Family Planning Services

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20.1 Overview
This section includes information on family planning services funded by Medicaid and non-Medicaid funding sources. 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. For information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from the Department of State Health Services (DSHS), refer to the website at www.dshs.state.tx.us/famplan.

20.2 Family Planning Providers
Texas Medicaid & Healthcare Partnership (TMHP) processes family planning claims and encounters for four different funding sources administered through DSHS and the Health and Human Services Commission (HHSC). These funding sources include Title V, X, XIX (Medicaid, including the Women’s Health Program), and Title XX. Agencies across Texas are awarded contracts for Titles V, X, and XX to provide services to low-income individuals who may not qualify for Medicaid services. These awards are granted through a competitive procurement process. DSHS contracts with a variety of providers, including local health departments, universities and medical schools, private nonprofit agencies, rural health clinics (RHCs), and hospital districts. Some contractors receive more than one type of funding. All contractors serve Medicaid-eligible individuals. Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services differ for each funding source. Family planning funding is not used to provide abortion services.

20.2.1 Women’s Health Program
Women’s Health Program (WHP) services are covered by Texas Medicaid (Title XIX) and provided on a fee-for-service basis.
Refer to: “Women’s Health Program” on page O-1 for a complete list of eligible diagnosis and procedure codes.

20.3 Provider Enrollment

20.3.1 Title XIX Enrollment
Only the following Medicaid provider types may be used to bill family planning services under Title XIX: physician, nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA), certified nurse-midwife (CNM), Federally Qualified Health Center (FQHC), or family planning agency. An NP and a CNS must be licensed as a registered nurse (RN) and recognized as an advanced practice nurse (APN) by the Texas Board of Nursing (BON).
Physicians who wish to provide Medicaid obstetrical and gynecological (OB/GYN) services are allowed to bypass Medicaid enrollment and obtain a Medicaid-only provider identifier for OB/GYN services regardless of provider specialty. Similarly, FQHCs do not need to apply for a separate physician or agency number. Family planning services are payable under the existing FQHC provider identifier using the family planning procedure codes in this section.
Family planning services provided by an RHC will not be paid if billed using the RHC’s provider identifier but may be billed using a physician’s or NP’s provider identifier. An RHC can also apply for enrollment as a family planning agency and bill using the family planning agency’s provider identifier.
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 and/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 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.
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.
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 health-care 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) § 371.1617(a)(6)(A). 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 health-care 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: “Provider Enrollment” on page 1-3 for more information about enrollment procedures.

20.3.2 Title V, X, and XX Contractors

Agencies that submit claims or encounter requests for Title V, X, or XX Family Planning services must have a contract with DSHS. The DSHS Community Health Services Section determines client eligibility and services policy. Refer to the DSHS Title V, X, and XX Family Planning Manual for specific eligibility and policy information at www.dshs.state.tx.us/famplan.

20.4 Guidelines for Family Planning Providers

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. Medicaid clients, including limited and managed 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. They must also be allowed the freedom to accept or reject services without coercion. 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 funded by Title X, XIX, or combined X and XX funds; however, 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. For family planning services provided by Title V- or Title XX-only clinics, the consent of a parent or other adult is governed by the Texas Family Code, Section 32. For more information, visit www.dshs.state.tx.us/famplan/contractor/rider13.shtm.

20.5 Family Planning Claim Billing

20.5.1 Family Planning and Third Party Insurance

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

20.5.2 Claims Information

All family planning services (Titles V, X, XIX, and XX) provided by physicians, PAs, NPs, CNSs, and family planning agencies who also contract with DSHS for Title V, X, or XX must be submitted to TMHP in an approved electronic format or on the Family Planning 2017 claim form (revised January 2007). Providers may copy the Family Planning 2017 claim form provided in this manual on page 5-47 or download it from the TMHP website at www.tmhp.com.

Family planning services provided to an RHC client must be billed using modifiers AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.

Medicaid family planning providers who do not also contract with DSHS for Title V, X, or XX, may use either the Family Planning 2017 claim form or the CMS-1500 claim form.

