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 Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.
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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/ 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 3.6.3.8, “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.


### 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2542</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:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</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 code J7300, J7302, or J7307).

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>V2501 V2502 V2503 V2509 V2512 V252 V2540 V2541 V2542 V2543</td>
</tr>
<tr>
<td>V2549 V255 V258 V259 V615</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 J7300 or J7302 with procedure code 58300.

An IUD insertion (procedure code 58300) may be reimbursed when billed with the same date of service as a dilation and curettage (procedure code 58120).

Procedure code J7302 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>V2502 V2503 V2509 V2511 V2513 V2540 V2542 V2549 V258 V259 V615</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 and may be reimbursed once every 3 rolling years.

Procedure code 11981 may be reimbursed for the insertion 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 (removal). Procedure code 11976 may be reimbursed when it is billed with diagnosis code V2543.

### 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 A4268 A4269 J1050 J3490* J7303 J7304 S4993 96372</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>V2501</td>
</tr>
<tr>
<td>V2549</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.

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 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.

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 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 theRemarks 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>V2501</td>
</tr>
<tr>
<td>V2541</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: Hysterectomy Acknowledgment forms are not sterilization consents.

Refer to: Form GN.2, “Sterilization Consent Form (English)” in this handbook.

Form GN.3, “Sterilization Consent Form (Spanish)” in this handbook.

Form GN.1, “Sterilization Consent Form Instructions (2 pages)” in this handbook.

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.

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, 58671, or A4264. An appropriate family planning diagnosis code must be billed when reporting facility fees for procedure codes 58565 or 58670.

Refer to: Form HS.11, “Ambulatory Surgical Center” in the Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks) for more information about ASC billing procedures.

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></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>Family Planning 2017 claim form or approved electronic format</td>
</tr>
<tr>
<td>Medicaid family planning providers who do not contract with DSHS</td>
<td>Family Planning 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, Family Planning 2017 claim form, or approved electronic format of either form</td>
</tr>
<tr>
<td>FQHC also contracts with DSHS</td>
<td>Family Planning 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 Family Planning 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 Form GN.6, “Family Planning 2017 Claim Form” in this handbook or download it from 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 6.5.5, “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

**Refer to:** Subsection 6.3.4, “National Drug Code (NDC)” in Section 6, “Claims Filing” *(Vol. 1, General Information).*

### 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 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.

### 3. TEXAS WOMEN’S HEALTH PROGRAM

#### 3.1 Texas Women’s Health Program (TWHP) Provider Enrollment

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.**

#### 3.2 TWHP Overview

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

The 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.

3.2.1 Guidelines for TWHP Family Planning 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.

Family planning 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 the TWHP.

Family planning 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 FDA-approved 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 family planning clients, not their parents, spouses, or any other individuals may consent to the provision of family planning services.

3.2.2 Referrals

If a TWHP provider identifies a health problem such as diabetes or high blood pressure, the provider must refer the 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.
3.2.2.1 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.

3.2.2.2 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 1-512-458-7796, or visit www.dshs.state.tx.us/bcccs/.

3.2.3 Abortions

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

Texas Human Resources Code, Section 32.024(c-1) and Texas Administrative Code Title 25, Part 1, Chapter 39, §§39.31-39.45 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 those services. 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.

Each year, providers that want to participate in the TWHP must certify in writing that they do not perform or promote elective abortions and do not affiliate with any entity that does. Certain TWHP providers must complete the TWHP Provider Certification form with an original signature. Providers may also use the TMHP website to disclose the required information through the Provider Information Management System (PIMS). The written form must be completed and submitted with an original handwritten signature, even if the information is additionally submitted online.

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 multispecialty physician group
- Physician Assistant
- Federally Qualified Health Center (FQHC)
- Maternity Services Clinic
- Family Planning Agency
- Rural Health Clinic - Freestanding/Independent
• Rural Health Clinic - Hospital Based
• Ambulatory Surgical Center - Freestanding/Independent

Submitting the certification online will display for clients on the Online Provider Lookup (OPL) that the provider renders TWHP services.

3.3 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 diseases (STDs)

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</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2542</td>
</tr>
</tbody>
</table>

The choice of diagnosis code must be based on the type of family planning service performed.

3.3.1 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 3.3, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of TWHP diagnosis codes.

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

3.3.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination for TWHP clients, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous tables in subsection 3.3.1, “Family Planning Annual Exams” in this handbook.

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.

3.3.2 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 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 99202 99203 99204 99205 99211 99212 99213 99214 99215</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><strong>New patient:</strong> 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><strong>Established patient:</strong> 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 3.3, “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

3.3.2.1 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, an annual family planning examination, or procedure code J7300, J7302, or J7307.

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.

3.3.3 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, Medicaid number, 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.


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 81025 82947 82948 84443</td>
</tr>
<tr>
<td>84702 84703 85013 85014 85018 85025 85027 85028 86318 86580 86592</td>
</tr>
<tr>
<td>86689 86695 86696 86701 86703 86736 86762 86803 86900 86901 87070</td>
</tr>
<tr>
<td>87086 87088 87102 87110 87205 87210 87220 87252 87340 87480</td>
</tr>
<tr>
<td>87490 87491 87510 87590 87591 87621 87660 87797 87800 87801</td>
</tr>
<tr>
<td>87810 87850 88142 88150 88164 88175 99000 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.

