically necessary. Texas Medicaid does not reimburse hysterectomies performed for the sole purpose of sterilization.

Providers can use any of the following procedure codes to submit claims for hysterectomy procedures:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>51925</td>
</tr>
<tr>
<td>58267</td>
</tr>
<tr>
<td>58541</td>
</tr>
<tr>
<td>58571</td>
</tr>
</tbody>
</table>

Providers can refer to the Texas Medicaid fee schedules on the TMHP website at [www.tmhp.com](http://www.tmhp.com) for components and fees that may be reimbursed.

7.14.1 Hysterectomy Acknowledgment
Hysterectomy services are considered for reimbursement when a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is faxed to TMHP, the claim is filed with a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form, or documentation supporting that the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form could not be obtained or was not necessary.

All Texas Medicaid clients (including those in a STAR or STAR+PLUS Program health plan) receiving hysterectomy services must sign a Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. The acknowledgment must be submitted to TMHP with the claim or to the client’s health plan.

The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form must be signed and dated by the client. The statement must indicate that the client was informed both orally and in writing before the surgery that the hysterectomy would leave her permanently incapable of bearing children.

**Note:** A client representative’s signature will be required for mentally incompetent clients.
The client’s eligibility file is updated upon receipt of the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. Claims for services related to the hysterectomy cannot be reimbursed unless the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is on file; therefore to avoid claim denials, each individual provider involved in the hysterectomy procedure is encouraged to submit a copy of the valid Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form rather than relying on another provider to do so.

The provider is responsible for maintaining the original, signed copy of the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form in the client’s medical record when a claim is submitted for consideration of payment. These records are subject to retrospective review.

When a hysterectomy, whether abdominal or vaginal, is performed without a client’s acknowledgement form:

- The hysterectomy procedure code is denied.
- The other surgical procedures are evaluated for their clinical relevance.
- Multiple procedures are processed according to the multiple surgery guidelines.

A Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the performing physician certifies that at least one of the following circumstances existed before the surgery:

- The patient was already sterile before the hysterectomy, and the cause of the sterility is stated (e.g., congenital disorder, sterilized previously, or postmenopausal). Providers must use a post menopause or sterilization diagnosis code on the claim form. If the provider submits a claim and does not attach the acknowledgment, the provider must maintain the signed statement in the client’s records, and the physician’s signature will not be required on the claim form. These records are subject to retrospective review.

- The patient requires a hysterectomy on an emergency basis because of a life-threatening situation. The physician must state the nature of the emergency and certify that it was determined that prior acknowledgment was not possible. Because the acknowledgment may be signed the day of or an hour before surgery, an emergency situation requires that the patient be unconscious or under sedation and unable to sign the acknowledgment.

Although the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the criteria previously listed are met, the performing physician must certify that one or more of the circumstances existed prior to the surgery. This certification may be submitted before the claim is submitted or attached to the claim and signed by the performing provider.

Refer to: Title 42 of CFR 441.255 and 25 TAC Part 1, Chapter 29, Subchapter F, section 25.501 for more information.

Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

For clients with retroactive Medicaid coverage, one of the following must be submitted with the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form:

- A copy of the client’s Your Texas Benefits Medicaid Card, which covers the date of the hysterectomy.
- A copy of the retroactive approval notice for Medicaid coverage.

Faxing Forms

All Medicaid providers may fax the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form to 1-512-514-4218. The form must include the client’s Texas Medicaid number. All consent forms should be faxed with a cover sheet that identifies the provider and includes the telephone number and address. If the fax is incomplete or the consent form is invalid, the form is returned by mail.
or fax for correction. Completed consent forms that are faxed for adjustments or appeals are validated in the TMHP system. However, claims associated with the consent forms must be appealed through the mail to Appeals/Adjustments at the following address:

Texas Medicaid & Healthcare Partnership  
Attn: Appeals/Adjustments  
PO Box 200645  
Austin, TX 78720-0645

7.15 Pap Smear (Cytopathology Studies)

Pap smears are benefits of Texas Medicaid for early detection of cancer. Family planning clients are eligible for annual Pap smears. Procurement and handling of the Pap smear are considered part of the E/M of the client and are not reimbursed separately.

The following procedure codes are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>88142</td>
</tr>
<tr>
<td>88165</td>
</tr>
</tbody>
</table>

These procedure codes must be billed with the place of service where the Pap smear is interpreted.

Procedure code 88141 is reimbursed in addition to and when billed with the cytopathology procedure codes in the table above.

Procedure code 88155 will only be reimbursed when billed in conjunction with one of the following procedure codes on the same date of service by the same provider:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>88142</td>
</tr>
<tr>
<td>88166</td>
</tr>
</tbody>
</table>

Note: Pap smear procedures will not be reimbursed separately to either the physician or a laboratory when billed on the same day as a THSteps medical check-up visit.

7.16 Clitoroplasty and Vaginoplasty

Clitoroplasty and vaginoplasty are performed for clients who possess ovaries and are female by genetic sex, but the external genitalia are not those of a normal female. Surgical correction of abnormalities of the external genitalia is the only indicated treatment for this disorder. Clitoroplasty and vaginoplasty procedure codes 56805 and 57335 may be considered for reimbursement for female clients who are 20 years of age and younger when submitted for reimbursement with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E250</td>
</tr>
<tr>
<td>E3451</td>
</tr>
</tbody>
</table>

7.17 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological services.

Gynecological health services are subject to retrospective review and recoupment if documentation does not support the service billed.
7.18 Claims Filing and Reimbursement

Gynecological services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to:

- Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to:

- Subsection 2.2.1.1, “Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits” in Section 2, “Texas Medicaid Fee-for-Service Reimbursement” (Vol. 1, General Information).

Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 requires that Medicare and Medicaid limit reimbursement for those physician services furnished in outpatient hospital settings (e.g., clinics and emergency situations) that are ordinarily furnished in physician offices.

7.18.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

7.19 National Drug Code

Refer to:


8 Claims Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>“Appendix A: State, Federal, and TMHP Contact Information” (Vol. 1, General Information)</td>
</tr>
<tr>
<td>CMS-1500 Paper Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>2017 Claim Form</td>
<td>Subsection 6.8 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>2017 Claim Form Instructions</td>
<td>Subsection 6.8.1 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Appendix A: State, Federal, and TMHP Contact Information</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>
9  Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday – Friday from 7 a.m. to 7 p.m., Central Time.

10  Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

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<thead>
<tr>
<th>Forms</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization Consent Form Instructions</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Sterilization Consent Form (English)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Sterilization Consent Form (Spanish)</td>
<td>Subsection 6.6.3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Abortion Certification Statements Form</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information</td>
<td></td>
</tr>
<tr>
<td>2017 Claim Form</td>
<td></td>
</tr>
<tr>
<td>Texas Women’s Health Program Certification</td>
<td></td>
</tr>
</tbody>
</table>

11  Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

<table>
<thead>
<tr>
<th>Claim Form Examples</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Claim Form</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner/Clinical Nurse Specialist (Family Planning)</td>
<td></td>
</tr>
</tbody>
</table>