Hospitals must use the UB-04 CMS-1450 claims form when billing family planning services. FQHCs may use either the UB-04 CMS-1450 or the Family Planning 2017 claim form to bill family planning Medicaid services; however, if an FQHC also contracts with DSHS to provide Titles V, X, or XX family planning services, the Family Planning 2017 claim form/format must be used to submit all family planning claims, including Title XIX family planning claims. Providers can call the TMHP Contact Center at 1-800-925-9126 to inquire about family planning services, such as reimbursement rates, procedures, or claims filing questions.

Providers may purchase CMS-1500 and UB-04 CMS-1450 claim forms from the vendor of their choice. TMHP does not supply the forms.

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.

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for information on electronic claims submissions.

“Claims Filing” on page 5-1 for general information about claims filing.

“Family Planning 2017 Claim Form” on page 5-47.

“Family Planning 2017 Claim Form Instructions” on page 5-48 for instructions for completing paper claims.

“CMS-1500 Claim Filing Instructions” on page 5-26, and “UB-04 CMS-1450 Claim Filing Instructions” on page 5-33. Blocks that are not referenced are not required for processing by TMHP and may be left blank.
20.5.2.1 Benefit Code
All claims and Sterilization Consent Forms submitted by family planning agencies must be submitted with benefit code FP3.

20.5.2.2 National Drug Codes (NDC)
All Family Planning providers must submit an NDC on professional or outpatient electronic and paper claims submitted with physician-administered prescription drug procedure codes. Codes in the A code series do not require an NDC.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

The unit of measurement codes are:
- F2—International unit
- GR—Gram
- ML—Milliliter
- UN—Unit

Unit quantities must also be provided on the claim. Depending on the claim type, the NDC information must be submitted as indicated below:

**UB-04 CMS 1450**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Revenue codes and description</td>
<td>Enter N4 and the 11-digit NDC number (number on the package or container from which the medication was administered), the unit of measure code, and the unit quantity with a floating decimal for fractional units (limited to 3 digits). Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025</td>
</tr>
</tbody>
</table>

**CMS-1500**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>24A</td>
<td>Date(s) of service</td>
<td>In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on the package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, services, or supplies</td>
<td>In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.</td>
</tr>
</tbody>
</table>

20.5.2.3 Medicaid Managed Care Claims
Providers must use the CMS-1500 (physician, nonfacility) or UB-04 CMS-1450 (hospital) claim forms and submit claims directly to Medicaid health maintenance organizations (HMOs) for Title XIX family planning services. Title V, X, or XX claims must always be submitted to TMHP directly using the Family Planning 2017 (Revised January 2007) claims form/ format.

Providers submitting claims for family planning services to TMHP for Primary Care Case Management (PCCM) may use the Family Planning 2017 claim form.

Hospitals must use the UB-04 CMS-1450 claim form when billing family planning services.

20.5.2.4 Billing HMOs for Out-of-Network Family Planning Services
Medicaid Managed Care, including STAR+PLUS HMOs, are responsible for reimbursing providers for family planning benefits. A family planning provider does not have to contract with the client’s HMO to be reimbursed for family planning services. Title XIX family planning providers should contact the client’s health plan for billing instructions.

20.5.2.5 Title X Encounter Filing
In clinics supported by Title X funds, it is important to collect encounter data (such as demographics and services provided) for all family planning clients served, even for full-pay clients, regardless of the funding source to which the claim is billed. These data are used to compile some of the elements of the Family Planning Annual Report. Certain fields on the claim form must be...
completed for all clients seen at Title X clinics, regardless of the funding source to which the claim is billed. Based on clinic information submitted in the provider’s most recent Title X or Title XX request for proposal (RFP), Compass21 rejects all claims from Title X clinics when the claims do not contain all the required information, regardless of the title being billed.

Clients in a Title X clinic who are not billed to another funding source are considered Title X-only clients. In some instances (such as when all Title V or XX funds are expended), services provided to a client normally eligible for another funding source are not billed to that funding source. A client whose income according to family size falls outside the eligibility guidelines for Titles V or XX would also be a Title X-only client. In these cases, a sliding fee scale that has been approved by the DSHS Community Health Services Section must be used to assess client fees for services received.

