# Table of Contents

1. **General Information** ................................................................................. GN-7
2. **Certified Nurse Midwives** ........................................................................ GN-7
   2.1 **Provider Enrollment** ........................................................................ GN-7
   2.2 **Services/Benefits, Limitations, and Prior Authorization** ...................... GN-8
      2.2.1 **Deliveries** .................................................................................. GN-8
      2.2.2 **Newborn Services** ...................................................................... GN-8
         2.2.2.1 **Hearing Screening** ................................................................. GN-9
         2.2.2.2 **Services Provided in a Birthing Center** ................................. GN-9
         2.2.2.3 **Antepartum & Postpartum Services** ...................................... GN-10
      2.2.3 **Prior Authorization** ..................................................................... GN-10
   2.3 **Documentation Requirements** ............................................................. GN-10
2.4 **Claims Filing and Reimbursement** ........................................................ GN-11
3. **Medicaid Title XIX family planning services** ........................................... GN-11
   3.1 **Title XIX Provider Enrollment** ........................................................... GN-11
   3.2 **Family Planning Overview** ................................................................. GN-12
      3.2.1 **Guidelines for Family Planning Providers** ................................. GN-13
      3.2.2 **Family Planning Services for Undocumented Aliens, Legalized Aliens** GN-13
   3.3 **Services/Benefits, Limitations, and Prior Authorization** ...................... GN-13
      3.3.1 **Family Planning Annual Exams** .............................................. GN-14
      3.3.2 **FQHC Reimbursement for Family Planning Annual Exams** ........... GN-15
      3.3.3 **Other Family Planning Office or Outpatient Visits** ....................... GN-15
      3.3.4 **Lab Specimen Handling and Testing** ......................................... GN-17
      3.3.5 **Providing Information to the Reference Laboratory** ...................... GN-17
   3.3.6 **Radiology Services** ................................................................. GN-17
      3.3.6.1 **External Contraceptives** ......................................................... GN-17
      3.3.6.2 **Intrauterine Device (IUD)** ......................................................... GN-18
         3.3.6.2.1 **Insertion of the IUD** ......................................................... GN-18
         3.3.6.2.2 **Removal of the IUD** ......................................................... GN-18
      3.3.6.3 **Contraceptive Capsules** ......................................................... GN-18
      3.3.6.4 **Occlusive Sterilization Device** ................................................. GN-18
      3.3.6.5 **Drugs and Supplies** .............................................................. GN-19
      3.3.6.6 **Prescriptions and Dispensing Medication** ............................... GN-19
      3.3.6.7 **Injection Administration** ....................................................... GN-19
   3.3.7 **Medical Counseling and Education** ............................................... GN-19
3.3.8 **Sterilization and Sterilization-Related Procedures** ............................ GN-20
      3.3.8.1 **Sterilization Consent** ............................................................. GN-20
      3.3.8.2 **Sterilization and Sterilization-Related Procedures** .................... GN-20
      3.3.8.3 **Medical Counseling and Education** ....................................... GN-19
      3.3.8.4 **Sterilization Consent** ............................................................. GN-20
5. Titles V, X, and XX Family Planning Services ........................................ GN-32
  5.1 Provider Enrollment for Titles VI, X, and XX Contractors .................... GN-32
  5.2 Family Planning Providers ............................................................. GN-32

4. Women’s Health Program (Title XIX Family Planning) ......................... GN-23
  4.1 Women’s Health Program (WHP) Provider Enrollment ....................... GN-23
  4.2 WHP Overview ................................................................................. GN-24
     4.2.1 Guidelines for WHP Family Planning Providers ....................... GN-24
     4.2.2 Referrals ................................................................................. GN-25
       4.2.2.1 Referrals for Breast and Cervical Cancer Screening, Diagnostics,
               and Treatment ........................................................................ GN-25
       4.2.2.2 Referrals for Clients Diagnosed with Breast or Cervical Cancer .. GN-25
     4.2.3 Abortions .................................................................................... GN-25
  4.3 Services/Benefits, Limitations, and Prior Authorization ....................... GN-26
     4.3.1 Family Planning Annual Exams .................................................. GN-26
     4.3.1.1 FQHC Reimbursement for Family Planning Annual Exams ....... GN-27
     4.3.2 Other Family Planning Office or Outpatient Visits ...................... GN-27
     4.3.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits GN-28
     4.3.3 Laboratory Procedures ............................................................. GN-28
     4.3.4 Radiology .................................................................................. GN-29
     4.3.5 Contraceptive Devices and Related Procedures ............................ GN-29
     4.3.6 Drugs and Supplies ................................................................... GN-30
       4.3.6.1 Prescriptions and Dispensing Medication .............................. GN-30
     4.3.7 Instruction in Natural Family Planning Methods ............................ GN-30
     4.3.8 Sterilization and Sterilization-Related Procedures ....................... GN-30
       4.3.8.1 Sterilization Consent ............................................................. GN-30
       4.3.8.2 Tubal Ligation ..................................................................... GN-31
       4.3.8.3 Anesthesia for Sterilization .................................................... GN-31
       4.3.8.4 Facility Fees for Sterilization ................................................ GN-31
       4.3.8.5 Hysteroscopic Sterilization .................................................... GN-31
     4.3.9 Eligibility Verification ............................................................... GN-31
  4.4 Documentation Requirements .......................................................... GN-31
  4.5 WHP Claims Filing and Reimbursement ............................................ GN-32
     4.5.1 Claims Information .................................................................... GN-32
       4.5.1.1 WHP and Third-Party Resource ............................................ GN-32
     4.5.2 Reimbursement ......................................................................... GN-32
     4.5.3 National Drug Code (NDC) ....................................................... GN-32

3. Documentation Requirements ............................................................. GN-20

3.5 Claims Filing and Reimbursement ..................................................... GN-21
  3.5.1 Claims Information ....................................................................... GN-21
     3.5.1.1 Family Planning and Third Party Resource ............................. GN-22
     3.5.1.2 Claims Filing For Title X-Supported Clinics ......................... GN-22
  3.5.2 Billing Procedures for Non-Family Planning Services Provided During a Family Planning Visit (Title XIX Only) ........................................ GN-23
  3.5.3 National Drug Code (NDC) ........................................................ GN-23

2. Services/Benefits, Limitations, and Prior Authorization ....................... GN-26
  2.1 Family Planning Annual Exams ....................................................... GN-26
     2.1.1 FQHC Reimbursement for Family Planning Annual Exams ....... GN-27
     2.2 Other Family Planning Office or Outpatient Visits ....................... GN-27
     2.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits GN-28
  2.3 Laboratory Procedures ................................................................. GN-28
  2.4 Radiology ....................................................................................... GN-29
  2.5 Contraceptive Devices and Related Procedures .................................. GN-29
  2.6 Drugs and Supplies ......................................................................... GN-30
     2.6.1 Prescriptions and Dispensing Medication .................................. GN-30
  2.7 Instruction in Natural Family Planning Methods ............................... GN-30
  2.8 Sterilization and Sterilization-Related Procedures ............................ GN-30
     2.8.1 Sterilization Consent ............................................................... GN-30
     2.8.2 Tubal Ligation ....................................................................... GN-31
     2.8.3 Anesthesia for Sterilization ...................................................... GN-31
     2.8.4 Facility Fees for Sterilization .................................................... GN-31
     2.8.5 Hysteroscopic Sterilization ...................................................... GN-31
  2.9 Eligibility Verification ....................................................................... GN-31
  2.10 Documentation Requirements ...................................................... GN-31

1. Services/Benefits, Limitations, and Prior Authorization ....................... GN-26
  1.1 Family Planning Annual Exams ...................................................... GN-26
     1.1.1 FQHC Reimbursement for Family Planning Annual Exams ....... GN-27
     1.2 Other Family Planning Office or Outpatient Visits ....................... GN-27
     1.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits GN-28
  1.3 Laboratory Procedures ................................................................. GN-28
  1.4 Radiology ....................................................................................... GN-29
  1.5 Contraceptive Devices and Related Procedures .................................. GN-29
  1.6 Drugs and Supplies ......................................................................... GN-30
     1.6.1 Prescriptions and Dispensing Medication .................................. GN-30
  1.7 Instruction in Natural Family Planning Methods ............................... GN-30
  1.8 Sterilization and Sterilization-Related Procedures ............................ GN-30
     1.8.1 Sterilization Consent ............................................................... GN-30
     1.8.2 Tubal Ligation ....................................................................... GN-31
     1.8.3 Anesthesia for Sterilization ...................................................... GN-31
     1.8.4 Facility Fees for Sterilization .................................................... GN-31
     1.8.5 Hysteroscopic Sterilization ...................................................... GN-31
  1.9 Eligibility Verification ....................................................................... GN-31
  1.10 Documentation Requirements ...................................................... GN-31
5.3 Services/Benefits, Limitations and Prior Authorization ......................... GN-33
5.3.1 Titles V and XX Family Planning Annual Exams ............................... GN-33
5.3.1.1 FQHC Reimbursement for Titles V and XX Family Planning Annual Exams . GN-34
5.3.2 Title V and XX Family Planning Office or Outpatient Visits ................ GN-34
5.3.2.1 FQHC Reimbursement for Title V and XX Family Planning Office or Outpatient Visits ............... GN-35
5.3.3 Laboratory Procedures ................................................................. GN-36
5.3.3.1 Title V Only ................................................................................. GN-36
5.3.3.2 Titles V and XX .............................................................................. GN-36
5.3.4 Radiology ......................................................................................... GN-38
5.3.5 Contraceptive Devices and Related Procedures ................................. GN-38
5.3.5.1 External Contraceptives .............................................................. GN-38
5.3.5.2 IUD ............................................................................................... GN-38
   5.3.5.2.1 Insertion of an IUD ................................................................. GN-38
   5.3.5.2.2 Removal of the IUD ............................................................... GN-39
5.3.5.3 Contraceptive Capsules .............................................................. GN-39
5.3.5.4 Medroxyprogesterone Acetate/Estradiol Cyapionate ..................... GN-39
5.3.6 Title V and XX Drugs and Supplies ................................................. GN-40
5.3.6.1 Prescriptions and Dispensing Medication ...................................... GN-40
5.3.7 Family Planning Education .............................................................. GN-40
5.3.7.1 Medical Nutrition Therapy ......................................................... GN-41
5.3.7.2 Title V and XX Instruction in Natural Family Planning Methods ...... GN-41
5.3.8 Sterilization and Sterilization-Related Procedures ............................... GN-41
5.3.8.1 Sterilization Consent ................................................................. GN-41
5.3.8.2 Title V and XX Incomplete Sterilizations ...................................... GN-41
5.3.8.3 Titles V, X, and XX Tubal Ligation .............................................. GN-41
5.3.8.4 Vasectomy .................................................................................. GN-41
5.3.8.5 Anesthesia for Sterilization ......................................................... GN-42
5.3.9 Prior Authorization .......................................................................... GN-42
5.4 Documentation Requirements ............................................................... GN-42
5.5 Claims Filing and Reimbursement ......................................................... GN-42
5.5.1 Claims Information .......................................................................... GN-42
5.5.1.1 Filing Deadlines ........................................................................ GN-42
5.5.1.2 Third-Party Resource ............................................................... GN-42
5.5.1.3 Title X Encounter Filing ......................................................... GN-42
5.5.2 Reimbursement .............................................................................. GN-43
5.5.2.1 Title X Payments ......................................................................... GN-43
5.5.3 National Drug Code (NDC) ............................................................ GN-43
6. Maternity Service Clinics ........................................................................ GN-43
6.1 Provider Enrollment ........................................................................... GN-43
6.1.1 Physician Responsibility ............................................................... GN-44
6.1.2 Case Management Services to High-Risk Individuals ..................... GN-44
6.2 Services, Benefits, Limitations, and Prior Authorization ....................... GN-44
6.2.1 Initial Antepartum Care Visit Components ...................................... GN-45
6.2.1.1 History ....................................................................................... GN-45
6.2.1.2 Physical Examination ............................................................ GN-45
6.2.1.3 Laboratory Tests ........................................................................ GN-45
6.2.1.4 Assessment ............................................................................... GN-46
6.2.1.5 Plan ............................................................................................ GN-46
6.2.1.6 Education and Counseling ....................................................... GN-46