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

3.3.4 Radiology

The following procedure codes may be reimbursed for radiology services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>74000 74010 74740 76830 76856 76857 76881 76882</td>
</tr>
</tbody>
</table>

3.3.5 * 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 11981 11982 11983 57170 58300 58301 96372 A4261 A4266</td>
</tr>
</tbody>
</table>
Procedure code 11976 may be reimbursed when it is billed with diagnosis code V2543.

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>V2501</td>
</tr>
<tr>
<td>V255</td>
</tr>
</tbody>
</table>

Procedure code J7302 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>V2502</td>
</tr>
</tbody>
</table>

Procedure codes J7300 or J7302 must be billed with procedure code 58300 on the same date of service to receive reimbursement for the IUD and the insertion of the IUD.

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.

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

### 3.3.6 Drugs and Supplies

Procedure codes A4267, A4268, A4269, J1050 and modifier U1, J7303, J7304, J7307, and S4993 may be reimbursed for drugs and supplies.

**Refer to:** Subsection 3.3, “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>V2501</td>
</tr>
<tr>
<td>V255</td>
</tr>
</tbody>
</table>

**Note:** The TWHP does not reimburse providers for counseling about emergency contraception or the provision of emergency contraception.
3.3.6.1 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 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. 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.

3.3.6.2 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.

3.3.7 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>V2501</td>
</tr>
<tr>
<td>V2541</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.

3.3.8 Sterilization and Sterilization-Related Procedures

Sterilization services may be reimbursed separately to family planning agencies or physicians. 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.

3.3.8.1 Sterilization Consent

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

Note: Hysterectomy Acknowledgment forms are not sterilization consents.

Refer to: Form GN.2, “Sterilization Consent Form (English)” in this handbook.
Form GN.3, “Sterilization Consent Form (Spanish)” in this handbook.
Form GN.1, “Sterilization Consent Form Instructions (2 pages)” in this handbook.

3.3.8.2 Tubal Ligation

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

3.3.8.3 Anesthesia for Sterilization

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

3.3.8.4 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.

3.3.8.5 Hysteroscopic Sterilization

Providers must use procedure code 58340 or procedure code 58565 with diagnosis code V252 to submit claims for the fallopian tube occlusion sterilization. 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.

3.3.8.6 TWHP Services After Sterilization

A hysterosalpingogram is recommended three months after a hysteroscopic sterilization procedure to ensure tubal occlusion. Procedure code 74740 and 58340 are considered for reimbursement in this circumstance when billed with diagnosis code V252.

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 client for family planning visits provided through TWHP.

3.3.9 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/TWH-search.asp for more information.

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

3.3.9.1 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 0980, 0986, or 0987 as the referenced diagnosis code.

Note: Other TWHP services will not be reimbursed if they are submitted with diagnosis codes 0980, 0986, or 0987 as referenced diagnoses.

3.3.10 TWHP Client Eligibility

3.3.10.1 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 and should disenroll from the program. Clients who have been sterilized cannot enroll in TWHP unless they are seeking to have the sterilization confirmed. Clients may enroll in TWHP to confirm the sterilization, but must disenroll afterwards.

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.

A client who has been approved for TWHP coverage remains enrolled in the program for 12 continuous months even if a sterilization procedure has been performed during the 12-months of coverage. After sterilization has been confirmed, a client is not eligible to renew 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.

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 the 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 the 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.

3.3.10.2 Eligibility Verification
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:

• www.tmhp.com

• 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

3.3.11 Prior Authorization
Prior authorization is not required for TWHP services.

3.4 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.

3.5 TWHP Claims Filing and Reimbursement

3.5.1 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.
3.5.1.1 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.

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

3.5.3 National Drug Code

3.5.4 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.

4. DEPARTMENT OF STATE HEALTH SERVICES (DSHS) FAMILY PLANNING PROGRAM SERVICES

4.1 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.

The DSHS website at www.dshs.state.tx.us/chscontracts/all_forms.shtm#fp for more information

4.2 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501</td>
</tr>
<tr>
<td>V2542</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.

### 4.2.1 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>New patient: Appropriate E/M procedure code with modifier FP</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 with modifier FP</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 4.2, “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.

4.2.1.1 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 4.2.1, “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.

4.2.2 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>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99202</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 4.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

4.2.2.1 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 3.5.3, “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 J7300, J7302, or J7307.

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.