While it will not result in a payment from DSHS, a Family Planning 2017 Claim Form with Title X encounter information must be submitted to TMHP for all Title X-only clients, so that required encounter data (demographics, etc.) are collected. Encounter forms for Title X clients are filled out the same way as for the other funding sources. Diagnosis information must be entered, and each of the services and/or tests provided to that client during the visit must be listed on the claim form. Sterilizations provided to Title X clients who are partial pay or no pay must follow the federal guidelines for sterilizations, and a completed Sterilization Consent Form must be faxed to TMHP at 1-512-514-4229. Providers must forward completed encounter forms to TMHP for processing. Payment for Title X services follows the current voucher system. Title X claims do not result in payments to DSHS, but they do result in an Explanation of Benefits (EOB) that can be used to assess reimbursement from the Comptroller.

20.5.2.7 Paper Form: Family Planning 2017 Claim Forms in a Title X-Supported Clinic

Titles V, XIX, and XX

Claims filed for services provided to clients eligible for Title V, XIX, or XX must have the funding source to which the claim is billed checked in Block 1 of the Family Planning 2017 claim form. Block 28, Level of Practitioner, must be completed for every Family Planning 2017 claim form submitted by a clinic that uses Title X funds.

Title X Only

The payment level must be selected in the Title X Only section of Block 1a. Depending on family size and income, the agency designates Title X clients as full pay, partial pay, or no pay for services. Block 28, Level of Practitioner, must also be completed.

20.5.2.8 Other Electronic Claims in the Title X-Supported Clinic

Electronic claims that are not submitted through TexMedConnect must follow the specifications for electronic claim submission. Providers should contact their commercial software vendor or TMHP through the TMHP website at www.tmhp.com or call the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638 for more information.

20.5.2.9 Title X Payments

Title X encounters submitted do not result in payments to the providers. To receive payment, providers must submit monthly or quarterly Financial Status Reports (FSRs) forms, along with a paper payment voucher, to the DSHS Contract Development and Support Branch and Claims Processing Unit. Title X providers continue to receive reimbursement from the Comptroller.

20.5.3 Filing Deadlines

<table>
<thead>
<tr>
<th>Title</th>
<th>Deadline</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>V,X,XX</td>
<td>120 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>XIX</td>
<td>95 days from the date of service on the claim or date of any third-party insurance EOB</td>
<td>120 days from the date of the R&amp;S Report on which the claim reached a finalized status</td>
</tr>
</tbody>
</table>

Note: If the filing deadline falls on a weekend or TMHP-recognized holiday, the filing deadline is extended until the next business day.
20.5.4 Claim Appeals

20.5.4.1 Two Appeal Methods to TMHP for Family Planning Titles V, X, and XX
An appeal is a request for reconsideration of a previously dispositioned claim.
Providers may use two methods to appeal Family Planning (Titles V, X, and XX) claims to TMHP: electronic or paper.

20.5.4.2 Electronic Appeal Submission
Electronic appeal submission is a method of submitting Texas Medicaid appeals using a personal computer (PC). The electronic appeals feature can be accessed by a business organization bridging directly into the TMHP EDI Gateway or by using TexMedConnect.
Advantages of Electronic Appeal Submission
Using electronic appeal submission provides the following advantages to the users:
• Increased accuracy of appeals filed to potentially improve cash flow.
• Print and download capabilities help maintain audit trails.
• Appeal submission windows can be automatically filled in with electronic R&S Report information, thereby reducing data entry time.
• Increases speed of payment processing.

Paper Appeals
Appeal the claim on paper by completing the following steps:
• Make a copy of the R&S page where the claim is reported or other official notification from TMHP.
• Circle one claim per R&S page for each adjustment.
• Identify the incorrect and/or missing information and submit changes that should be used to appeal the claim.
• Attach a copy of supporting medical documentation that is necessary or requested by TMHP.
• Attach a copy of the original claim, if available, or the corrected claim form for the appeal. Claim copies are helpful when the appeal involves medical policy or procedure coding issues.
Submit correspondence, adjustments, and appeals to the following address:
Texas Medicaid & Healthcare Partnership
Inquiry Control Unit
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

20.5.4.3 Disallowed Appeals
If the provider’s claim denies with EOB 00008, “Title X provider must provide level of practitioner information,” the provider needs to submit a new claim with the correct level of practitioner. This claim denial cannot be appealed using the above-stated methods.