GN-5
6.2.2 Subsequent Antepartum Care Visits ......................................................... GN-46
6.2.2.1 Physical Examination ................................................................ GN-47
6.2.2.2 Laboratory Tests ........................................................................ GN-47
6.2.3 Postpartum Care Visit ........................................................................ GN-47
6.2.4 Prior Authorization ............................................................................ GN-47

6.3 Documentation Requirements ................................................................. GN-47
6.4 Claims Filing and Reimbursement .......................................................... GN-47

7. Gynecological Health Services ................................................................. GN-48
7.1 Assays for the Diagnosis of Vaginitis ...................................................... GN-48
7.2 Diagnostic Hysteroscopy ......................................................................... GN-49
7.3 Abortions ................................................................................................. GN-49
7.3.1 Prior Authorization for Abortions ....................................................... GN-50
7.4 Examination Under Anesthesia .............................................................. GN-50
7.5 Hysterectomy Services ........................................................................... GN-50
7.5.1 Hysterectomy Acknowledgment Form .............................................. GN-50
7.6 Pap Smear (Cytopathology Studies) ....................................................... GN-52
7.7 Surgery for Masculinized Females ......................................................... GN-52
7.8 Documentation Requirements ............................................................... GN-52
7.9 Claims Filing and Reimbursement ........................................................ GN-53
7.10 National Drug Code (NDC) ................................................................. GN-53

8. Claims Resources ..................................................................................... GN-54
9. Contact TMHP ......................................................................................... GN-54
10. Forms ........................................................................................................ GN-54
    GN.1 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Instructions ........ GN-55
    GN.2 Specimen Submission Form G1-C, Maternal Serum Prenatal Triple Screen ................................ GN-56
    GN.3 Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen (Spanish, 2 Pages) ........ GN-57
    GN.4 Birthing Center Report (Newborn Child or Children) (Form 7484) ............................................. GN-59
    GN.5 Sterilization Consent Form Instructions (2 pages) .................................................................. GN-60
    GN.6 Sterilization Consent Form (English) .................................................................................... GN-62
    GN.7 Sterilization Consent Form (Spanish) ................................................................................ GN-63
    GN.8 Abortion Certification-Statements Form ........................................................................ GN-64
    GN.9 Hysterectomy Acknowledgement Form ........................................................................ GN-65

11. Claim Form Examples .............................................................................. GN-66
    GN.10 Family Planning Claim Form ........................................................... GN-67
    GN.11 Maternity Service Clinic ................................................................. GN-68
    GN.12 Nurse Practitioner/Clinical Nurse Specialist (Family Planning) ........................................ GN-69

Note: A comprehensive Index, including Volume 1 and all handbooks from Volume 2, is included at the end of Volume 1 (General Information).
GYNECOLOGICAL AND REPRODUCTIVE HEALTH, OBSTETRICS, AND FAMILY PLANNING SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for Texas Medicaid Certified Nurse Midwives (CNM), Family Planning Providers, and Maternity Service Clinics (MSC). The handbook provides information about Texas Medicaid’s benefits, policies, and procedures 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) §371.1617(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 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:** 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” Introduction (Vol. 1, General Information)

Section 8, Managed Care (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 family planning clinics receiving Title V, X, or XX funding from DSHS.

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Documentation Requirements

2. CERTIFIED NURSE MIDWIVES

2.1 Provider Enrollment

To enroll in Texas Medicaid, a CNM must be a licensed registered nurse recognized by the Texas Board of Nursing (BON) as an advanced practice registered nurse (APRN) and authorized to practice as a nurse-midwife. A CNM must be a Medicare participating provider in order to enroll in Texas Medicaid. If a CNM is enrolling into a Family Planning Group, Medicare enrollment is not a requirement.

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

**Refer to:** DSHS website at www.dshs.state.tx.us/famplan for information about family planning and the locations of family planning clinics receiving Title V, X, or XX funding from DSHS.
All providers of laboratory services must comply with the rules and regulations of the *Clinical Laboratory Improvement Amendments* (CLIA). Providers that are not CLIA certified are not reimbursed for laboratory services.

A CNM must identify the licensed physician or group of physicians with whom there is an arrangement for referral and consultation if medical complications arise. The collaborating physician does not have to be a participating provider in Texas Medicaid. According to TAC, §354.1252 (3), if the collaborating physician or group is not a participating provider in Texas Medicaid, the CNM must inform clients of their potential financial responsibility. If the arrangement is changed or canceled, the CNM must notify TMHP Provider Enrollment in writing within two weeks after the change or cancellation.

CNMs are encouraged to participate in or make referrals to family planning agencies. CNMs may enroll as providers of THSteps medical checkups for newborns younger than two months of age and adolescent females.

*Refer to:* “Provider Enrollment” in *General Information Handbook (Vol. 1, Provider Handbooks)* for more information about enrollment in Texas Medicaid.


Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in *Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks).*

### 2.2 Services/Benefits, Limitations, and Prior Authorization

CNMs may be reimbursed for primary care services including family planning, gynecology services, THSteps services, treatment of acute minor illnesses, chronic stable conditions provided to women throughout their lives, and to newborns for the first two months of life. CNMs may also be reimbursed for the maternity cycle care for female clients when performed in a maternity service clinic.

CNM-performed services are covered by Texas Medicaid if the services are within the scope of practice for CNMs as defined by state law, and consistent with rules and regulations made by the Texas BON or other appropriate state licensing authority.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately from antepartum care visits. Childbirth education classes are not a benefit of Texas Medicaid.

#### 2.2.1 Deliveries

CNMs may be reimbursed for procedure code 59409, 59410, 59612, or 59614 for delivery services. Deliveries must be performed in a participating Medicaid general or acute care hospital, or facility licensed and approved for the operation of maternity and newborn services, or in the home.

#### 2.2.2 Newborn Services

Routine newborn care, attendance at delivery, newborn resuscitation, neonatal critical care, and intensive (noncritical) care services are benefits to CNMs for clients who are birth through 28 days of age.

The following procedure codes may be used by CNMs to bill newborn services:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>*POS</th>
</tr>
</thead>
<tbody>
<tr>
<td>99460</td>
<td>3, 7</td>
</tr>
</tbody>
</table>

*POS Description Key:
1 - Office
2 - Home
3 - Hospital - Inpatient
5 - Hospital - Outpatient
7 - Birthing Center
Retrospective review may be performed to ensure documentation supports the medical necessity of the service and any modifier used when billing the claim.

Procedure code 99462 is limited to one per date of service by any provider and will be denied when billed for the same date of service by the same provider as procedure code 99238 or 99239. Procedure codes 99460 and 99463 are limited to once per lifetime, any provider, when provided in the hospital or birthing room (either hospital or birthing center) setting.

Hospital discharge (procedure codes 99238 and 99239) is denied when billed for the same date of service by the same provider as newborn care (procedure code 99460, 99461, or 99463).

Refer to: Subsection 6.3.1.8, “Newborn Examination” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for a list of required components for an initial THSteps examination.


### 2.2.2.1 Hearing Screening

The facility where the birth occurred must offer the parents a hearing screening for the newborn before discharging the newborn. This hearing screen is part of the delivery service and not separately billable.

Refer to: Subsection 6.3.2.4.2, “Hearing Screening” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for details about hearing screenings performed as part of the THSteps visits.

### 2.2.2.2 Services Provided in a Birthing Center

Physicians and CNMs may bill for the following services when performed in a birthing center setting:

- Deliveries and admission costs must be billed with procedure code 59409 or 59410.
- Procedure codes 99460 and 99463 may be billed for newborn care.
- If the client is discharged prior to delivery, procedure code 99215 without the TH modifier may be billed for labor services which include admission costs.
CNMs and physicians must indicate services performed in a birthing center by submitting claims using POS 7, or the electronic equivalent, to receive the increased reimbursement rate. The higher reimbursement rate allows CNMs and physicians to compensate the birthing center for the use of the facility.

### 2.2.2.3 Antepartum & Postpartum Services

CNMs and physicians are limited to a combined total of 20 outpatient antepartum care visits and two postpartum care visits per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation should reflect the need for increased visits and is subject to retrospective review. Bill antepartum/postpartum services using the following procedure codes with modifier TH:

<table>
<thead>
<tr>
<th>Procedure Codes and Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>59430</td>
</tr>
<tr>
<td>99212-TH</td>
</tr>
</tbody>
</table>

Procedure code 59430 is not submitted with modifier TH.

Providers should bill the most appropriate new or established antenatal visit code or postnatal visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

**Refer to:** Section 3, “Medicaid Title XIX family planning services” in this handbook.

### 2.2.3 Prior Authorization

Prior authorization is not required for any of these services except delivery in the home. For prior authorization of a home delivery, the CNM must submit a written request for prior authorization during the client’s third trimester of pregnancy. The CNM must include a statement signed by a licensed physician who has examined the client during the third trimester and determined at that time that she is not at high risk and is suitable for a home delivery. Documentation must also include a plan for access to emergency transport for mother and neonate, if needed. Requests for home delivery prior authorizations must be submitted to the TMHP Medical Director at the following address:

Texas Medicaid & Healthcare Partnership  
Special Medical Prior Authorization  
12357-B Riata Trace Parkway, Suite 150  
Austin, TX 78727  
Fax: 1-512-514-4213

Claims submitted for home deliveries performed by a CNM without prior authorization will be denied.

### 2.3 Documentation Requirements

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

CNMs must bill maternity services in one of two ways: itemizing each service individually on one claim form and filing at the time of delivery (the filing deadline is applied to the date of delivery) or itemizing each service individually and submitting claims as the services are rendered (the filing deadline is applied to each individual date of service).

CNM services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

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

According to 1 TAC §355.8161, the Medicaid rate for CNMs is 92 percent of the rate paid to a physician (doctor of medicine [MD] or doctor of osteopathy [DO]) for the same service and 100 percent of the rate paid to physicians for laboratory services, X-ray services, and injections. The 92 percent fee is not reflected within the fee schedule and is applied before the payment is processed. 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 4.1, “General Medicaid Eligibility” in Section 4, Client Eligibility (Vol. 1, General Information) for information about crossover payments.
- Section 3, TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
- Subsection 2.2, “Reimbursement Methodology” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information) for more information about reimbursement.

3. MEDICAID TITLE XIX FAMILY PLANNING SERVICES

3.1 Title XIX Provider Enrollment

The following guidelines and exceptions apply for family planning providers:

- Physicians who wish to provide Texas Medicaid obstetric and gynecological (OB-GYN) services are allowed to bypass Medicare enrollment and obtain a Medicaid-only provider identifier for OB-GYN services regardless of provider specialty.
- Federally qualified health centers (FQHCs) do not need to apply for a separate physician or agency number. FQHCs must use their NPI, the appropriate benefit code as applicable, and the family planning procedure codes in this section.
- Rural health clinics (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. An RHC can also apply for enrollment as a family planning agency.

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 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 healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 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 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: Section 1, Provider Enrollment and Responsibilities (Vol. 1, General Information) for more information about enrollment procedures.


### 3.2 Family Planning Overview

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 Titles V, X, XIX, and XX:

• Title XIX funds are available for family planning services provided to Texas Medicaid clients. Title XIX funds are also available for limited family planning services provided to Women’s Health Program (WHP) 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.

• Titles V and XX funds are available for eligible clients and are granted annually by DSHS to contracted family planning providers. TMHP processes Titles V and XX claims and reimburses providers according to the individually granted funds.

• Title X encounters 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.
Agencies across Texas are awarded contracts for Titles V, X, and XX 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 and medical schools, private nonprofit agencies, RHCs, and hospital districts. Some contractors receive more than one type of funding. All contractors serve Texas 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.