4.2.3 Laboratory Procedures

4.2.3.1 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 Code</th>
<th>80061</th>
<th>81000</th>
<th>81001</th>
<th>81002</th>
<th>81003</th>
<th>81015</th>
<th>81025</th>
<th>82947</th>
<th>82948</th>
<th>84443</th>
</tr>
</thead>
<tbody>
<tr>
<td>84702</td>
<td>84703</td>
<td>85013</td>
<td>85014</td>
<td>85018</td>
<td>85025</td>
<td>85027</td>
<td>85028</td>
<td>86580</td>
<td>86592</td>
<td>86689</td>
</tr>
<tr>
<td>86695</td>
<td>86696</td>
<td>86701</td>
<td>86703</td>
<td>86762</td>
<td>86803</td>
<td>86900</td>
<td>86901</td>
<td>87070</td>
<td>87086</td>
<td></td>
</tr>
<tr>
<td>87088</td>
<td>87102</td>
<td>87110</td>
<td>87205</td>
<td>87210</td>
<td>87220</td>
<td>87252</td>
<td>87340</td>
<td>87480</td>
<td>87490</td>
<td></td>
</tr>
<tr>
<td>87491</td>
<td>87510</td>
<td>87590</td>
<td>87591</td>
<td>87621</td>
<td>87660</td>
<td>87800</td>
<td>87810</td>
<td>87850</td>
<td>88142</td>
<td></td>
</tr>
<tr>
<td>88150</td>
<td>88164</td>
<td>99000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Refer to: Subsection 3.3.3, “Laboratory Procedures” in this handbook for more information about family planning laboratory services requirements.

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.

4.2.4 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>74000</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

4.2.5 Contraceptive Devices and Related Procedures

4.2.5.1 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>
</tr>
</thead>
<tbody>
<tr>
<td>57170</td>
</tr>
</tbody>
</table>

4.2.5.2 * IUD
IUD services may be reimbursed using the following:

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>58300</td>
</tr>
</tbody>
</table>

4.2.5.2.1 Insertion of an IUD
The IUD and the insertion of the IUD may be reimbursed using procedure code J7300 or J7302 with procedure code 58300.

The following reimbursement may apply:
- Procedure code J7300 or J7302 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.

4.2.5.2.2 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.

4.2.5.3 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 (diagnosis code V2543) may be considered for reimbursement with procedure code 11976 (removal).

4.2.5.4 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.

4.2.6 Drugs and Supplies

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

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

4.2.6.1 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 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.

**4.2.6.2 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.

**4.2.7 Family Planning Education**

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

**4.2.7.1 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.

**4.2.7.2 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.

**4.2.8 Sterilization and Sterilization-Related Procedures**

**4.2.8.1 Sterilization Consent**

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

**Note:** Hysterectomy Acknowledgment forms are not sterilization consents.

**Refer to:** Form GN.2, “Sterilization Consent Form (English)” in this handbook.  
Form GN.3, “Sterilization Consent Form (Spanish)” in this handbook.  
Form GN.1, “Sterilization Consent Form Instructions (2 pages)” in this handbook.

**4.2.8.2 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.

**4.2.8.3 Tubal Ligation**

Procedure code 58600 may be reimbursed for any sterilization procedure performed on a female client. Reimbursement for procedure code 58600 includes all preoperative, intra-operative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, and so on).
4.2.8.4 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.

4.2.9 Prior Authorization

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

4.3 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.

4.4 Claims Filing and Reimbursement

4.4.1 Claims Information

Providers must use the appropriate claim form to submit DSHS Family Planning Program claims to TMHP.

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

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

4.4.1.1 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.

4.4.1.2 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.

4.4.2 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/contractor/default.shtm#code.
4.4.2.1 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.

4.4.3 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.

4.4.4 National Drug Code


5. GYNECOLOGICAL HEALTH SERVICES

5.1 Services, Benefits, Limitations, and Prior Authorization

Gynecological examinations, surgical procedures, and treatments are benefits of Texas Medicaid.

The following gynecological procedures and services are benefits of Texas Medicaid:

- Assays for the diagnosis of vaginitis
- Endometrial cryoablation
- Uterine suspension
- Salpingostomy
- Diagnostic hysteroscopy
- Abortion (Criteria is described in a later section)
- Laminaria insertion
- Examination under anesthesia
- Hysterectomy
- Surgery for masculinized female
- Pap smear (cytopathology studies)
Refer to: Section 2, “Medicaid Title XIX family planning services” in this handbook for information about contraception, sterilizations, and family planning annual examinations.

5.2 Endometrial Cryoablation
Endometrial cryoablation (procedure code 58356) is a benefit of Texas Medicaid.

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

5.4 Salpingostomy
Salpingostomy (procedure code 58770) is a benefit of Texas Medicaid.

5.4.1 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

5.5 Assays for the Diagnosis of Vaginitis
Vaginitis assay procedure codes 87480, 87510, 87660, 87797, and 87800 are benefits of Texas Medicaid.
If more than one of procedure code 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 are denied. Only one procedure code (87480, 87510, 87660, 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, or 87660) 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, and 87660 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, and 87660 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.

5.6 Diagnostic Hysteroscopy

Diagnostic hysteroscopy (procedure code 58555) is a benefit of Texas Medicaid when submitted with one of the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2180</td>
</tr>
</tbody>
</table>

5.7 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>
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</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: Form GN.4, “Abortion Certification Statements Form” in this handbook for a copy of the required statements.

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.

5.7.1 Services Related to Abortion Procedures

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.

5.8 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.

5.9 Laminaria Insertion

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

5.10 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>
</tbody>
</table>

Providers can refer to the Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for components and fees that may be reimbursed.
5.10.1 Hysterectomy Acknowledgment Form

Hysterectomy services are considered for reimbursement when a signed Hysterectomy Acknowledgment Form is faxed to TMHP, the claim is filed with a signed Hysterectomy Acknowledgment Form, or documentation supporting that the Hysterectomy Acknowledgment 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 Hysterectomy Acknowledgment Form. The acknowledgment must be submitted to TMHP with the claim or to the client’s health plan.