20.5.5 Billing Procedures for Non-Family Planning Services Provided During a Family Planning Visit
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 agency must bill for non family planning services using a physician’s or NP’s provider identifier. The agency provider identifier is used to bill family planning services only.
• A physician, NP, or FQHC must bill both family planning services and nonfamily planning services, using the correct physician’s, NP’s, or FQHC’s 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.

20.5.6 Limited Medicaid Coverage
Title XIX family planning services are exempt from the limited program and rules.

20.5.6.1 Family Planning Services for Undocumented Aliens, Legalized Aliens
Undocumented aliens are identified for 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. Emergency-only services do not cover family planning under Texas Medicaid to prevent future unintended pregnancies. All providers are strongly encouraged to promote the benefits and availability of family planning services under Titles V, X, and XX for this population. The family planning funding sources cover the provision of contraceptive devices, supplies, counseling, and sterilizations for these clients. Providers are asked to be aware of the importance of referral of these clients to family planning providers who receive Titles V, X, and XX funds with the goal of preventing future unintended pregnancies and births.

20.6 Diagnosis Codes
Providers should use one of the following diagnosis codes in conjunction with all procedures and services. The choice of diagnosis code should be based on the type of family planning service performed.

<table>
<thead>
<tr>
<th>Diagnoses Codes</th>
<th>V2501</th>
<th>V2502</th>
<th>V2504</th>
<th>V2509</th>
<th>V251</th>
</tr>
</thead>
<tbody>
<tr>
<td>V252</td>
<td>V2540</td>
<td>V2541</td>
<td>V2542</td>
<td>V2543</td>
<td></td>
</tr>
</tbody>
</table>
20.7 Procedure Codes and Reimbursement Amounts

Title XIX family planning providers are reimbursed in accordance with 1 TAC 355.8584. See the applicable fee schedule on the TMHP website at www.tmhp.com.

20.7.1 Family Planning Annual Exams

A family planning annual 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. 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.

**Title XIX Only**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Fee for Title XIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204* With modifier FP</td>
<td>$90.07</td>
</tr>
<tr>
<td>99214* With modifier FP</td>
<td>$52.86</td>
</tr>
</tbody>
</table>

* Services payable to an FQHC based on an all-inclusive rate per visit.

**Title V and XX Only**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Fee for Title V or XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204 With modifier FP</td>
<td>$48.28</td>
</tr>
<tr>
<td>99214 With modifier FP</td>
<td>$41.46</td>
</tr>
</tbody>
</table>

20.7.2 Other Family Planning Office or Outpatient Visits

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 and/or referral, if indicated
- Education/counseling or referral, if indicated
- Scheduling of office or clinic visit, if indicated

For any family planning service other than an intrauterine device or an annual exam with a new patient, FQHCs should bill procedure code 99214 with modifier FP with the claim so FQHCs can receive an encounter rate reimbursement. This includes family planning services...
that are not annual exams and visits where only a contraceptive injection is provided. FQHCs are only reimbursed for procedure codes 99204, 99214, J7300, and J7302. All other procedure codes are marked as “informational.” Procedure codes 99204 and 99214 must be billed with modifier FP.

20.7.3 Laboratory Procedures

20.7.3.1 Laboratory Procedures—Title V Only
Laboratory tests for Title V clients may be sent to the DSHS laboratory and/or one of its designated affiliates for processing at no cost to the provider. This cost is covered by the Title V Program and the DSHS laboratory.

Providers who choose not to use the DSHS laboratories can send their specimens to another laboratory of their choice, but they are not reimbursed by DSHS for those services. These tests, whether provided by DSHS or another laboratory facility, must be documented on the Family Planning claim form to track the services provided and to collect accurate statewide data.

Refer to: “Laboratory Procedures—Titles V and XX” on page 20-9 to identify which tests are provided by DSHS at no cost to Title V contractors.

20.7.3.2 Laboratory Procedures—Title XIX Only
Medicaid family planning service providers must document all laboratory services ordered in the client’s medical record as medically necessary and reference an appropriate diagnosis. Any test specimen sent to a laboratory for interpretation should not be billed on the family planning provider’s claim. The laboratory bills Texas Medicaid directly for the tests it performs.