3.2.1 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 an registered nurse (RN), physicians assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).
- 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 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.
- Family planning clients must be allowed the freedom to accept or reject services without coercion.
- 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, providers may refer to the DSHS website at www.dshs.state.tx.us/famplan/contractor/rider13.shtm.

3.2.2 Family Planning Services for Undocumented Aliens, Legalized 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 family planning to prevent future unintended pregnancies.

All providers are encouraged to promote the benefits and availability of family planning services under Titles V, X, and XX and to refer interested clients to family planning providers who receive Titles V, X, and XX funds. These family planning funding sources cover the provision of contraceptive devices, supplies, counseling, and sterilizations for these and all other family planning clients.

3.3 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
For family planning claims to process correctly, 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>V251</td>
</tr>
<tr>
<td>V2542</td>
</tr>
<tr>
<td>V258</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 should be based on the type of family planning service performed.

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

### 3.3.1 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.

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>
<tr>
<td>99205</td>
</tr>
<tr>
<td>99214</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 (99201-99205) 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>
</tbody>
</table>
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. Providers may appeal denied claims using modifier 25 if the reason for the additional visit was for a separate, distinct service from the family planning visit or surgical procedure. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

### 3.3.1.1 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 Section 3.3.1.

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 3 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 3 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

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling/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/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>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99211</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient: Most appropriate E/M procedure code (99201-99205) 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 (99211-99215) 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:** Section 3.3, “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. Providers may appeal denied claims using modifier 25 if the reason for the additional visit was for a separate, distinct service from the family planning visit or surgical procedure. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

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

FQHCs may be reimbursed for 3 family planning encounters per client, per year regardless of the reason for the encounter. The 3 encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7300 or J7302.

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 3, “Federally Qualified Health Center,” in the *Outpatient Services Handbook* (Vol. 2, *Provider Handbooks*) for more information about FQHC services.

### 3.3.3 Laboratory Procedures

All family planning laboratory services must be billed with a family planning diagnosis code. 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.
3.3.3.1 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, Laboratory, and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks)

3.3.3.2 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.

3.3.3.3 Lab Specimen Handling and Testing

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

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 a 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. The appropriate procedure code may be reimbursed for Pap smear interpretations when billed with modifier SU in the office setting indicating that the screening and interpretation were actually performed in the office.

Refer to: Section 3.3.1 “Family Planning Annual Exams” in this handbook for more information about annual family planning examinations and other office visits.

3.3.3.4 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. The family planning diagnosis code must be included so that the reference laboratory knows to bill the service as a family planning services.

3.3.4 Radiology Services

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

These procedures can be billed on either the Family Planning 2017 claim form or the CMS-1500 claim form.

3.3.5 Contraceptive Devices and Related Procedures

3.3.5.1 External Contraceptives

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

- Procedure code A4261 (cervical cap)
- Procedure code A4266 (diaphragm)
3.3.5.2 Intrauterine Device (IUD)

3.3.5.2.1 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. 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.
- An office visit will be denied when billed on the same date of service as 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). The following reimbursement may apply:

- Procedure code 58120 (dilation and curettage) may be reimbursed at full allowance.
- Procedure code 58300 (IUD insertion) may be reimbursed at half the allowed amount.
- Procedure code J7300 or J7302 (IUD device) 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.

3.3.5.2.2 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.

3.3.5.3 Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307 and procedure code 11975 (insertion) or 11977 (removal with reinsertion).

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).

3.3.5.4 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.
3.3.6 Drugs and Supplies

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4267</td>
</tr>
<tr>
<td>J7303</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 A9150 for the medication to treat a monilia infection is not reimbursed through Title XIX Medicaid. 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.

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 or to the client’s Medicaid managed care organization (MCO). 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.

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.

3.3.6.2 Injection Administration

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 96372. If billed without procedure code J1055, procedure code 96372 must be billed with a family planning diagnosis and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

Refer to: Subsection 3.3, “Services/Benefits, Limitations, and Prior Authorization” in this handbook for a list of family planning diagnosis codes.

3.3.7 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.

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.
3.3.8 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
www.tmhp.com/FeeSchedules/Presentation/Views/FeeSchedules.aspx.

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

Note: Hysterectomy Acknowledgment forms are not sterilization consents.

Refer to: Form GN-6, “Sterilization Consent Form (English)” in Section 9 of this handbook.
Form GN-7, “Sterilization Consent Form (Spanish)” in Section 9 of this handbook.
Form GN-5,”Sterilization Consent Form Instructions (2 pages)” in Section 9 of this
handbook.

3.3.8.2 Anesthesia for Sterilization
Procedure codes 00851, 00840, and 00940 may be reimbursed for anesthesia for sterilization services
when billed with the regular anesthesia modifier. Procedure codes 00840 and 00940 must also be billed
with a family planning diagnosis code.

Refer to: Subsection 6.2.7.2, “Anesthesia” in Section 6, “Claims Filing” (Vol. 1, General Information)
for more information about anesthesia modifiers.

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

3.3.8.4 Vasectomy
Procedure code 55250 should be used for any sterilization procedure 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 (i.e., physician, anesthesiologist, facility,
laboratory, and so on). 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.

3.3.8.5 Facility Fees for Sterilization
Hospital-based and freestanding ASCs may be reimbursed for procedure code 58600, 58615, 58670,
58671, 55200, 55250, 58565, or A4264. An appropriate family planning diagnosis code must be billed
when reporting facility fees related to tubal ligation.

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

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

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

Gynecological and reproductive health, obstetrics, and family planning services are subject to retro-
spective review and recoupment if documentation does not support the service billed.
# 3.5 Claims Filing and Reimbursement

## 3.5.1 Claims Information

Providers may use the following claim forms to submit claims to TMHP or the client’s MCO:

<table>
<thead>
<tr>
<th>Providers</th>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Fee-For-Service Claims Submitted to TMHP</strong></td>
<td></td>
</tr>
<tr>
<td>All family planning services provided by physicians, PAs, NPs, CNs, and family planning agencies who also contract with DSHS for Title V, X, or XX</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 for Title V, X, or XX</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 to provide Titles V, X, or XX</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 to provide Titles V, X, or XX family planning services</td>
<td>Family Planning 2017 claim form or approved electronic format</td>
</tr>
<tr>
<td><strong>Medicaid Managed Care Claims Submitted to TMHP</strong></td>
<td></td>
</tr>
<tr>
<td>Physicians and other nonfacility family planning providers</td>
<td>Family Planning 2017 claim form or approved electronic format</td>
</tr>
<tr>
<td>Hospitals</td>
<td>UB-04 CMS-1450 claim form</td>
</tr>
<tr>
<td><strong>Medicaid Managed Care Claims Submitted to the HMO</strong></td>
<td></td>
</tr>
<tr>
<td>Medicaid managed care organizations, 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.</td>
<td></td>
</tr>
<tr>
<td>Physicians and other nonfacility family planning providers</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Hospitals</td>
<td>UB-04 CMS-1450</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 Section 10 of 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 6.5.4, “CMS-1500 Instruction Table” Claim Filing Instructions” 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.

3.5.1.1 Family Planning and Third Party Resource
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.

3.5.1.2 Claims Filing For Title X-Supported Clinics
The following information applies to claims filing for Title X-supported clinics:

<table>
<thead>
<tr>
<th>Filing Media</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic TexMedConnect Claims</td>
<td>All claims and encounters for clients at Title X clinics must have Title X checked in the Title X Payment Level section under the Patient tab of the electronic claim form. This selection ensures that the required fields on the claim form are completed. Electronic claims filed for services provided to clients eligible for Title V, XIX, or XX must have the Funding Source box to which the claim is billed (Family Planning Program Block) checked on the Patient tab. The level of practitioner, in the General section of the Claim tab of the electronic claim form, must also be selected by a clinic that uses Title X funds. For Title X-only, the Title X box must be checked and the payment level must be selected in the Title X Payment Level block under the Patient tab. Depending on family size and income, the agency designates Title X clients as full pay, partial pay, or no pay for services. The Level of Practitioner in the General section of the Claim tab of the electronic claim form must also be selected.</td>
</tr>
</tbody>
</table>
### 3.5.2 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 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.

### 3.5.3 National Drug Code (NDC)


### 4. WOMEN’S HEALTH PROGRAM (TITLE XIX FAMILY PLANNING)

#### 4.1 Women’s Health Program (WHP) Provider Enrollment

Providers who deliver family planning services, have completed the Medicaid-enrollment process through TMHP, and do not perform elective abortions are eligible to participate. The following provider types may bill family planning services under the WHP:

- Physician
- Physician assistant (PA)
- Advanced nurse practitioner (NP)
- Clinical nurse specialist (CNS)
- Certified nurse midwife (CNM)
- Federally qualified health center (FQHC)
• Family planning agency
• Freestanding and hospital-based ambulatory surgical centers (for tubal ligations)
• Laboratory
• Rural health clinic (RHC)

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

Subsection 3.1, “Title XIX Provider Enrollment” in this handbook.

### 4.2 WHP Overview

WHP was authorized by the 79th Texas Legislature in 2005 and implemented by HHSC in January 2007. The Centers for Medicare & Medicaid Services (CMS) granted HHSC a demonstration waiver to operate WHP from January 1, 2007, through December 31, 2011. The goal of the program is to expand access to family planning services to reduce unintended pregnancies in the eligible population. WHP participants receive a limited, family planning benefit that supports the goal of the program. WHP participants do not have access to full Texas Medicaid coverage. Not all Texas Medicaid family planning benefits are payable under WHP.

**Refer to:** Section 3.2, “Family Planning Overview,” in this handbook for an overview of family planning funding sources.

#### 4.2.1 Guidelines for WHP Family Planning Providers

WHP provides an annual family planning exam, family planning services, and contraception for women who meet the following qualifications:

- Be 18 through 44 years of age
- Be United States citizens and eligible immigrants
- Be residents of Texas
- Do not currently receive full Medicaid benefits including Medicaid for pregnant women, Children’s Health Insurance Program (CHIP), or Medicare Part A or B.
- Do 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
- Have a household income at or below 185 percent of the federal poverty level
- Are not pregnant
• Are 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 a RN, PA, NP, or CNS. WHP participants may receive services from any provider that participates in the WHP.

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 Food and Drug Administration (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 funded by Title XIX.

4.2.2 Referrals

Per federal government requirements, if a WHP provider identifies a health problem such as diabetes or high blood pressure, the provider must refer the WHP patient to another doctor or clinic that can treat her. As mandated by Section 32.0248, Human Resources Code, WHP does not reimburse for office visits where WHP 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.

4.2.2.1 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.

4.2.2.2 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/.

4.2.3 Abortions

Elective and non-elective abortions are not reimbursable services under the WHP.

In addition, Section 32.0248, Human Resources Code, prohibits payment of WHP funds to a provider that performs elective abortions. A provider that performs elective abortions (through either surgical or medical methods) for any patient is ineligible to serve WHP clients and cannot be reimbursed for those services. This prohibition has been in effect since September 1, 2005. This prohibition only applies to providers delivering services to WHP clients. The prohibition does not impact services delivered to Medicaid clients not enrolled in the WHP.

“Elective abortion” means the use of any means to terminate the pregnancy of a female whom the attending physician knows to be pregnant with the intention that the termination of the pregnancy by those means is reasonably likely to cause the death of the fetus, except that the term does not include an abortion: (1) to terminate a pregnancy that resulted from an act of rape or incest; or (2) in the case where
a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endan-
gering physical condition caused by or arising from the pregnancy itself, that would, as certified by a
physician, place a woman in danger of death unless an abortion is performed.

4.3 Services/Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through WHP. WHP benefits are
limited Title XIX benefits 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)

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

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2501 V2502 V2504 V2509 V251 V252 V2540 V2541 V2542 V2543</td>
</tr>
<tr>
<td>V2549 V255 V258 V259 V2651</td>
</tr>
</tbody>
</table>

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

4.3.1 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 WHP 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>
</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>
</table>
| New patient: Most appropriate E/M procedure code (99201-99205) with modifier FP and a
  WHP diagnosis code | 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 |

* The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.
Refer to: Section 4.3, “Services/Benefits, Limitations, and Prior Authorization” in this handbook for the list of WHP diagnosis codes.