A Hysterectomy Acknowledgement Statement 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.

The client’s eligibility file is updated upon receipt of the signed Hysterectomy Acknowledgment Form. Claims for services related to the hysterectomy cannot be reimbursed unless the signed Hysterectomy Acknowledgement 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 Hysterectomy Acknowledgment Form rather than relying on another provider to do so.

The provider is responsible for maintaining the original, signed copy of the Hysterectomy Acknowledgement 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 Hysterectomy Acknowledgment 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 hysterectomy acknowledgement statement 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.

Form GN.5, “Hysterectomy Acknowledgement Form” in this handbook.

Faxing Forms
All Medicaid providers may fax Hysterectomy Acknowledgment Forms 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

5.11 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>88141*</td>
</tr>
<tr>
<td>88142</td>
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<td>88143</td>
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<td>88147</td>
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<td>88148</td>
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<td>88166</td>
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<tr>
<td>88167</td>
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<tr>
<td>88174</td>
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</tbody>
</table>

* Procedure code 88141 must be used to bill the interpretation portion of any gynecological cytopathology test, and is reimbursed in addition to the other procedure codes in this table.

** Procedure code 88155 is not reimbursed when billed in addition to any of the procedure codes in this table except 88141.

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

5.12 Surgery for Masculinized Females
Masculinized females 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. 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 diagnosis code 2552, 25950, 25951, 25952, or 7527.

5.13 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.

**5.14 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. Super-bills, 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.

**5.14.1 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.

**5.15 National Drug Code**

*Refer to:* Subsection 6.3.4, “National Drug Code (NDC)” in Section 6, “Claims Filing” *(Vol. 1, General Information)*.

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**6. CLAIMS RESOURCES**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td>Appendix F <em>(Vol. 1, General Information)</em></td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide <em>(Vol. 1, General Information)</em></td>
</tr>
</tbody>
</table>
7. 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.

8. FORMS
Sterilization Consent Form Instructions

Per Title 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Ensure all required fields are completed for timely processing.

Fax or mail the Sterilization Consent Form five business days before submitting the associated claim(s) to expedite the processing of the Sterilization Consent Form and associated claim(s).

Fax fully completed Sterilization Consent Forms to Texas Medicaid & Healthcare Partnership (TMHP) at 1-512-514-4229. Claims and appeals are not accepted by fax. Only send family planning sterilization correspondence to this fax number.

Note: Hysterectomy Acknowledgment forms are not sterilization consents and should be faxed to 1-512-514-4218.

Clients must be at least 21 years of age when the consent form is signed. If the client was not 21 years of age when the consent form was signed, the consent will be denied. Changing signature dates is considered fraudulent and will be reported to the Office of the Inspector General (OIG).

There must be at least 30 days between the date the client signs the consent form and the date of surgery, with the following exceptions:

Exceptions: (1) Premature delivery - There must be at least 72 hours between the date of consent and the date of surgery. The informed consent must have been given at least 30 days before the expected date of delivery. (2) Emergency Abdominal Surgery - There must be at least 72 hours between the date of consent and the date of surgery. Operative reports detailing the need for emergency surgery are required.

Listed below are field descriptions for the Sterilization Consent Form. Completion of all sections is required to validate the consent form, with only two exceptions:

Exceptions: Race and Ethnicity Designation is requested but not required. The Interpreter’s Statement is not required as long as the consent form is written in the client’s language, or the person obtaining the consent speaks the client’s language. If this section is partially completed, the consent will be denied for incomplete information.

This Sterilization Consent Form may be copied for provider use. Providers are encouraged to frequently recopy the original form to ensure legible copies and to expedite consent validation.

Required Fields
All of the fields must be legible in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form. Resubmission of legible information must be indicated on the consent form itself. Resubmission with information indicated on a cover page or letter will not be accepted.

Consent to Sterilization
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Date of Birth (month, day, year).
• Client’s Name (first and last names are required).
• Name of Doctor or Clinic.
• Name of the Sterilization Operation.
• Client’s Signature.
• Date of Client Signature - Client must be at least 21 years of age on this date. This date cannot be altered or added at a later date.

Effective Date 07/30/2007/Revised Date 03/10/2010
Interpreters Statement (If applicable)
- Name of Language Used by Interpreter.
- Interpreters Signature.
- Date of Interpreters Signature (month, day, year).

Statement of Person Obtaining Consent
- Client's Name (first and last names are required).
- Name of the Sterilization Operation.
- Signature of Person Obtaining Consent - The statement of person obtaining consent must be completed by the person who explains the surgery and its implications and alternate methods of birth control. The signature of person obtaining consent must be completed at the time the consent is obtained. The signature must be an original signature, not a rubber stamp.
- Date of the Person Obtaining Consent's Signature (month, day, year) - Must be the same date as the clients signature date.
- Facility Name - Clinic/office where the client received the sterilization information.
- Facility Address - Clinic/office where the client received the sterilization information.