All providers of laboratory services must comply with the rules and regulations of the Clinical Laboratory Improvement Amendments (CLIA). Providers not complying with CLIA are not reimbursed for laboratory services. Only the office or lab actually performing the laboratory test procedure and holding the appropriate CLIA certificate may bill for the procedure.

If a provider does not perform the laboratory procedure, the provider may be reimbursed one lab handling fee a day, per client, unless multiple specimens are obtained and sent to different laboratories. Procedure code 99000 with modifier FP is paid for handling and/or conveyance of the specimen from the provider’s office to a laboratory.

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 (place of service [POS] 1) by using the modifier SU (e.g., 88150-SU).

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 Texas Medicaid 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., the procedure must be billed with a family planning diagnosis.

For a complete list of Title XIX laboratory procedures, providers can refer to the Texas Medicaid fee schedules located on the TMHP website at www.tmhp.com/file_library/file_library/fee_schedules.

20.7.3.3 Laboratory Procedures—Titles V and XX
The following list of laboratory procedures and reimbursements are those authorized for billing by Titles V and XX family planning service providers with appropriate documentation in the client’s record.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061</td>
<td>$0*</td>
<td>NA</td>
</tr>
<tr>
<td>81002</td>
<td>$3.54</td>
<td>$3.54</td>
</tr>
<tr>
<td>81015</td>
<td>$4.20</td>
<td>$4.20</td>
</tr>
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<td>81025</td>
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<tr>
<td>88230</td>
<td>$0*</td>
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</tbody>
</table>

* Title V providers do not receive reimbursement for services performed free of charge by the DSHS Laboratory. For correct tracking of services performed, providers are required to include these services on their Title V Family Planning claims filed with TMHP.
Refer to: “Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2.

20.7.4 Radiology
Radiology services are to be performed for the purpose of localization of an intrauterine device (IUD).

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Fee for Titles V, XIX and XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>74000</td>
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</tr>
<tr>
<td>74010</td>
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<tr>
<td>76830</td>
<td>$74.74</td>
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</tbody>
</table>

*Title XIX only. Not a payable benefit for Titles V and XX.

Title XIX Only
These procedures can be billed on either the Family Planning 2017 claim form or the CMS-1500 claim form. Physicians, NPs, CNSs, PAs, and FQHCs may bill any radiology code that is medically necessary.

20.7.5 Contraceptive Devices and Related Procedures
The following applies to Titles V, XIX, and XX:

- Procedure codes J7300 or J7302 must be billed with 58300 on the same date of service to receive reimbursement for the IUD and the insertion of the IUD.
- An IUD insertion/procurement of the IUD may be reimbursed when billed on the same date of service as a dilation and curettage. Procedure code 58120 is reimbursed at full allowance. Procedure code 58300 may be considered for reimbursement separately from procedure code J7302. Procedure codes J7300 and J7302 are 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 surgical procedure is paid at full allowance and the IUD insertion billed using procedure code 58300 is paid at half the allowed amount.

For Title XIX only, procedure code 58301 may be considered for reimbursement when an IUD is extracted from the uterine cavity. Procedure code 58301 is not considered for reimbursement when submitted with the same date of service as an office visit.

Procedure code J7307 must be billed with procedure code 11975 or 11977 on the same date of service to be considered for reimbursement for the contraceptive capsule and the implantation of the contraceptive capsule.

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.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V and XX Fee</th>
<th>Title XIX Fee</th>
</tr>
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</tr>
<tr>
<td>E1399* with modifier UD</td>
<td></td>
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<tr>
<td>J7300</td>
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<td>J7307</td>
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<tr>
<td>57170</td>
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<tr>
<td>58300</td>
<td>$69.00</td>
<td>Clients 20 years of age or younger: $72.45 Clients 21 years of age or older: $69.00</td>
</tr>
<tr>
<td>58301</td>
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* Title XIX only. Not a payable benefit for Titles V and XX.