### 4.3.1 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 tables in Section 4.3.1.

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 3 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 3 years.

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

### 4.3.2 Other Family Planning Office or Outpatient Visits

WHP 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.

WHP 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 only of pregnancy testing, sexually transmitted infection testing, or a repeat Pap test after an abnormal result. If a provider identifies a health problem such as diabetes, high blood pressure, a pap test abnormality, or a sexually transmitted infection, the provider is required to refer the WHP client to another physician or clinic that can treat them.

Referrals of medical problems for WHP clients are limited only to health practitioners who do not perform or promote elective abortions, nor contract or affiliate with entities that perform or promote elective abortions.

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

Refer to: Subsection 1.4.9.1, “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 WHP family planning diagnosis code:

<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 (99201-99205) with a WHP 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 (99211-99215) with a WHP 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:** Section 4.3, “Services/Benefits, Limitations, and Prior Authorization” in this handbook for the list of WHP diagnosis codes.

Family planning services provided during a WHP 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/counseling or referral, if indicated
- Scheduling of office or clinic visit, if indicated

**4.3.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits**

FQHCs may be reimbursed for 3 family planning encounters per client per year regardless of the reason for the encounter. The 3 encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7300 or J7302.

A WHP 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 3, “Federally Qualified Health Center,” in the *Outpatient Services Handbook, (Vol. 2, Provider Handbooks)* for more information about FQHC services.

**4.3.3 Laboratory Procedures**

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 WHP diagnosis so the laboratory may bill Texas Medicaid for its family planning lab services. The WHP diagnosis code must be included so that the reference laboratory knows to bill the service as a family planning services.
Refer to: Section 4.3, “Services/Benefits, Limitations, and Prior Authorization,” in this handbook for the list of WHP diagnosis codes.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks).

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061</td>
</tr>
<tr>
<td>84702</td>
</tr>
<tr>
<td>86689</td>
</tr>
<tr>
<td>87086</td>
</tr>
<tr>
<td>87490</td>
</tr>
<tr>
<td>87850</td>
</tr>
</tbody>
</table>

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

Procedure code 87797 will be denied if submitted for the same date of service as procedure code 87800. 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 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.

4.3.4 Radiology

Procedure codes 74000, 74010, and 76830 may be reimbursed for radiology services.

4.3.5 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>57170</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.

Procedure codes 58300 and 58301 will not be considered for reimbursement if they are submitted with the same date of service as an office visit.

The following services are benefits of WHP with the diagnosis codes indicated:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11976</td>
</tr>
<tr>
<td>11977</td>
</tr>
</tbody>
</table>
4.3.6 Drugs and Supplies

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4267</td>
</tr>
<tr>
<td>A4268</td>
</tr>
<tr>
<td>A4269</td>
</tr>
<tr>
<td>J1055</td>
</tr>
<tr>
<td>J7303* with modifier U1</td>
</tr>
<tr>
<td>J7304* with modifier U1</td>
</tr>
</tbody>
</table>

* Modifier U1 must be used to indicate that the client received supplies in the provider's office and not by prescription through the Medicaid Vendor Drug Program.

4.3.6.1 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.

4.3.7 Instruction in Natural Family Planning Methods

Procedure code H1010 is a benefit of the WHP and is limited to one service per day when billed by any provider.

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.

4.3.8 Sterilization and Sterilization-Related Procedures

Sterilization services may be reimbursed separately to family planning agencies or physicians. FQHCs will receive an encounter rate for sterilization services when an encounter code is billed.

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.

4.3.8.1 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-6, “Sterilization Consent Form (English),” Section 9 of this handbook.

Form GN-7, “Sterilization Consent Form (Spanish),” Section 9 of this handbook.

Form GN-5, “Sterilization Consent Form Instructions (2 pages),” Section 9 of this handbook.
4.3.8.2 Tubal Ligation
Procedure code 58600, 58611, 58615, 58670, or 58671 may be reimbursed for tubal ligations.

4.3.8.3 Anesthesia for Sterilization
Procedure code 00851 must be used when reporting anesthesia services for a sterilization procedure.

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

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

4.3.8.5 Hysteroscopic Sterilization
Providers must use 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.

A hysterosalpingogram is recommended 3 months after a hysteroscopic sterilization procedure to ensure tubal occlusion. Procedure code 74740 is considered for reimbursement in this circumstance when billed with diagnosis code V252.

4.3.9 Eligibility Verification
The WHP Medicaid Identification card (Form H3087) visibly indicates the program in the black box in the upper right area of the card. The card also contains a notice to providers that WHP-covered services are limited to an annual visit and exam and contraception, except emergency contraception.

Client eligibility may 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).

WHP clients will have the following identifiers on the feedback received from the stated source:

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

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

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

4.5.1 Claims Information
Providers must use the appropriate claim form to submit WHP claims to TMHP.

Refer to: Section 3.5, “Claims Filing and Reimbursement,” in this handbook for more information about filing family planning claims.

4.5.1.1 WHP and Third-Party Resource
Federal and state regulations mandate that family planning client information be kept confidential.

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

4.5.2 Reimbursement
Services provided under WHP are reimbursed according to Medicaid rules at standard Medicaid rates.

4.5.3 National Drug Code (NDC)

5. TITLES V, X, AND XX FAMILY PLANNING SERVICES

5.1 Provider Enrollment for Titles V, X, and XX Contractors
Agencies that submit claims or encounters 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.

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

Subsection 3.1, “Title XIX Provider Enrollment” in this handbook.

5.2 Family Planning Providers
TMHP processes family planning claims and encounters for four different funding sources administered through DSHS and HHSC. These funding sources include Titles V, X, XIX, and XX.

Refer to: Section 3.2, “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.
5.3 Services/Benefits, Limitations and Prior Authorization

This section contains information about family planning services funded through Titles V, X, and XX funding sources 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)

For Title V, X, or XX claims, 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 V2502 V2504 V2509 V251 V252 V2540 V2541 V2542 V2543</td>
</tr>
<tr>
<td>V2549 V255 V2562 V258 V259 V2651</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 should be based on the type of family planning service performed.

5.3.1 Titles V and XX 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.

Titles V and XX family 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:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>$22.64</td>
<td>$22.64</td>
</tr>
<tr>
<td>99202</td>
<td>$35.73</td>
<td>$35.73</td>
</tr>
<tr>
<td>99203</td>
<td>$48.28</td>
<td>$48.28</td>
</tr>
<tr>
<td>99204</td>
<td>$70.64</td>
<td>$70.64</td>
</tr>
<tr>
<td>99205</td>
<td>$87.83</td>
<td>$87.83</td>
</tr>
<tr>
<td>99211</td>
<td>$11.73</td>
<td>$11.73</td>
</tr>
<tr>
<td>99212</td>
<td>$19.64</td>
<td>$19.64</td>
</tr>
<tr>
<td>99213</td>
<td>$29.52</td>
<td>$29.52</td>
</tr>
<tr>
<td>99214</td>
<td>$41.46</td>
<td>$41.46</td>
</tr>
<tr>
<td>99215</td>
<td>$63.84</td>
<td>$63.84</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: Procedure codes 99201-99205 with modifier FP</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: Procedure codes 99211-99215 with modifier FP</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 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 for Titles V and XX clients.

Refer to: Section 5.3, “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. Providers may appeal denied claims using modifier 25 if the reason for the additional visit was for a separate, distinct service from the family planning visit. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client’s medical record and made available to Texas Medicaid upon request.

5.3.1.1 FQHC Reimbursement for Titles V and XX 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 Section 5.3.1 with 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 3 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 3 years.

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

5.3.2 Title V and XX Family Planning Office or Outpatient Visits

Other family planning E/M visits are allowed for routine contraceptive surveillance, family planning counseling/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/counseling or referral, if indicated
- Scheduling of office or clinic visit, if indicated
For general family planning visits, Titles V and XX family providers must bill one of the following, most appropriate evaluation and management (E/M) procedure code:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>$22.64</td>
<td>$22.64</td>
</tr>
<tr>
<td>99202</td>
<td>$35.73</td>
<td>$35.73</td>
</tr>
<tr>
<td>99203</td>
<td>$48.28</td>
<td>$48.28</td>
</tr>
<tr>
<td>99204</td>
<td>$70.64</td>
<td>$70.64</td>
</tr>
<tr>
<td>99205</td>
<td>$87.83</td>
<td>$87.83</td>
</tr>
<tr>
<td>99211</td>
<td>$11.73</td>
<td>$11.73</td>
</tr>
<tr>
<td>99212</td>
<td>$19.64</td>
<td>$19.64</td>
</tr>
<tr>
<td>99213</td>
<td>$29.52</td>
<td>$29.52</td>
</tr>
<tr>
<td>99214</td>
<td>$41.46</td>
<td>$41.46</td>
</tr>
<tr>
<td>99215</td>
<td>$63.84</td>
<td>$63.84</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: Procedure codes 99201-99205</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: Procedure codes 99211-99215</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 for Titles V and XX clients.

Refer to: Section 5.3, “Services/Benefits, Limitations and Prior Authorization,” in this handbook for the list of family planning diagnosis codes.

5.3.2.1 FQHC Reimbursement for Title V and XX 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 Section 4.5.3.

FQHCs may be reimbursed for 3 family planning encounters per client per year regardless of the reason for the encounter. The 3 encounters may include any combination of general family planning encounters, an annual family planning examination, or procedure code J7300 or J7302.

The new patient procedure codes will be limited to one new patient E/M procedure code 3 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 3 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. Providers may appeal denied claims using modifier 25 if the reason for the additional visit was for a separate, distinct service from the
family planning visit. Documentation that supports the provision of a significant, separately-identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Refer to: Section 3, “Federally Qualified Health Center” in the Outpatient Services Handbook, (Vol. 2, Provider Handbooks) for more information about FQHC services.

5.3.3 Laboratory Procedures

5.3.3.1 Title V Only

Laboratory tests for Title V clients may be sent to the DSHS laboratory 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.

5.3.3.2 Titles V and XX

The following procedure codes may be reimbursed for Titles V and XX family planning laboratory services:

<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>$18.51</td>
</tr>
<tr>
<td>81000</td>
<td>$0*</td>
<td>$4.40</td>
</tr>
<tr>
<td>81001</td>
<td>$4.40</td>
<td>$4.40</td>
</tr>
<tr>
<td>81002</td>
<td>$3.54</td>
<td>$3.54</td>
</tr>
<tr>
<td>81003</td>
<td>$3.15</td>
<td>$3.15</td>
</tr>
<tr>
<td>81015</td>
<td>$4.20</td>
<td>$4.20</td>
</tr>
<tr>
<td>81025</td>
<td>$8.74</td>
<td>$8.74</td>
</tr>
<tr>
<td>82947</td>
<td>$0*</td>
<td>$5.42</td>
</tr>
<tr>
<td>82948</td>
<td>$4.44</td>
<td>$4.44</td>
</tr>
<tr>
<td>84443</td>
<td>$0*</td>
<td>$23.55</td>
</tr>
<tr>
<td>84702</td>
<td>$0*</td>
<td>$12.24</td>
</tr>
<tr>
<td>84703</td>
<td>$0*</td>
<td>$10.53</td>
</tr>
<tr>
<td>85013</td>
<td>$3.27</td>
<td>$3.27</td>
</tr>
<tr>
<td>85014</td>
<td>$0*</td>
<td>$3.32</td>
</tr>
<tr>
<td>85018</td>
<td>$3.27</td>
<td>$3.27</td>
</tr>
<tr>
<td>85025</td>
<td>$10.74</td>
<td>$10.74</td>
</tr>
<tr>
<td>85027</td>
<td>$0*</td>
<td>$9.07</td>
</tr>
<tr>
<td>86580</td>
<td>$7.36</td>
<td>$7.36</td>
</tr>
<tr>
<td>86592</td>
<td>$0*</td>
<td>$5.90</td>
</tr>
<tr>
<td>86689</td>
<td>$0*</td>
<td>$26.75</td>
</tr>
<tr>
<td>86695</td>
<td>$18.48</td>
<td>$18.48</td>
</tr>
<tr>
<td>86696</td>
<td>$27.13</td>
<td>$27.13</td>
</tr>
</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.
### Procedure Code | Title V Fee | Title XX Fee
--- | --- | ---
86701 | $0* | $12.28
86703 | $19.22 | $19.22
86762 | $0* | $19.89
86803 | $0* | $20.01
86900 | $0* | $4.18
86901 | $0* | $4.18
87070 | $11.90 | $11.90
87076 | 11.16 | 11.16
87077 | 11.16 | 11.16
87086 | $0* | $11.32
87088 | $0* | $11.35
87102 | $0* | $11.77
87110 | $27.46 | $27.46
87205 | $5.90 | $5.90
87210 | $5.98 | $5.98
87220 | $5.98 | $5.98
87252 | $0* | $36.54
87340 | $0* | $14.48
87480 | $28.10 | $28.10
87490 | $0* | $27.71
87491 | $0* | $49.20
87510 | $28.10 | $28.10
87590 | $0* | $27.71
87591 | $0* | $25.00
87621 | $0* | $49.20
87660 | $28.10 | $28.10
87800 | $56.22 | $56.22
87810 | $16.82 | $16.82
87850 | $16.82 | $16.82
88142 | $0* | $25.00
88150 | $0* | $14.60
88164 | $0* | $14.80
88175 | $0* | $37.13
99000 | $3.73 | $3.73
Q0111 | $5.98 | $5.98

* 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.