Physicians Statement
- Clients Name (first and last names are required).
- Date of Sterilization Procedure (month, day, year) - Must be at least 30 days and no more than 180 days from the date of the clients consent except in cases of premature delivery or emergency abdominal surgery.
- Name of the Sterilization Operation.
- Expected Date of Delivery (EDD) - Required when there are less than 30 days between the date of the client consent and date of surgery. Clients signature date must be at least 30 days prior to EDD.
- Circumstances of Emergency Surgery - Operative report(s) detailing the need for emergency abdominal surgery are required.
- Physicians Signature - Stamped or computer-generated signatures are not acceptable.
- Date of Physicians Signature (month, day, year) - This date must be on or after the date of surgery.

Paperwork Reduction Act Statement
This is a required statement and must be included on every Sterilization Consent Form submitted.

Additional Required Fields
- Medicaid or Family Planning Number - Clients submitted as Titles V, X, and XX may not have a Family Planning number. Please simply indicate the appropriate Title below.
- Date Client Signed the Consent (month, day, year).
- The following provider identification numbers will be required to expedite the processing of the consent form:
  o TPI
  o NPI
  o Taxonomy
  o Benefit Code
- Provider/Clinic Phone Number.
- Provider/Clinic Fax Number (If available).
- Family Planning Title for Client - Indicate by circling V, X, XIX (Medicaid), or XX.
GN.2 Sterilization Consent Form (English)

Sterilization Consent Form

Fax Consent Form to 1-512-514-4229

Client Medicaid or Family Planning Number:

Date Client Signed: / / (month/day/year)

Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by projects or programs receiving federal funds.

Consent to Sterilization

I have asked for and received information about sterilization from ___________________________ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as ___________________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _______ (month), _______ (day), _______ (year). I ___________________________ hereby consent of my own free will to be sterilized by ___________________________ (doctor or clinic) by a method called ___________________________ (specify type of operation).

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to Representatives of the Department of Health and Human Services or Employers of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

Client's Signature: ___________________________ Date of Signature: / / (month/day/year)

Notice: You are requested to supply the following information, but it is not required.

Race and Ethnicity Designation

☐ Not Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American

☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ White

Interpreter's Statement

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.

Interpreter's Signature: ___________________________ Date of Signature: / / (month/day/year)

Statement of Person Obtaining Consent

Before ___________________________ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation ___________________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent: ___________________________ Date of Signature: / / (month/day/year)

Facility Name: ___________________________

Facility Address: ___________________________

Physician's Statement

Shortly before I performed a sterilization operation upon ___________________________ (name of individual to be sterilized), on _______ / _______ / _______ (date of sterilization), I explained to him/her the nature of the sterilization operation ___________________________ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Close out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery - individual's expected date of delivery: _______ / _______ / _______ (month, day, year)

☐ Emergency abdominal surgery (describe circumstances): ___________________________

Physician's Signature: ___________________________ Date of Signature: / / (month/day/year)

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OASO/OIRA/PRA, 200 Independence Ave., S.W., Suite 337-H, Washington D.C. 20201, Attn: PRA Reports Clearance Officer

HHS-687

All fields in this box required for processing.

TP: ___________________________

NPI: ___________________________

Taxonomy: ___________________________

Benefit Code: ___________________________

Provider/Clinic Telephone: ___________________________

Provider/Clinic Tax Number: ___________________________

Title billed (check one): ☐ V ☐ X ☐ 00 (Medicaid) ☐ 0X

Effective Date 09/01/2010 Revised Date 07/01/2010
GN.3 Sterilization Consent Form (Spanish)

Consentimiento para Esterilización

Yo he solicitado y he recibido información de (médico o clínico) sobre la esterilización. Cuando inicialmente solicitó esta información, me dijeron que la decisión de ser esterilizado/a es completamente mía. Me dijeron que yo podría decidir no ser esterilizado/a. Si decidí no esterilizarme/a, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderá ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como Asistencia Temporal para Familias Necesitadas o Medicaid, que recibo actualmente o para los cuales podría calificar.

Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedarme embarazada, no quiero tener hijos o no quiero procrear hijos. Me informaron sobre otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He echado estas opciones y he decidido ser esterilizado/a.

Entiendo que será esterilizado/a por medio de una operación conocida como: (especificar el tipo de operación). Me explicaron las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se llevará a cabo hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizado/a no resultará en la retención de ningún beneficio a que le ha proporcionado por programas o proyectos que reciben fondos federales.

Tengo por lo menos 21 años y nací el ___ (mes) ___ (día) ___ (año). Yo, (especificar tipo de operación) por el método llamado (especificar tipo de operación).

Mi consentimiento vence 180 días a partir de la fecha que aparece abajo con mi firma.

También doy mi consentimiento para que se presente esta forma y otros expedientes médicos sobre la operación a: Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales. He recibido una copia de esta forma.

Firma: ________________________________
Fecha: / / (mes, día, año)

Declaración De La Persona Que Obtiene Consentimiento

Antes de que, (nombre completo del cliente) firme la Forma de Consentimiento para la Esterilización, le explicado de a (nombre de persona por ser esterilizado/a) en / / (fecha de esterilización), le explicado de a (especificar el tipo de operación), para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento. Le explicado a la persona que será esterilizada/a que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente. Le explicado a la persona que será esterilizada/a que hay disponibles otros métodos de anticoncepción que son temporales.