20.7.6 Drugs and Supplies

<table>
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<th>Procedure Code</th>
<th>Title V and XX Fee</th>
<th>Title XIX Fee</th>
</tr>
</thead>
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</tr>
<tr>
<td>A4269</td>
<td>$4.00</td>
<td>$4.00</td>
</tr>
<tr>
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<td>$48.10</td>
<td>$61.91</td>
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<td>$15.96</td>
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<tr>
<td>S4993</td>
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<td>$20.88</td>
</tr>
<tr>
<td>90772**</td>
<td>NA</td>
<td>$8.00</td>
</tr>
</tbody>
</table>

* Title V and Title XX only. For Title XIX, clients are provided a prescription to be filled through the Vendor Drug Program.
** Title XIX only. Not a payable benefit for Titles V and XX.
20.7.6.1 Dispensing Medication
Family planning providers have a choice of dispensing family planning drugs and supplies directly to the client and billing TMHP, or giving clients a prescription to take to a pharmacy. Family planning drugs and supplies that are dispensed directly to the client are billed to TMHP or a Medicaid managed care organization (MCO). Family planning providers may dispense up to a one year supply of contraceptives in a 12 month period using procedure codes J7303, J7304, or S4993. Providers must include the appropriate family planning diagnosis code.

Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed for up to a six month supply. Providers who also contract with DSHS for Title V, X, or XX should refer to the DSHS Title V, X, and XX Family Planning Policy Manual for additional guidance on dispensing medication to Title V, X, or XX clients.

Procedure code J3490 may be billed when a prescription medication to treat a genital infection is provided to the client. Procedure code A9150 with modifier FP may be billed when a nonprescription medication to treat a monilia infection is provided to the client. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule. Additionally, pharmacies under the Vendor Drug Program contract are allowed to fill the prescription for up to six months at a time.

20.7.6.2 Injection Administration—Title XIX Only
Injection administration billed by a provider is reimbursed separately from the medication. When billing procedure code J1055, the injection administration should be billed using procedure code 90772. If billed without procedure code J1055, procedure code 90772 must be billed with a family planning diagnosis and a family planning modifier (FP) and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

20.7.7 Medical Counseling and Education

20.7.7.1 Instruction in Natural Family Planning Methods (Per Session)—Title V, XIX, and XX
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.

20.7.7.2 Introduction to Family Planning in Hospital Setting/ Auspices—Title V and XX Only
Procedure code S9445 with modifier FP consists of an overview of family planning benefits to encourage pregnant or postpartum women to use family planning services following delivery.

20.7.7.3 Nutritionist Visit—Title V Only
Procedure code S9470 is provided by a licensed dietician for clients with a high-risk condition; for example, diabetes, hypertension, lipid disorders, and others. This procedure code may only be billed for clients with a high-risk condition.

Refer to: “Licensed Dietitians (CCP)” on page 43-52 for more information about Texas Health Steps (THSteps) nutritional counseling for clients birth through 20 years of age.

20.7.7.4 Method-Specific Education/ Counseling—Title V and XX Only
Procedure code 99401 with modifier FP provides information about the contraceptive method chosen for use by the client, including its proper use, the possible side effects and complications, its reliability, and its reversibility. The service is provided when initiating a contraceptive method, when changing contraceptive methods, or when having difficulty with a current method.

The educational counseling must include at least the following:
- Verbal and written instructions for correct use of the method and self-monitoring
- Information regarding the method’s mode of action, safety, benefits, and effectiveness
- Information regarding risks, potential side effects, and complications of the method and what to do if they occur
- Backup method: review when appropriate and instructions on the correct use
- When prescribing a diaphragm or cervical cap, include a demonstration of the correct insertion and removal procedures

20.7.7.5 Problem Counseling—Title V and XX Only
Procedure code 99402 with modifier FP is billed when clients have problems they wish to discuss that are not related to a contraceptive method. Examples include pregnancy, sexually transmitted diseases (STDs), social and marital problems, health disorders, sexuality concerns, preconception counseling, and options counseling for an unintended pregnancy.

Clients who may become pregnant and in whom the assessment reveals potential pregnancy risks must receive preconception counseling regarding the modification/reduction of that risk.