Appropriate documentation must be maintained in the client’s record.
Refer to: Section 4.3.3, “Laboratory Procedures”, in this handbook for more information about family planning laboratory services requirements.

Subsection 2.1.1, “Clinical Laboratory Improvement Amendments (CLIA)” in Radiology, Laboratory and Physiological Lab Services Handbook (Vol. 2, Provider Handbooks).

5.3.4 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>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>74000</td>
<td>$22.91</td>
<td>$22.91</td>
</tr>
<tr>
<td>74010</td>
<td>$27.00</td>
<td>$27.00</td>
</tr>
<tr>
<td>76830</td>
<td>$74.74</td>
<td>$74.74</td>
</tr>
<tr>
<td>76856</td>
<td>$74.74</td>
<td>$74.74</td>
</tr>
<tr>
<td>76857</td>
<td>$46.64</td>
<td>$46.64</td>
</tr>
<tr>
<td>76880</td>
<td>$67.10</td>
<td>$67.10</td>
</tr>
</tbody>
</table>

5.3.5 Contraceptive Devices and Related Procedures

5.3.5.1 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>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4261 (cervical cap)</td>
<td>$24.22</td>
<td>$24.22</td>
</tr>
<tr>
<td>A4266 (diaphragm)</td>
<td>$10.01</td>
<td>$10.01</td>
</tr>
<tr>
<td>57170</td>
<td>$38.00</td>
<td>$38.00</td>
</tr>
</tbody>
</table>

5.3.5.2 IUD
Procedure codes J7300, J7302, 58300, and 58301 may be reimbursed as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7300</td>
<td>$403.75</td>
<td>$403.75</td>
</tr>
<tr>
<td>J7302</td>
<td>$478.08</td>
<td>$478.08</td>
</tr>
<tr>
<td>58300</td>
<td>$74.74</td>
<td>$74.74</td>
</tr>
<tr>
<td>58301</td>
<td>$69.55</td>
<td>$69.55</td>
</tr>
</tbody>
</table>

5.3.5.2.1 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.

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). The following reimbursement may apply:
- Procedure code 58120 (dilation and curettage) may be reimbursed at full allowance.
• Procedure code 58300 (IUD insertion) may be reimbursed at half the allowed amount.
• Procedure code J7300 or J7302 (IUD device) 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.

5.3.5.2.2 Removal of the IUD
Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity. Procedure code 58301 will not be reimbursed when submitted with the same date of service as an office visit.

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.

5.3.5.3 Contraceptive Capsules
Procedure codes J7307, 11975, 11976, and 11977 may be reimbursed as follows:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7307</td>
<td>$585.11</td>
<td>$585.11</td>
</tr>
<tr>
<td>11975</td>
<td>$152.25</td>
<td>$152.25</td>
</tr>
<tr>
<td>11976</td>
<td>$152.25</td>
<td>$152.25</td>
</tr>
<tr>
<td>11977</td>
<td>$304.50</td>
<td>$304.50</td>
</tr>
</tbody>
</table>

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307 and procedure code 11975 (insertion) or 11977 (removal with reinsertion).

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).

5.3.5.4 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.

Procedure code J1056 may be reimbursed for medroxyprogesterone acetate/estradiol cypionate when 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>V2502</td>
</tr>
<tr>
<td>V2509</td>
</tr>
<tr>
<td>V615</td>
</tr>
</tbody>
</table>
5.3.6 Title V and XX Drugs and Supplies

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

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4267</td>
<td>$0.22</td>
<td>$0.22</td>
</tr>
<tr>
<td>A4268</td>
<td>$2.00</td>
<td>$2.00</td>
</tr>
<tr>
<td>A4269</td>
<td>$4.00</td>
<td>$4.00</td>
</tr>
<tr>
<td>A9150</td>
<td>$14.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>J1055</td>
<td>$53.48</td>
<td>$53.48</td>
</tr>
<tr>
<td>J3490</td>
<td>$5.90</td>
<td>$5.90</td>
</tr>
<tr>
<td>J7303</td>
<td>$40.65</td>
<td>$40.65</td>
</tr>
<tr>
<td>J7304</td>
<td>$15.36</td>
<td>$15.36</td>
</tr>
<tr>
<td>S4993</td>
<td>$20.88</td>
<td>$20.88</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 A9150 may be reimbursed when a nonprescription medication to treat a monilia infection is provided to the client.

5.3.6.1 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.

Title V, X, and XX clients may have their prescriptions filled at the clinic pharmacy.

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.

*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.


5.3.7 Family Planning Education

The following medical counseling and education procedure code may be reimbursed as indicated:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1010</td>
<td>$7.61</td>
<td>$7.61</td>
</tr>
</tbody>
</table>
5.3.7.1 **Medical Nutrition Therapy**

For clients requiring intensive nutritional guidance, medical nutrition therapy can be provided as an allowable and billable service using procedure code 97802. Medical nutrition 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.

The reimbursement rate for procedure code 97802 for Titles V and XX is $17.18.

5.3.7.2 **Title V and XX Instruction in Natural Family Planning Methods**

Procedure code H1010 is a benefit of Title V and XX and is intended to instruct a couple or an individual in methods of natural family planning and is limited to twice a year.

5.3.8 **Sterilization and Sterilization-Related Procedures**

5.3.8.1 **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-6, “Sterilization Consent Form (English)” Section 9 of this handbook.

Form GN-7, “Sterilization Consent Form (Spanish)” Section 9 of this handbook.

Form GN-5, “Sterilization Consent Form Instructions (2 pages)” Section 9 of this handbook.

5.3.8.2 **Title V and XX 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.

5.3.8.3 **Titles V, X, and XX Tubal Ligation**

Procedure code 58600 may be reimbursed for any sterilization procedure performed on a female client by a family planning agency using Title V, X, or XX. The following 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):

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>58600</td>
<td>$1,800.00</td>
<td>$1,800.00</td>
</tr>
</tbody>
</table>

5.3.8.4 **Vasectomy**

Procedure code 55250 may be reimbursed for any sterilization procedure performed on a male by a family planning agency using Title V, X, XIX, or XX. The following 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.):

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Title V Fee</th>
<th>Title XX Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>55250</td>
<td>$253.75</td>
<td>$253.75</td>
</tr>
</tbody>
</table>

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.
5.3.8.5 **Anesthesia for Sterilization**

Procedure codes 00840, 00851, and 00940 may be reimbursed for anesthesia for sterilization services when billed with the regular anesthesia modifier. Procedure codes 00840 and 00940 must also be billed with a family planning diagnosis code.

Refer to: Subsection 6.2.7.2, “Anesthesia” in Section 6, “Claims Filing” (Vol. 1, General Information) for more information about anesthesia modifiers.

5.3.9 **Prior Authorization**

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

5.4 **Documentation Requirements**

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

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

5.5 **Claims Filing and Reimbursement**

5.5.1 **Claims Information**

Providers must use the appropriate claim form to submit Titles V and XX claims to TMHP.

Refer to: Section 3.5, “Claims Filing and Reimbursement” in this handbook for more information about filing family planning claims.

5.5.1.1 **Filing Deadlines**

The following table summarizes the filing deadlines for Titles V, X, and XX claims:

<table>
<thead>
<tr>
<th>Title</th>
<th>Deadline</th>
<th>Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>V, X, XX</td>
<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>
</tbody>
</table>

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

Note: As stated in the DSHS Policy and Procedure Manual for Title V, Title X, and Title XX Family Planning Services, all claims and appeals must be submitted and processed within 60 days after the end of the contract period.

5.5.1.2 **Third-Party Resource**

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.

5.5.1.3 **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. This data is 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 infor-
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 who receive services in a Title X clinic are considered Title X-only clients if their services are not billed to another funding source. 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, and so on) 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 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 submittal process outlined by the DSHS Claims Processing Unit.

5.5.2 Reimbursement
Reimbursement for family planning procedures is available on the DSHS web site at www.dhs.state.tx.us/famplan/contractor/default.shtm#code.

5.5.2.1 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.

5.5.3 National Drug Code (NDC)

6. MATERNITY SERVICE CLINICS

6.1 Provider Enrollment
To enroll in Texas Medicaid, maternity service clinics (MSCs) must submit a complete application and meet the following requirements:

- Be a facility that is not an administrative, organizational, or financial part of a hospital
- Be organized and operated to provide maternity clinic services to outpatients
- Comply with all applicable federal, state, and local laws and regulations
- Employ or have a contractual agreement or formal arrangement with a licensed physician (doctor of medicine [MD] or doctor of osteopathy [DO]) who assumes professional responsibility for the services provided to the clinic’s patients
- Adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of Health, unless otherwise specified by the department or its designee
• Ensure that services provided to each patient are commensurate with the patient’s risk assessment and documented in the patient’s medical record.

The supervising physician’s license information must be provided. Providers cannot be enrolled in Texas Medicaid if their licenses are due to expire within 30 days.

Medicare certification is not a prerequisite for MSC enrollment.

6.1.1 Physician Responsibility

To meet the requirement to assume professional responsibility for the services provided to the clinic’s clients, the supervising physician must do the following:

• See the client at least once
• Prescribe the type of care to be provided or approve the client’s plan of care
• Periodically review the need for continued care (if the services are not limited by the prescription)

The physician must base the plan of care on a risk assessment completed by the physician or by licensed, professional clinic staff. The assessment must be based on findings obtained through a health history, laboratory or screening services, and a physical examination.

6.1.2 Case Management Services to High-Risk Individuals

An MSC that wants to bill and receive reimbursement for case management services to high-risk individuals including infants, pregnant adolescents, and women must meet the eligibility criteria for case management services. To be considered for reimbursement for case management for these clients, the MSC must enroll as a group in Case Management for Children and Pregnant Women (CPW), and each eligible case manager must enroll as a performing provider.


6.2 Services, Benefits, Limitations, and Prior Authorization

Services billed by an MSC are those provided by a physician or by licensed, professional clinic staff and be determined to be reasonable and medically necessary for the care of a pregnant adolescent or woman during the prenatal period and subsequent 60-day postpartum period. MSC benefits do not include deliveries.

MSCs are limited to 20 outpatient antepartum care visits and two postpartum care visits per pregnancy. Normal pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. If more than 20 visits are medically necessary, the provider can appeal with documentation supporting pregnancy complications. The high-risk client’s medical record documentation should reflect the need for increased visits and is subject to retrospective review.