Le explicué que la esterilización es diferente porque es permanente. Le informo a la persona que será esterilizada/a que hay disponibles otros métodos de anticoncepción que son temporales. Le explicué que la esterilización es diferente porque es permanente. Le informo a la persona que será esterilizada/a que hay disponibles otros métodos de anticoncepción que son temporales.

Un poco antes de realizar la operación para la esterilización a (nombre de persona por ser esterilizado/a), en / / (fecha de esterilización), le explicó de a (especificar el tipo de operación), el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le explicó de a la persona que será esterilizada/a que hay disponibles otros métodos de anticoncepción que son temporales. Le explicó de a la persona que será esterilizada/a que hay disponibles otros métodos de anticoncepción que son temporales. Le explicó de a la persona que será esterilizada/a que hay disponibles otros métodos de anticoncepción que son temporales.

Declaración Sobre Ley De Reducción De Trimites

De acuerdo con la Ley de Reducción de Trimites de 1995, ninguna persona está obligada a responder a una solicitud de información a menos que muestre un número de control válido de ONS. El número de control válido de ONS para esta forma es 0857-0705. Se ha estimado que el tiempo promedio necesario para completar esta recolección de información en 1 hora y 15 minutos por respuesta. Incluido el tiempo para revisar las instrucciones, buscar fuentes de información existente, reunir los datos necesarios y completar y revisar la recolección de información. Si tiene alguna consulta sobre la exactitud del cálculo (a) del tiempo de sugerencias para mejorar esta forma, por favor escriba a: U.S. Department of Health & Human Services, OSGO/OIRA, 200 Independence Ave., S.W., Suite 337-H, Washington D.C. 20201; Atención: PRA Reports Clearance Officer.

TPI: NPI: Taxonomy:
Benefit Code: Provider/Clinic Telephone: Provider/Clinic Fax Number:
Tillied Billed (check one): ☑ V ☑ X ☑ XX (Medicaid) ☑ XX

Effective Date_05/01/2010/Revised Data_07/14/2010
GN.4 Abortion Certification Statements Form

The signature of the physician must be original script (not stamped or typed). A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time.

"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 ____________________________
GN.5  Hysterectomy Acknowledgement Form

MEDICAID CLIENT IDENTIFICATION NUMBER / / / / / / / /

Hysterectomy Acknowledgment

I hereby acknowledge that I was, prior to surgery ____________ (month, day, year), informed both orally and in writing that a hysterectomy (surgical removal of the uterus) will render the individual on whom that procedure is performed permanently incapable of bearing children.

_________________________  __________________________
Signature of Client or Designated Representative  Date

Reconocimiento

Yo afirmo haber sido informada verbalmente y por escrito, antes de la cirugía ______________ (mes, día, año) que una histerectomía (extracción quirúrgica del útero) dejará a la persona a la cual se haya operado permanentemente, incapaz de tener hijos.

_________________________  __________________________
Firma del Cliente o Representante Designado  Fecha

Interpreter's Statement

To be used if an interpreter is provided to assist the individual having the hysterectomy.

I have translated to the individual having a hysterectomy the information and advice presented orally by the individual obtaining consent. I have also read the consent form to ___________________ in ___________________ language and explained its contents to her. To the best of my knowledge and belief she understood this explanation.

_________________________  __________________________
Signature of Interpreter  Date

Revised 8/22/95
**Family Planning 2017 Claim Form**

1. **Choose one:**
   - Family Planning Program: XIX
   - DSHS Family Planning Program (DFPP)

2. **DFPP only:**
   - Partial Pay
   - No Pay

3. **Billing Provider TPI:**
   - Billing provider NPI

4. **Eligibility Date (MM/DD/YYYY):**

5. **Family Planning No. (Medicaid PCN if XIX):**

6. **Address (Street, City, State):**

7a. **ZIP Code**

8. **County of Residence:**

9. **Date of Birth (MM/DD/YYYY):**

10. **Sex:**
   - F
   - M

11. **Patient Status:**
   - New Patient
   - Established Patient

12. **Patient’s Social Security Number**

13. **Race (Code #):**
   - White (1)
   - Black (2)
   - Amerindian/Asian/Nat (6)
   - Nativi/Non-Pacifik (7)
   - More than one race (8)

13b. **Ethnicity:**
   - Hispanic (5)
   - Non-Hispanic (0)

14. **Medical Status:**
   - Married (1)
   - Never Married (2)
   - Formerly Married (3)

15. **Family Income (All): $**

15a. **Family Size**

16. **Number Times Pregnant**

17. **Number Live Births**

18. **Number Living Children**

19. **Primary Birth Control Method**
   - Oral Contraceptive
   - Condom
   - IUD
   - Norplant
   - Other

20. **Primary Birth Control Method at End of This Visit**

21. **If No Method Used at End of This Visit, Give Reason** (Required only if #20 = r)
   - Refused
   - Pregnant
   - Inconclusive
   - Not feasible
   - Personal preference

22. **Is There Other Insurance Available?**
   - Y (If Y, Complete Items 23-25a.)
   - N

24a. **Insured’s Policy/Group No.:**

24b. **Benefit Code**

24c. **Other Insurance Pd. Ant.:**

25a. **Date of Notification**

25b. **Name of Referring Provider**

26. **Referring Other ID**

27a. **Referring Provider**

27b. **Referring NPI**

29. **Diagnosis Code (Relate Items 1, 2, 3, or 4 to Item 32D by Line # in 32E):**
   - 1.
   - 2.
   - 3.
   - 4.