20.7.7.6 Teen Group Counseling—Title XX Only
Procedure code S94411 is used for group presentations and/or discussions conducted with a minimum of five adolescents 19 years of age or younger. Sessions are reimbursed at $1.50 per person for 5 to 49 people or a total of $75 for 50 or more participants. Topics for discussion include, but are not limited to, human anatomy, human sexuality, personal physical care and
hygiene, skills to resist sexual coercion, methods of family planning, and STDs. The provider should prepare a written statement for each session that indicates where and when the session was held, the specific topic(s) discussed, and the number of participants. These statements are kept by the provider and may be reviewed by the DSHS Quality Management Branch staff during site visits.

20.7.7 Initial Patient Education - Title V and XX Only
Procedure code 99429 with modifier FP is provided to facilitate selection of an effective contraceptive method. Every new client requesting contraceptive services or family planning medical services must be provided initial client education either verbally, in writing, or by audiovisual materials. Over-the-counter contraceptive methods may be provided before the client receives the initial client education but must be accompanied by written instructions on correct use. The initial client education may vary according to the educator’s evaluation of the client’s current knowledge. It may include the following:

- General benefits of family planning services and contraception.
- Information on male and female basic reproductive anatomy and physiology.
- Information regarding the benefits and potential side effects and complications of all available contraceptive methods.
- Information about all of the clinic’s available services, the purpose and sequence of clinic procedures, and routine schedule of return visits.
- Breast self-examination rationale and instruction, unless provided during physical exam (for females).
- Information on human immunodeficiency virus (HIV)/STD infection and prevention and safer sex discussion.
- Information about the importance of having a THSteps medical and dental check up.

20.7.8 Sterilization and Sterilization-Related Procedures
Sterilization services are a benefit when billed by an agency, an FQHC, or a physician. FQHCs and physicians must use the most appropriate current procedural terminology (CPT) procedure code for payment. The codes with the global fees listed in the following table are developed for family planning agencies only:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Fee for Titles V and XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>55250*</td>
<td>$253.75</td>
</tr>
<tr>
<td>58600*</td>
<td>$1800.00</td>
</tr>
</tbody>
</table>

* Global fee (includes all services, i.e. facility, physician, anesthesia, recovery, and pre- and postsurgical care).

20.7.8.1 Incomplete Sterilizations—Title V and XX only
For incomplete procedures, diagnosis code V641, V642, or V643 must be present on the claim in addition to the diagnosis for sterilization. Providers must use the most appropriate diagnosis code for each situation. Incomplete sterilizations are billed at cost. All charges related to the procedure are tracked cumulatively.

20.7.8.2 Tubal Ligation
Procedure code 58600 must be used for any sterilization procedure performed on a female client by a family planning agency using Title V, X, or XX. This procedure code is paid as a global fee to include preoperative, intraoperative, and postoperative services by all parties involved, (i.e., physician, anesthesiologist, facility, laboratory, etc.). Procedure code 58600, 58615, 58670, or 58671 must be used for Title XIX. Sterilizations are considered to be permanent, once per lifetime procedures. When a client’s claim history shows a previous sterilization, providers are asked to appeal and must provide supporting documentation for the need for repeat sterilization. Per federal regulation 42 Code of Federal Regulations (CFR) 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

For a complete list of Title XIX sterilization procedures, providers should refer to the Texas Medicaid fee schedules located on the TMHP website at www.tmhp.com/file-library/file-library/fee-schedules. Refer to: “Sterilization Consent Form (English)” on page B-100 and “Sterilization Consent Form (Spanish)” on page B-101.

“Sterilization Consent Form and Instructions” on page 20-13.
“Women’s Health Program” on page O-1 for information on billing the Women’s Health Program for sterilizations.

20.7.8.3 Vasectomy
Procedure code 55250 should be used for any sterilization procedure performed on a male by a family planning agency using Title V, X, XIX, or XX. This procedure code is paid as a global fee to include preoperative, intraoperative, and postoperative services by all parties involved (i.e., physician, anesthesiologist, facility, laboratory, etc.). Vasectomies are considered to be permanent, once-per-lifetime procedures. When a client’s claim history shows a previous vasectomy, providers will be asked to appeal and must provide supporting documentation for the need for repeat sterilization. Per federal regulation 42 CFR 50, Subpart B, all sterilization procedures require an approved Sterilization Consent Form.