Procedure codes in the following table are for antepartum and postpartum care visits:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>59430</th>
<th>99201-TH</th>
<th>99202-TH</th>
<th>99203-TH</th>
<th>99204-TH</th>
<th>99205-TH</th>
<th>99211-TH</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212-TH</td>
<td>99213-TH</td>
<td>99214-TH</td>
<td>99215-TH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Procedure code 59430 is not submitted with modifier TH
Note: The antepartum visits must be billed with modifier TH
Providers should bill the most appropriate new or established antepartum visit code or postpartum visit code. New patient codes may be used when the client has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years (36 months).

An MSC may be reimbursed for antepartum and postpartum care visits only. Hemoglobin, hematocrit and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied. MSCs that are enrolled in CPW case management as a group may be reimbursed for these services under the group provider identifier assigned to their facility.

Medical services must be furnished on an outpatient basis by the physician or by licensed, professional clinic staff under the direction of the physician and must be within the staff’s scope of practice or licensure as defined by state law. Although the physician does not necessarily have to be present at the clinic when services are provided, the physician must assume professional responsibility for the medical services provided at the clinic and ensure through approval of the plan of care (POC) that the services are medically appropriate. The physician must spend as much time in the clinic as is necessary to ensure that clients are receiving medical services in a safe and efficient manner in accordance with accepted standards of medical practice.

MSCs must follow the procedures outlined throughout this manual. All service, frequency, and documentation requirements are applicable.

Providers submitting charges for high-risk antepartum care must document the high-risk diagnosis on the claim form and document the condition in the client’s medical record.

### 6.2.1 Initial Antepartum Care Visit Components

The following initial antepartum care visit components should be completed as early as possible in the client’s pregnancy.

#### 6.2.1.1 History

History includes obstetric and gynecological, present pregnancy, medical/surgical, substance use, environmental, nutritional, psychosocial (including violence), and family support system.

#### 6.2.1.2 Physical Examination

Physical examination includes height, weight, blood pressure; head, neck, lymph, breasts, heart, lungs, back, abdomen, pelvis, rectum, extremities, and skin; and uterine size, fetal heart rate, and location.

#### 6.2.1.3 Laboratory Tests

The initial hematocrit or hemoglobin and each subsequent hematocrit or hemoglobin is included in the visit fee and is not separately reimbursable to MSCs.

The laboratory services listed may not be billed using the MSC provider identifier. These services may be ordered by MSC personnel and provided by a reference laboratory.

MSCs referring laboratory work are required to supply the reference laboratory with the client’s Medicaid number, as well as the MSC provider identifier for laboratory work including, but not limited to, the following:

- Hemoglobin, hematocrit, or CBC
- Urinalysis
- Blood type and Rh
- Antibody screen
- Rubella antibody titer
• Serology for syphilis
• Hepatitis B surface antigen
• Cervical cytology
• Other laboratory tests

The following tests may be performed at the initial antepartum care, as indicated:
• Pregnancy test
• Gonorrhea test
• Urine culture
• Sickle cell test
• Tuberculosis (TB) test
• HIV antibody screen
• Chlamydia test

Multiple marker screens for neural tube defects must be offered if the client initiates care between 16 and 20 weeks.

6.2.1.4 Assessment
Assessment includes pregnancy, general health, medical, and psychosocial.

6.2.1.5 Plan
Plan includes pregnancy, preventive health, medical, and referral as indicated.

6.2.1.6 Education and Counseling
Education and counseling includes pregnancy, delivery, nutrition, breast-feeding, family planning, and preventive health. The education and counseling should also include the need for a medical home and information about THSteps medical and dental checkups for the child.

The complete physical examination may be completed at the second visit if the MSC’s routine involves a two-stage initial evaluation.

6.2.2 Subsequent Antepartum Care Visits
The following is a recommended guide for the frequency of subsequent antepartum visits for a regular pregnancy:
• One visit every four weeks for the first 28 weeks of pregnancy.
• One visit every two to three weeks from 28 to 36 weeks of pregnancy.
• One visit per week from 36 weeks to delivery.

More frequent visits may be medically necessary. Physicians, CNMs, and MSCs are limited to 20 antepartum care visits per pregnancy and 2 postpartum care visits per pregnancy after discharge from the hospital, without documentation of a complication of pregnancy.

Each subsequent visit must include the following:
• Interim History
• Problems
• Maternal status
• Fetal status
6.2.2.1 Physical Examination

- Weight, blood pressure
- Fundal height, fetal position and size, and fetal heart rate
- Extremities

6.2.2.2 Laboratory Tests

- Urinalysis for protein and glucose every visit
  
  Note: Note: The urinalysis for protein and glucose, hemoglobin, and hematocrit is included in the visit fee and is not separately reimbursable to MSCs.

- Hematocrit or hemoglobin repeated once a trimester and at 32 to 36 weeks of pregnancy
- Multiple marker screen for fetal abnormalities offered at 16 to 20 weeks of pregnancy
- Repeated antibody screen for Rh negative women at 28 weeks (followed by Rho immune globulin administration if indicated)
- Gestational diabetes screen at 24 to 28 weeks of pregnancy, one hour post 50 gram glucose load

Other laboratory tests as indicated by the medical condition of the client

6.2.3 Postpartum Care Visit

Postpartum care provided by MSCs must be billed using procedure code 59430. A maximum of two postpartum visits are allowed within the 60 day postpartum period. However, it is preferable for the MSC to enroll as a family planning agency and bill the postpartum visits as family planning services.

6.2.4 Prior Authorization

Prior authorization is not needed for services rendered in maternity service clinics.

6.3 Documentation Requirements

Each client must have a complete and accepted standard medical record with documentation for the initial visit with procedures, as well as each subsequent visit with procedures. Such records must be made available when requested by HHSC or TMHP for utilization and quality assurance reviews as required by federal regulations. The documentation record or a true copy or narrative abstract must be sent to the hospital of delivery by the client’s 35th week of pregnancy. The record must be made available to the client if the client transfers care to another institution. Records completed by licensed professional clinic staff under the direction of a physician must be signed by the supervising physician.

6.4 Claims Filing and Reimbursement

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

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

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

Subsection 6.5, “CMS-1500 Claim Filing Instructions” in Section 6, “Claims Filing” (Vol. 1, General Information). Blocks that are not referenced are not required for processing by TMHP and may be left blank.
MSCs are reimbursed in accordance with 1 TAC §355.8201. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

7. GYNECOLOGICAL HEALTH SERVICES

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
- Diagnostic hysteroscopy
- Abortion (Criteria described in later section)
- Examination under anesthesia
- Hysterectomy
- Surgery for masculinized female
- Pap smear (cytopathology studies)

Refer to: Section 3, “Medicaid Title XIX family planning services” in this handbook for information about contraception, sterilizations, and family planning annual examinations.

7.1 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.

Procedure code 87797 is denied if it is submitted for the same date of service as procedure code 87800. Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797. Claims may be subject to retrospective review if they are submitted with diagnosis codes that do not support medical necessity.

If a positive test result was not treated, documentation must be present indicating why treatment was not rendered.
7.2 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</th>
<th>2180</th>
<th>6210</th>
<th>62130</th>
<th>6215</th>
<th>6262</th>
<th>6264</th>
<th>6266</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6268</td>
<td>6270</td>
<td>6271</td>
<td>6266</td>
<td>6268</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.3 Abortions

According to a revision of the Hyde Amendment, under P.L. 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>
<th>59830</th>
<th>59840</th>
<th>59841</th>
<th>59850</th>
<th>59851</th>
<th>59852</th>
<th>59855</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>59856</td>
<td>59857</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

One of the following statements signed by the physician is mandatory for any abortion performed. Substitute wording will not be accepted. One of these statements must accompany any claim for 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.)
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 and one of the following modifiers as applicable:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1</td>
<td>Endangerment of the mother’s life</td>
</tr>
<tr>
<td>W2</td>
<td>Rape</td>
</tr>
<tr>
<td>W3</td>
<td>Incest</td>
</tr>
</tbody>
</table>

Performing physicians, facilities, anesthesiologists, and CRNAs 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.

7.3.1 Prior Authorization for Abortions
Refer to: Form GN.8, “Abortion Certification-Statements Form” in Section 9, Forms, in this handbook for a sample form.

Important: To bill a Texas Medicaid client for a service that TMHP denies as not medically necessary, the billing provider must ensure that the client or client’s guardian has signed an acknowledgment statement obtained by the physician who has contact with the client.

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

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

7.5 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>Diagnosis</th>
<th>51925</th>
<th>58150</th>
<th>58152</th>
<th>58180</th>
<th>58200</th>
<th>58210</th>
<th>58240</th>
</tr>
</thead>
<tbody>
<tr>
<td>58260</td>
<td>58262</td>
<td>58263</td>
<td>58267</td>
<td>58270</td>
<td>58275</td>
<td>58280</td>
<td></td>
</tr>
<tr>
<td>58285</td>
<td>58290</td>
<td>58291</td>
<td>58292</td>
<td>58293</td>
<td>58294</td>
<td>58541*</td>
<td></td>
</tr>
<tr>
<td>58542*</td>
<td>58543*</td>
<td>58544*</td>
<td>58548*</td>
<td>58550*</td>
<td>58552*</td>
<td>58553*</td>
<td></td>
</tr>
<tr>
<td>58554*</td>
<td>58570</td>
<td>58571</td>
<td>58572</td>
<td>58573</td>
<td>59135</td>
<td>59525</td>
<td></td>
</tr>
</tbody>
</table>

* Assistant surgeons may be reimbursed when assisting a surgeon with these procedures

7.5.1 Hysterectomy Acknowledgment Form
Hysterectomy services are considered for reimbursement when 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 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. 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.

The Hysterectomy Acknowledgement Form contains the acknowledgment statement of sterility by patient which informs clients that a hysterectomy will leave them permanently incapable of bearing children. According to federal and state regulations, reimbursement for a hysterectomy is available if the claim is filed with an acknowledgment statement, signed and dated by the client that indicates the client was informed both orally and in writing before the surgery that the hysterectomy would leave her permanently incapable of bearing children.

Each individual provider involved in the hysterectomy procedure is requested to submit a copy of a valid Hysterectomy Acknowledgment Form rather than relying on another provider. The client’s eligibility file is updated upon receipt of the signed Hysterectomy Acknowledgment Form. Subsequent claims for services related to the hysterectomy are referenced to the valid acknowledgment form.

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 must be attached to the claim and signed by the performing provider.

For more information, refer to Title 42 of the Code of Federal Regulations (CFR) 441.255 and 25 TAC Part 1, Chapter 29, Subchapter F, section 25.501.

Refer to: Form GN.9, “Hysterectomy Acknowledgement Form” in Section 9, Forms, 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

7.6 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>88153</td>
</tr>
<tr>
<td>88157</td>
</tr>
</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.

Procedure code 88144 is not a benefit because the procedure it describes has not been FDA-approved.

The Pap smears procedure codes are not reimbursed separately to either the physician or a laboratory when submitted with the same date of service as a THSteps medical checkup visit (procedure code 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, or 99395).

Refer to: Subsection 6.3.2.6.7, “Additional Required Laboratory Tests Related to Medical Checkups for Adolescents” in Children’s Services Handbook (Vol. 2, Provider Handbooks) for more information about THSteps and laboratory procedure benefits.

7.7 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 20 years of age or younger when submitted for reimbursement with diagnosis code 2552, 25950, 25951, 25952, or 7527.

7.8 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including gynecological services.
Gynecological health services are subject to retrospective review and recoupment if documentation does not support the service billed.

7.9 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 certain 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, “Physician Services in Outpatient Hospital Setting” in Section 2, Texas Medicaid Reimbursement (Vol. 1, General Information).