30. **Authorization Number**

31. **Date of Occurrence (MM/DD/YYYY):**

32. **Dates of Service**
   - From | To
   - MM DD | MM DD

32a. **Performing Provider #**

33. **Federal Tax ID Number/EIN**

34. **Patient’s Account No. (optional):**

35. **Patient Co-Pay Assessed**

36. **Total Charges**

37. **Signature of Physician or Supplier**
   - Date:

38. **Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office):**

38a. **NPI**

38b. **Other ID**

39. **Physician’s, Supplier’s Billing Name, Address, Zip Code & Phone No.:**

Form Revised: December 2013
Texas Women’s Health Program Certification

Texas Women’s Health Program Certification

This certification pertains to the following billing or performing provider:

Provider Name ____________________________
Federal Tax ID Number ___________________
NPI Number ______________________________

Provider’s primary billing address:
Street Address ____________________________
Street Address City/State/Zip Code ___________
Telephone Number __________________________

Provider’s primary physical address:
Street Address ____________________________
Street Address City/State/Zip Code ___________
Telephone Number __________________________

DEFINITIONS

For the purposes of this certification, as provided for by Title 25 of the Texas Administrative Code, Sections 30.31 through 30.45, the following terms are defined as follows:

The term “affiliate” means:
(A) An individual or entity that has a legal relationship with another entity, which relationship is created or governed by at least one written instrument that demonstrates:

(i) common ownership, management, or control;
(ii) a franchise;
(iii) the granting or extension of a license or other agreement that authorizes the affiliate to use the other entity’s brand name, trademark, service mark, or other registered identification mark.

The “written instruments” referenced above may include a certificate of formation, a franchise agreement, standards of affiliation, bylaws, or a license, but do not include agreements related to a physician’s participation in a physician group practice, such as a hospital group agreement, staffing agreement, management agreement, or collaborative practice agreement.

The term “promote” means advancing, furthering, advocating, or popularizing elective abortion by, for example:

(1) taking affirmative action to secure elective abortion services for a Texas Women’s Health Program (TWHP) client (such as making an appointment, obtaining consent for the elective abortion, arranging for transportation, negotiating a reduction in an elective abortion provider fee, or arranging or scheduling an elective abortion procedure); however, the term does not include providing upon the patient’s request neutral, factual information and non-directive counseling, including the name, address, telephone number, and other relevant information about a provider;

(2) furnishing or displaying to a TWHP client information that publicizes or advertises an elective abortion service or provider; or

(3) using, displaying, or operating under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

My name is _________________________________. I am the provider or, if the provider is an organization,

I am the provider’s (title or position) __________________________. I am of sound mind, capable of making this certification, and I am personally acquainted with the facts stated here. If I am representing an organizational provider, I am authorized to make this certification on the provider’s behalf.
Throughout the remainder of this document, the word “I” will represent the individual provider that is completing this form or the organizational provider on whose behalf the form is being completed. If this form is being completed on behalf of an organizational provider, the word “I” is inclusive of the organizations, owners, officers, employees, and volunteers, or any combination of these.

Appendix A: Additional Forms

Page A-10

12/04/12
I understand that, under Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45, I am not qualified to participate in the TWHP, or to bill the program for services if I perform or promote elective abortions, or I am an affiliate of an entity that performs or promotes elective abortions.

By checking the boxes under each statement below, I affirm that each of the following statements is true. I understand that my failure to mark each of the statements will be regarded as my representation that the statement is false:

1. I do not perform or promote elective abortions outside the scope of the TWHP.
   - I affirm that this statement is true and correct.

2. I am not an affiliate of an entity that performs or promotes elective abortions.
   - I affirm that this statement is true and correct.

3. In offering or performing a TWHP service, I do not promote elective abortions within the scope of the TWHP.
   - I affirm that this statement is true and correct.

4. In offering or performing a TWHP service, I maintain physical and financial separation between my TWHP activities and any elective abortion-performing or abortion-promoting activity. In particular:
   a. All TWHP services are physically separated from any elective abortion activities, no matter what entity is responsible for the activities;
   b. The governing board or other body that controls me has no board members who are also members of the governing board of an entity that performs or promotes elective abortions;
   c. None of the funds that I receive for performing TWHP services are used to directly or indirectly support the performance or promotion of elective abortions by an affiliate, and my accounting records confirm this;
   d. At my location and in my public electronic communications, I do not display any signs or materials that promote elective abortion.
   - I affirm that this statement is true and correct.

5. I do not use, display, or operate under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.
   - I affirm that this statement is true and correct.