Refer to: “Sterilization Consent Form (English)” on page B-100 and “Sterilization Consent Form (Spanish)” on page B-101.

“Sterilization Consent Form and Instructions” on page 20-13.
20.7.8.4 Anesthesia for Sterilization
Providers must use modifier FP, when reporting anesthesia services for a sterilization procedure.
The following procedure codes require modifier FP, in addition to the regular anesthesia modifier, if the service is a sterilization CPT anesthesia code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>00840</td>
</tr>
<tr>
<td>00921</td>
</tr>
</tbody>
</table>

20.7.8.5 Facility Fees for Sterilization
Hospital-based and freestanding ASCs may be reimbursed for procedure codes 58600, 58615, 58670, or 58671 with an appropriate WHP or family planning diagnosis code when reporting facility fees related to tubal ligation. Refer to: “Ambulatory Surgical Center” on page 9-2 for more information about ASC billing procedures.

20.7.9 Sterilization Consent Form and Instructions
Per federal regulation 42 CFR 50, Subpart B, all sterilizations require a valid consent form regardless of the funding source. Providers must use the consent form provided in this manual in Appendix B and ensure all required fields are completed for timely processing. These fields are listed in “Required Fields” on page 20-5.

Providers should fax 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). Providers must fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229. Claims and appeals are not accepted by fax, so providers can send only Family Planning sterilization correspondence to this fax number. Failure to do so may delay claim processing or cause the claim to be denied.

Note: Hysterectomy Acknowledgment forms discussed in Section 34 are not sterilization consents and should be faxed to 1-512-514-4218.

Refer to: “Sterilization Consent Form (English)” on page B-100 and “Sterilization Consent Form (Spanish)” on page B-101.

20.7.9.1 Sterilization Consent Form Instructions
Clients must be 21 years of age or older when the consent form is signed. If the client was 20 years of age or younger when the consent form was signed, the consent is denied. Changing signature dates is considered fraudulent and is 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:

• Premature delivery—There must be at least 30 days between the date of consent and the client’s expected date of delivery.
• Cases of emergency abdominal surgery not associated with pregnancy—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 published in this manual. Completion of all sections is required to validate the consent form, with only two 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; however, if this section is only partially completed, the consent is not accepted as a valid consent.

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. Providers must fax fully completed Sterilization Consent Forms to TMHP at 1-512-514-4229.

20.7.9.2 Required Fields
All of the fields must be legible in order for the consent form to be valid. Any illegible field results 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 is not 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)
• Client’s signature
• Date of client signature—Client must be 21 years of age or older on this date. This date cannot be altered or added at a later date.

Interpreter’s Statement (If Applicable)
• Name of language used by interpreter
• Interpreter’s signature
• Date of interpreter’s 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 client’s signature date.

• Facility name—Clinic/office where the client received the sterilization information.

• Facility address—Clinic/office where the client received the sterilization information.

Physician's Statement

• Client's 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 client’s 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. Client’s 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.

• Physician's signature—Stamped or computer-generated signatures are not acceptable.

• Date of physician’s 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

• The following provider identification numbers are required to expedite the processing of the consent form:
  • Texas Provider Identifier (TPI)
  • National Provider Identifier (NPI)
  • Taxonomy
  • Benefit code

• Provider/clinic phone number

• Provider/clinic fax number (If available)

• Family planning title for client—Indicated by circling V, X, XIX, or XX

### 20.7.10 Claim Filing Resources

Providers can refer to the following sections and/or forms when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Inquiry System</td>
<td>xiii</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>3-1</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>5-15</td>
</tr>
<tr>
<td>Family Planning 2017 Claim Form</td>
<td>5-47</td>
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<tr>
<td>Family Planning 2017 Claim Form Instructions</td>
<td>5-48</td>
</tr>
<tr>
<td>Communications Guide</td>
<td>A-1</td>
</tr>
<tr>
<td>Acronym Dictionary</td>
<td>F-1</td>
</tr>
<tr>
<td>Women’s Health Program</td>
<td>O-1</td>
</tr>
</tbody>
</table>