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

7.10 National Drug Code (NDC)

Refer to:
8. CLAIMS RESOURCES

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronym Dictionary</td>
<td>Appendix F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>TMHP Telephone and Address Guide (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Certified Nurse-Midwife (CNM) Claim Form Example</td>
<td>Form MD.13, Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook (Vol. 2, Provider Handbooks)</td>
</tr>
<tr>
<td>CMS-1500 Claim Filing Instructions</td>
<td>Subsection 6.5 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Family Planning 2017 Claim Form</td>
<td>Subsection 6.8 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Family Planning 2017 Claim Form Instructions</td>
<td>Subsection 6.8.1 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Maternity Service Clinic Claim Form Example</td>
<td>Form GN-7, Section 10 of this handbook</td>
</tr>
<tr>
<td>State and Federal Offices Communication Guide</td>
<td>Appendix A (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>Subsection 6.2 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>Section 3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Blank Claim Form</td>
<td>Subsection 6.6.3 (Vol. 1, General Information)</td>
</tr>
<tr>
<td>UB-04 CMS-1450 Claim Filing Instructions</td>
<td>Subsection 6.6 (Vol. 1, General Information)</td>
</tr>
</tbody>
</table>

9. CONTACT TMHP

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

10. FORMS
GN.1  Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen, Instructions

Note: Form G-1C, Maternal Serum Prenatal Triple Screen, is provided for the provider’s convenience. Previously it was part of the G-1B form. It is not a THSteps form.

G-1C Maternal Serum Prenatal Triple Screen Specimen Submission Form’s Instructions

For information on Triple Screens, call: 1-800-687-4363 or 1-888-963-7111 x7138 or Fax: (512) 458-7139.

For mailing and specimen packaging information, visit DSHS Laboratory Services Section’s web page at http://www.dshs.state.tx.us/lab.

The specimen submission form must accompany each specimen.

The patient’s name listed on the specimen must match the patient’s name listed on the form.

If the Date of Collection field is not completed, the specimen will be rejected.

Section 1. SUBMITTER INFORMATION

All submitter information is required.

Submitter/TPI number, Submitter name and Address: The submitter number is a unique number that is issued by the Department of State Health Services (DSHS) Laboratory Services Section assigns to each of our submitters. For Texas Health Steps (THSteps) specimens, use the pre-assigned Texas Provider Identifier (TPI) number. To obtain a TPI number and THSteps enrollment, contact Texas Medicaid and Healthcare Partnership (TMHP) at 1-800-925-9126.

To request a DSHS Laboratory Services Section submittor number, a master form, or to change submitter information, please call (888) 963-7111 x7578 or (512) 458-7578, or fax (512) 458-7533.

NPI Number: Beginning May 23, 2007, all health care providers must use the National Provider Identifier (NPI) number and the TPI number or other submitter number will no longer be used. The NPI number is the new national standard identifier for health care providers adopted by the Centers for Medicare & Medicaid Services (CMS) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To obtain an NPI number, contact the National Plan and Provider Enumeration System (NPPES) toll free at (800) 465-3203 or via their web site at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Indicate the submitter’s name, address, city, state, and zip code. Please print clearly, use a pre-printed label, or use a photocopy of a master form provided by the Laboratory Services Section.

Contact Information: Indicate the telephone number and name of the person to contact at the submitting facility in case the laboratory needs additional information about the specimen. The fax number should indicate the number of the fax machine where the report should be sent.

Clinic Code: Please provide, if applicable. This is a code that the submitter furnishes to help them identify which satellite office submits a specimen and to help the submitter identify where the lab report belongs, if the submitter has a primary mailing address with satellite offices.

Section 2. PATIENT INFORMATION

Complete all patient information including last name, first name, middle initial, address, city, state, zip code, telephone number, country of origin, race/ethnicity, date of birth, age, sex, social security number (SSN), pregnant, medical record number, ICD diagnosis code, and previous DSHS lab specimen number.

NOTE: The patient’s name listed on the specimen must match the patient’s name listed on the form.

Information that is required to bill Medicare, Medicaid, or private insurance has been marked with double asterisks (**). You may use a pre-printed patient label.

ICD Diagnosis Code: Indicate the diagnosis code that would help in processing, identifying, and billing of this specimen.

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

In order to interpret this test, all patient information in this section of this form must be provided. Without the date of collection, accurate gestational age, maternal weight, maternal date of birth, maternal race, and information about maternal diabetic status, a complete assessment cannot be made. The time and date the specimen is removed from freezer must be provided to determine specimen acceptability.
GN.2 Specimen Submission Form G1-C, Maternal Serum Prenatal Triple Screen

Section 1. SUBMITTER INFORMATION — (** REQUIRED)

Submitter/TPI Number ** Submitter Name ** Physician's Name ** NPI Number ** Address ** City ** State ** Zip Code ** Phone ** Fax **

Section 2. PATIENT INFORMATION — (** REQUIRED)

Last Name ** First Name ** MI ** Address ** Telephone Number ** City ** State ** Zip Code ** Country of Origin ** Race: [ ] White / Caucasian [ ] African American [ ] Black or African American [ ] Native American / Native Alaskan [ ] Asian [ ] Other

Ethnicity: [ ] Hispanic [ ] Filipino [ ] Korean [ ] Multiracial [ ] Not Specified [ ] Other

DOB (mm/dd/yyyy) ** Age ** Sex [ ] Male [ ] Female [ ] Unknown SSN ** Pregnant? [ ] Yes [ ] No [ ] Unknown

Medical Record Number ICD Diagnosis Code ** Previous DSHS Specimen Lab Number

Section 3. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

O.B. History G_____________ P_____________ AB_____________ Signature *

Multiple fetuses? ** Specify number of fetuses: **

On insulin prior to pregnancy (IDDM)? **

Maternal medication ** Specify: **

Repeat specimen? ** If yes, indicate reason: **

Gestational Age (Select one calculation method.)

DATE of LMP (mm/dd/yyyy) ** Ultrasound dating weeks days (mm/dd/yyyy) **

If sono by 1/10 of week ** weeks on (mm/dd/yyyy) **

Physical exam weeks days (mm/dd/yyyy) **

Estimated Delivery Date (mm/dd/yyyy) **

Current Weight ** Date of Collection ** Time of Collection ** Collected By ** Time and Date of Removal from Freezer prior to shipping (REQUIRED) **

Section 4. PHYSICIAN INFORMATION — (** REQUIRED)

Physician’s Name ** Address ** Physician’s NPI Number **

Section 5. PAYOR SOURCE – (REQUIRED)

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or DSHS Program. If Medicaid or Medicare is indicated, the Medicaid/Medicare number is required. If private insurance or DSHS Program is indicated, the required billing information below is designated with an asterisk (*).

Submitter ** Private Insurance **

Medicaid ** Medicare **

Medicaid/Medicare #: [ ] Title V – Family Planning [ ] Other: ___________

[ ] Title V – MCH

[ ] Title X – Family Planning

[ ] Title XX – Family Planning

Group Name * Group Number *

Signature of patient or responsible party.

(All information is required for testing.)

I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of State Health Services, Laboratory Services Section. Signature of patient or responsible party.

FOR DSHS LABORATORY USE ONLY

Specimen received

Specimen condition

Verify specimen

Date *

Edit

Completed

Mailed & faxed

Revised, mailed & faxed

(All information is required for testing.)

Revised, mailed & faxed
Specimen Submission Form G-1C, Maternal Serum Prenatal Triple Screen (Spanish, 2 Pages)

Sección 1. DATOS DEL REMITENTE – (** REQUERIDO)
- Núm. de remitente y de TPS (**)
- Nombre del remitente (**)
- Número del médico (**)
- Ciudad (**)
- Estado (**)
- Código Postal (**)
- Núm. de teléfono (**)
- Correo electrónico (**)
- Dirección (**)
- Código de la clínica

Sección 2. DATOS DEL PACIENTE – (**) REQUERIDO
- Apellido (**)
- Primer nombre (**)
- Iniciales del 2.° nombre (**)
- Raza (**)
- Etnia (**)
- Fecha de nacimiento (mm/dd/aaaa) (**)
- Edad (**) Núm. de Seguro Social (**)
- Se aplica, ¿es embarazada? (**)
- Ciudad (**)
- Estado (**)
- Código Postal (**)
- Núm. de expediente médico
- Código diagnóstico de ICD (**)
- Núm. previo del laboratorio de muestras del DSHS

Sección 3. SOLICITUD DE PRUEBA TRIPLE Y DATOS DEL PACIENTE
- Historial de obesidad
- G P A B
- ¿Fetos múltiples? (**)
- Uso de insulina previo al embarazo (IDDM) (**)
- Medicamento materno (**)
- ¿Repetir la muestra? (**)

Edad de gestación (elija un método de cálculo).
<table>
<thead>
<tr>
<th>Fecha de LMP</th>
<th>(mm/dd/aa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Día de ultrasonido</td>
<td>semanas</td>
</tr>
<tr>
<td>Si es ecografía a 1/10 de semana</td>
<td>semanas</td>
</tr>
<tr>
<td>Examen físico</td>
<td>semanas</td>
</tr>
<tr>
<td>Fecha de parto calculada</td>
<td>(mm/dd/aa) por: U6 LMP</td>
</tr>
</tbody>
</table>

**Completado**

**Mandado & faxado**

**Revisado, mandado & faxado**

**Fecha y hora de remoción del Congelador antes del envío (REQUERIDO)**

**Revisado, mandado & faxado**

**Ejemplo**
GN.4 Birthing Center Report (Newborn Child or Children) (Form 7484)

MAIL FORM TO:

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin, TX 78714-9030

PURPOSE: This form is to be used by BIRTHING CENTERS ONLY to report the birth of a child of a mother currently eligible under the Medicaid program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child’s FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid client number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child’s Medicaid claim.

To avoid delay in processing the child’s Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

<table>
<thead>
<tr>
<th>Mother's Name (Last, First, MI)</th>
<th>Admission Date (mm/dd/yy)</th>
<th>Mother's Medicaid client No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother's Mailing Address--Street</th>
<th>Mother's D.O.B. (mm/dd/yy)</th>
<th>Mother's Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State, ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child's Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child's D.O.B. (mm/dd/yy)</th>
<th>Child's Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child's Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child's D.O.B. (mm/dd/yy)</th>
<th>Child's Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child's Name (Last, First, MI)</th>
<th>Sex</th>
<th>Child's D.O.B. (mm/dd/yy)</th>
<th>Child's Medical Record No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has the mother relinquished her rights to the newborn child? □Yes □No
If “Yes,” give date of relinquishment: ________________________

<table>
<thead>
<tr>
<th>Certified Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthing Center Name</th>
<th>Certification No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C N M O G</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthing Center Address - Street</th>
<th>TPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State, ZIP</th>
<th>Birthing Center Telephone No.</th>
<th>Date Form Mailed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date Rec’d in Data Integrity

Date Rec’d in Data Integrity
GN.5 Sterilization Consent Form Instructions (2 pages)

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_07302007/Revised Date_03102010
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
- 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:
  - TPI
  - NPI
  - Taxonomy
  - 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.6 Sterilization Consent Form (English)

## Sterilization Consent Form

(Fax Consent Form to 1-512-514-4229)

<table>
<thead>
<tr>
<th>Client Medicaid or family planning number:</th>
<th>Date Signed: / / (month/day/year)</th>
</tr>
</thead>
</table>

**Notice:** Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects 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 A.F.D.C. 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 withdrawal 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 __________________________.

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 Employees 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.

<table>
<thead>
<tr>
<th>Client's Signature:</th>
<th>Date of Signature: / / (month/day/year)</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Interpreter Signature:</th>
<th>Date of Signature: / / (month/day/year)</th>
</tr>
</thead>
</table>

### 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 known as __________________________ (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 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.

<table>
<thead>
<tr>
<th>Signature of person obtaining consent:</th>
<th>Date of Signature: / / (month/day/year)</th>
</tr>
</thead>
</table>

### Facility Information

<table>
<thead>
<tr>
<th>Facility name:</th>
<th>Facility address:</th>
</tr>
</thead>
</table>

### 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 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.

<table>
<thead>
<tr>
<th>Physician’s Signature:</th>
<th>Date of Signature: / / (month/day/year)</th>
</tr>
</thead>
</table>

### Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OMB Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CAR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs.

Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual’s consent, pursuant to any applicable confidentiality regulations.

### CPT ONLY - COPYRIGHT 2009 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

Effective Date: 01152008/Revised Date: 03112010
GN.7 Sterilization Consent Form (Spanish)

Sterilization Consent Form (Spanish)

(Fax Consent Form in 1-512-514-4229)

Client Medicaid or family planning number:  /  Date Client Signed: / (month/day/year)

Nota: La decisión de no esterilizarse que usted puede tomar en cualquier momento, no causa el retiro o la retención de ningún beneficio que le sea proporcionado por programas o proyectos que reciben fondos federales.

Yo he solicitado y he recibido información de (médico o clínica) sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decidí no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F.D. o Medicaid, que recibo actualmente o para los cuales seré elegible.

Entiendo que la esterilización se considera una operación permanente e irreversible. Yo he decidido que no quiero quedarme embarazada, no quiero tener hijos ni quiero procrear hijos en el futuro. He rechazado las recomendaciones y no he decidido ser esterilizada/o. He recibido la explicación de las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará 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 esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales. Tengo por lo menos 21 años y nací en (mes) (día) (año). Yo, (nombre de la persona esterilizada/o) por medio de la presente doy mi consentimiento de mi voluntad para ser esterilizada/o por (método o clínica) por el método llamado .

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido el consentimiento para la esterilización. También le he dado/mis el Forma de Consentimiento en idioma y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/hé ah entendido esta explicación.

Declaración Del Intérprete

Sí he proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada: He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido el consentimiento para la esterilización. También le he dado/mis el Forma de Consentimiento en idioma y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/hé ah entendido esta explicación.

Declaración De La Persona Que Obtiene Consentimiento

Antes de que (nombre de persona) firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/hél el detalle de la 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 aconsejé a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente. Le he explicado a la persona que será esterilizada que puede retirar el consentimiento en cualquier momento y que ella/hél no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales. A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/hél ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

Declaración Sobre Ley De Reducción De Trámites

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, OASHTF-Budget Room 503 HHV Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la información proporcionada de esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales. Todas la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgaran sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.

All Fields in This Box Required for Processing

TPI: Provider Code:
NPI: Provider/clinic telephone:
Taxonomy: Provider/Clinic fax number:

Benefit Billed (check one): V X XIX (Medicaid) XX

Effective Date_01152008|Revised Date_03112010

CPT ONLY. COPYRIGHT 2009 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.

GN-63
GN.8 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.9  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
11. CLAIM FORM EXAMPLES
### GN.10 Family Planning Claim Form

#### Family Planning 2017 Claim Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family Planning Program:</td>
<td>V XIX XX</td>
</tr>
<tr>
<td>1a. Full Pay</td>
<td>☐</td>
</tr>
<tr>
<td>1b. Title X Partial Pay</td>
<td>☐</td>
</tr>
<tr>
<td>1c. Only No Pay</td>
<td>☐</td>
</tr>
<tr>
<td>2a. Billing Provider TPI</td>
<td>1234567-89</td>
</tr>
<tr>
<td>2b. Billing Provider NPI</td>
<td>987654321</td>
</tr>
<tr>
<td>3. Provider Name</td>
<td>Joe Smith</td>
</tr>
<tr>
<td>4. Eligibility Date (V or XX)</td>
<td>01/02/2009</td>
</tr>
<tr>
<td>5. Family Planning No. (Medicaid PCN if XIX)</td>
<td></td>
</tr>
<tr>
<td>6. Patient’s Name (Last Name, First Name, Middle Initial)</td>
<td>Doe, Jane</td>
</tr>
<tr>
<td>7. Address (Street, City, State)</td>
<td>341 Tosca Way, Houston, TX 77485</td>
</tr>
<tr>
<td>8. County of Residence</td>
<td>Harris</td>
</tr>
<tr>
<td>9. Date of Birth (MM/DD/CCYY)</td>
<td>02/02/1971</td>
</tr>
<tr>
<td>10. Sex</td>
<td>F X M</td>
</tr>
<tr>
<td>11. Patient Status</td>
<td>New Patient Established Patient</td>
</tr>
<tr>
<td>12. Patient’s Social Security Number</td>
<td>123 - 45 - 6789</td>
</tr>
<tr>
<td>13. Race (Code #)</td>
<td>White (1) Black (2) American Indian/Alaska Native (4) Asian (5) Unk/Not Rep (6) Native Hawaiian/Pacific Islander (7) More than one race (8)</td>
</tr>
<tr>
<td>13a. Ethnicity</td>
<td>Hispanic (5) Non-Hispanic (0)</td>
</tr>
<tr>
<td>14. Marital Status</td>
<td>Married (1) Never Married (2) Formerly Married (3)</td>
</tr>
<tr>
<td>15. Family Income (All)</td>
<td>$</td>
</tr>
<tr>
<td>16. Number Times Pregnant</td>
<td>1</td>
</tr>
<tr>
<td>17. Number Live Births</td>
<td>1</td>
</tr>
<tr>
<td>18. Number Living Children</td>
<td>1</td>
</tr>
<tr>
<td>19. Primary Birth Control Method Before Initial Visit</td>
<td>a=Oral Contraceptive b=1-Month hormonal injection c=3-Month hormonal injection d=Cervical cap/diaphragm e=Abstinence f=Hormonal implant g=Male condom h=Female condom i=Hormonal/Contraceptive patch j=Spermicide (used alone) k=Intrauterine device (IUD) l=Vaginal ring m=Fertility awareness method (FAM) n=Sterilization o=Contraceptive sponge</td>
</tr>
<tr>
<td>20. Primary Birth Control Method at End of This Visit</td>
<td>a=Refused b=Pregnant c=Inconclusive Preg Test d=Seeking Preg</td>
</tr>
<tr>
<td>21. If No Method Used at End of This Visit, Give Reason (Required only if #20 = r)</td>
<td>e=Infertile f=Rely on Partner g=Medical</td>
</tr>
<tr>
<td>22. Is There Other Insurance Available?</td>
<td>Y ☐ N ☐</td>
</tr>
<tr>
<td>23. Other Insurance Name and Address</td>
<td>If Y, Complete Items 23 – 25.</td>
</tr>
<tr>
<td>24a. Insured’s Policy/Group No.</td>
<td></td>
</tr>
<tr>
<td>24b. Benefit Code</td>
<td></td>
</tr>
<tr>
<td>25a. Date of Notification</td>
<td>01/02/2009</td>
</tr>
<tr>
<td>26. Name of Referring Provider</td>
<td>Joe Smith</td>
</tr>
<tr>
<td>27a. Referring Other ID</td>
<td></td>
</tr>
<tr>
<td>27b. Referring NPI</td>
<td>987654321</td>
</tr>
<tr>
<td>28. Level of Practitioner</td>
<td>Physician Nurse Mid Level Other</td>
</tr>
<tr>
<td>29. Diagnosis Code (Relate Items 1, 2, 3, or 4 to Item 32D by Line # in 32E)</td>
<td>1. V25.09</td>
</tr>
<tr>
<td>30. Authorization Number</td>
<td></td>
</tr>
<tr>
<td>31. Date of Occurrence (MM / DD / CCYY)</td>
<td></td>
</tr>
<tr>
<td>32. Dates of Service</td>
<td></td>
</tr>
<tr>
<td>From</td>
<td>To</td>
</tr>
<tr>
<td>MM/DD/CCYY</td>
<td>MM/DD/CCYY</td>
</tr>
<tr>
<td>1</td>
<td>01/02/2009</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>33. Federal Tax ID Number/EIN</td>
<td></td>
</tr>
<tr>
<td>34. Patient’s Account No. (optional)</td>
<td></td>
</tr>
<tr>
<td>35. Patient Co-Pay Assessed (V, X or XX)</td>
<td>$</td>
</tr>
<tr>
<td>36. Total Charges</td>
<td>$48.27</td>
</tr>
<tr>
<td>37. Signature of Physician or Supplier Date:</td>
<td>01/02/2009</td>
</tr>
<tr>
<td>Signed:</td>
<td>Joe Smith</td>
</tr>
<tr>
<td>38. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)</td>
<td></td>
</tr>
<tr>
<td>38a. NPI</td>
<td></td>
</tr>
<tr>
<td>38b. Other ID</td>
<td></td>
</tr>
<tr>
<td>39. Physician’s, Supplier’s Billing Name, Address, Zip Code &amp; Phone No.</td>
<td>Joe Smith 1234 Oak Drive Houston, Texas 77485 (281)123-4567</td>
</tr>
</tbody>
</table>
GN.11 Maternity Service Clinic

HEALTH INSURANCE CLAIM FORM

1. INSURED'S I.D. NUMBER

2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

3. DATE OF CURRENT ILLNESS

4. EMPLOYMENT? (Current or Previous)

5. PATIENT'S BIRTH DATE

6. EMPLOYER'S NAME OR SCHOOL NAME

7. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

8. PATIENT'S NAME

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

14. DATE OF CURRENT ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. B. C. D. E.

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ORgrund for Non-Assignment

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. SERVICE FACILITY LOCATION INFORMATION

GN-68

CPT ONLY - COPYRIGHT 2009 AMERICAN MEDICAL ASSOCIATION. ALL RIGHTS RESERVED.
GN.12 Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

Family Planning 2017 Claim Form

1. Family Planning Program: XIX
   XX

1a. Title X Full Pay [ ]
    Title X Partial Pay [ ]
    Title X Only [ ]
    Title X No Pay [ ]

2a. Billing Provider TPI 1234567-89
   2b. Billing Provider NPI 9768450132

3. Provider Name
   Smith, Jenny

4. Eligibility Date (V or XX)
   (MM/DD/YYYY)
   01/02/2009

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

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

7. Address (Street, City, State)
   341 Tosca Way, Houston, TX
   7a. ZIP code 77485

8. County of Residence
   Harris

9. Date of Birth (MM/DD/YYYY)
   02/02/1971

10. Sex M [ ]

11. Patient Status
    New Patient [ ]
    Established Patient [ ]

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

13. Race (Code #)
    White (1) Black (2)
    Hispanic (3) Non-Hispanic (0)

14. Marital Status
    (1) Married (2) Never Married (3) Formerly Married

15. Family Income (All)

16. Number Times Pregnant

17. Number Live Births

18. Number Living Children

19. Primary Birth Control Method
    Before Initial Visit
    G = Oral Contraceptive
    b = Hormonal Implant
    K = Intrauterine device (IUD)
    m = Vaginal ring
    n = Male condom
    f = Female condom
    o = Male sterilization
    p = Female sterilization
    q = Male contraceptive patch
    s = Female contraceptive patch
    a = Abstinence
    Other method

20. Primary Birth Control Method
    at End of This Visit
    c = Oral contraceptive
    e = Hormonal implant
    s = Intrauterine device (IUD)
    v = Vaginal ring
    C = Male condom
    M = Female condom
    h = Male contraceptive patch
    j = Female contraceptive patch
    D = Abstinence
    Other method

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

22. Is There Other Insurance Available?
    Y [ ]
    N [ ]

23. Other Insurance Name and Address

24a. Insured’s Policy/Group No.

24b. Benefit Code


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 32b by Line # in 32E)
   1. V25.1
   2. V25.42

30. Authorization Number

31. Date of Occurrence
    (MM / DD / CCYY)

32. A
    B
    C
    D
    E
    F
    G
    H

33. Federal Tax ID Number/EIN

34. Patient’s Account No. (optional)

35. Patient Co-Pay Assessed (V, X or XX)

36. Total Charges

37. Signature of Physician or Supplier
   Date: 01/02/2009
   Signed: Joe Smith

38. Name and Address of Facility Where Services Were
   Rendered (If Other Than Home or Office)
   Joe Smith
   1234 Oak Drive
   Houston, Texas 77485

38a. NPI

38b. Other ID