In addition, I understand and acknowledge that:
- If I fail to complete and submit this certification, I will be disqualified from the TWHP and the Texas Department of State Health Services (DSHS) or its designee (henceforth, "DSHS") will deny any claims I submit for TWHP services.
- If, after I submit this signed certification, I perform, agree to perform, or promote elective abortions, or I affiliate or agree to affiliate with an entity that performs or promotes elective abortions, I will notify DSHS at least 30 calendar days before I perform or promote an elective abortion or affiliate with an entity that does so. If I fail to notify DSHS as required, I will be disqualified from the TWHP and DSHS will deny any claims I submit for TWHP services.
- If, while participating in the TWHP, I perform or promote an elective abortion, I will be disqualified from the TWHP, and DSHS will deny any claims I submit for TWHP services.
- If I submit this certification and agree to its terms, but DSHS determines that I am in fact ineligible to participate in the TWHP, DSHS may place a payment hold on claims submitted by me or my organization for TWHP services until DSHS can make a final determination regarding my eligibility:
- If DSHS determines that I am ineligible to receive funds under the TWHP:
  a) DSHS may recoup TWHP funds paid on claims that I have incurred since the date the provider became ineligible;
  b) DSHS will deny all TWHP claims that I have submitted since the date of ineligibility, and;
  c) I will remain ineligible to participate in the TWHP until I comply with Texas Human Resources Code section 32.024(c-1) and Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45.
- If knowingly make a false statement or misrepresentation on this certification, DSHS may consider me to have committed fraud or tampered with a government record under the laws of Texas, and I may be excluded from participation in the TWHP.
I also understand that, to enable DSHS to verify my or my organization's eligibility to participate in the TWHP, I must complete and return this certification form to DSHS at the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

If statements 1 – 5 are all marked “true,” the effective date of the Certification spans from the date of form completion through the end of the Certification year.

Notes: Each provider must complete a new certification and mail it to TMHP by the end of each calendar year.

If any of statements 1 – 5 are not true, you must request an immediate termination of your TWHP certification:

☐ Terminate WHP Certification

Signature: ________________________________________________________________

Printed Name: ____________________________________________________________

Title: ____________________________________________________________________

Date: ____________________________________________________________________
9. CLAIM FORM EXAMPLES
GN.8 Family Planning Claim Form
### GN.9 Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

**Family Planning 2017 Claim Form**

#### 1. Choose case:
- [ ] Family Planning Program: NIN
- [ ] DHHS Family Planning Program (DPFP)

#### 1a. DPPP only:
- [ ] Partial Pay
- [ ] No Pay

#### 2a. Billing Provider TPI:
- 1234567-89

#### 2b. Billing provider NPI:
- [ ]

#### 3. Provider Name:
- Smith, Jenny

#### 4. Eligibility Date (MM/DD/YYYY):
- 01/02/2014

#### 5. Family Planning No. (Medicaid PCN if NIN):
- [ ]

#### 6. Patient’s Name (Last Name, First Name, Middle Initial):
- Doe, Jane

#### 7. Address (Street, City, State):
- 341 Tosca Way, Houston, TX 77485

#### 8. County of Residence:
- Harris

#### 9. Date of Birth (MM/DD/YYYY):
- 02/03/1981

#### 10. Sex:
- [X] F  [ ] M

#### 11. Patient Status:
- [ ] New Patient
- [X] Established Patient

#### 12. Patient’s Social Security Number:
- 123-456-7089

#### 13. Race (Code #):
- [ ] White (1)
- [ ] Black (2)
- [ ] Asian (3)
- [ ] Other (4)
- [ ] American Indian/Alaska Native (5)
- [ ] Non-Hispanic (6)
- [ ] Hispanic (7)
- [ ] More than one race (8)

#### 14. Marital Status:
- [ ] Married
- [ ] Never Married
- [ ] Formerly Married

#### 15. Family Income (All): $
- [ ]

#### 16. Number Times Pregnant Before Initial Visit:
- 1

#### 17. Number Live Births:
- 1

#### 18. Number Living Children:
- 1

#### 19. Primary Birth Control Method Before Initial Visit:
- Oral Contraceptive

#### 20. Primary Birth Control Method at End of This Visit:
- Abstinence

#### 21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r):
- [ ]

#### 22. Is There Other Insurance Available?
- [ ] Y

#### 23. Other Insurance Name and Address:
- [ ]

#### 24. Benefit Code:
- [ ]

#### 25. Other Insurance P/mL. Am.:
- [ ]

#### 25a. Date of Notification:
- [ ]

#### 26. Name of Referring Provider:
- [ ]

#### 27a. Referring Other ID:
- [ ]

#### 27b. Referring NPI:
- [ ]

#### 28. Level of Practitioner:
- [ ] Physician
- [ ] Nurse
- [ ] Mid Level
- [ ] Other

#### 29. Diagnosis Code (Relate Items 1, 2, 3, or 4 to Item 32D by Line # in 32E):
- [ ] V25.1

#### 30. Authorization Number:
- [ ]

#### 31. Date of Occurrence (MM/DD/YYYY):
- [ ]

#### 32. Dates of Service:
- [ ]

#### 33. Federal Tax ID Number/EBI:
- [ ]

#### 34. Patient’s Account No. (optional):
- [ ]

#### 35. Patient Co-Pay Assessed:
- [ ]

#### 36. Total Charges:
- [ ]

#### 37. Signature of Physician or Supplier:
- [ ]

#### 38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office):
- [ ]

#### 39. Physician’s, Supplier’s Billing Name, Address, Zip Code & Phone No.:
- [ ]

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*Form Revised: December 2013*

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GN-59

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