Texas Medicaid Provider Procedures Manual
December 2016

Volume 2
Provider Handbooks

Women’s Health Services Handbook
WOMEN’S HEALTH SERVICES HANDBOOK

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1  *General Information*

The information in this handbook is intended for women’s health services providers, Health and Human Services Commission (HHSC) Family Planning providers, and Healthy Texas Women (HTW) program providers. The handbook provides information about Texas Medicaid’s benefits, policies, and procedures that are applicable to these service providers.

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

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

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

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

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

The Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks) for information about Texas Medicaid fee-for-service and Title XIX family planning benefits for gynecological and reproductive health services.

2  **Healthy Texas Women (HTW) Program Overview**

The goal of HTW is to expand access to women’s health and family planning services to reduce unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and wellbeing of women and their families in the eligible population.

HTW is established to achieve the following objectives:

- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions.
- Ensure the efficient and effective use of state funds in support of these objectives and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly-funded healthcare (including federally-funded healthcare) by providing low-income Texans access to safe, effective services that are consistent with these objectives.
- Enforce Human Resources Code, §32.024(c-1) and any other state law that regulates delivery of non-federally funded family planning services.
Refer to: Subsection 1.1, “Family Planning Overview” in the Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks) for an overview of family planning funding sources.

The HTW page of the TMHP website at www.tmhp.com for more information about provider certification.

2.1 Guidelines for HTW Providers

HTW provides family planning services, related preventive health services that are beneficial to reproductive health, and other preventive health services that positively affect maternal health and future pregnancies for women who meet the following qualifications:

- Must be 15 through 44 years of age
  
  Note: Women who are 15 through 17 years of age must have a parent or legal guardian apply on their behalf.

- Must be a United States citizen or eligible immigrant

- Must be a resident of Texas

- Does not currently receive benefits through a Medicaid program (including Medicaid for Pregnant Women), Children’s Health Insurance Program (CHIP), or Medicare Part A or B.

- Has a household income at or below 200 percent of the federal poverty level

- Is not pregnant

- Does not have other insurance that covers the services HTW provides

Exception: A client with other private health insurance may be eligible to receive HTW services if she believes that a third party may retaliate against her or cause physical or emotional harm if she assists HHSC or its designee with pursuing claims against that third party.

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

HTW 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 HTW-covered methods of contraception must be made available to the client, either directly or by referral to another provider of contraceptive services. Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.

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

Client eligibility may also be verified using the following sources:

- The TMHP website at www.tmhp.com

- The Automated Inquiry System (AIS)

- TexMedConnect

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

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

HTW clients will receive 12 months of continuous eligibility unless:

- The client dies.
- The client voluntarily withdraws from HTW.
- The client no longer satisfies the HTW eligibility criteria.
- State law no longer allows the woman to be covered.
- HHSC or its designee determines the client provided information affecting her eligibility that was false at the time of application.

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

2.1.1 Referrals
If a provider identifies a health problem that is not within their scope of practice, the provider must refer the HTW client to another doctor or clinic that can treat her. As mandated by Texas Human Resources Code, Section 32.024(c-1), HTW does not reimburse for office visits where HTW 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.

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

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

2.1.3 Abortions
Elective and non-elective abortions are not covered by HTW.

Texas Human Resources Code Section 32.024(c-1) and Title 1 Texas Administrative Code, §382.17 prohibit the participation of a provider that performs or promotes elective abortions or affiliates with an entity that performs or promotes elective abortions.

A provider that performs elective abortions (through either surgical or medical methods) or that is affiliated with an entity that performs or promotes elective abortions for any patient is ineligible to serve HTW clients and cannot be reimbursed for any services rendered to a HTW client. This prohibition only applies to providers delivering services to HTW clients.

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

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

Refer to: Subsection 2.2, “HTW Provider Enrollment” in this handbook for more information about certification regarding elective abortions.

2.2 HTW Provider Enrollment

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

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

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

The following provider types are required to certify:

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

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

2.3 * Services, Benefits, Limitations, and Prior Authorization

This section includes information on women’s health and family planning services funded through HTW. HTW benefits include:

- Contraceptive services
- Pregnancy testing and counseling
• Preconception health screenings (e.g., screening for obesity, hypertension, diabetes, cholesterol, smoking, and mental health)
• Sexually transmitted infection (STI) services
• Treatment for the following chronic conditions:
  • Hypertension
  • Diabetes
  • High cholesterol
• Breast and cervical cancer screening and diagnostic services:
  • Radiological procedures including mammograms
  • Screening and diagnosis of breast cancer
  • Diagnosis and treatment of cervical dysplasia
• Immunizations
• Treatment of postpartum depression

The following procedure codes are benefits for HTW:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th><strong>Contraceptive and STI Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>00851 11976 11981 11982 11983 57170 58300 58301 58340 58562</td>
<td></td>
</tr>
<tr>
<td>58565 58600 58611 58615 58670 58671 73060 74000 74010 74740</td>
<td></td>
</tr>
<tr>
<td>76800 76857 76881 76882 80061 80300 80301 80302 81000 81001</td>
<td></td>
</tr>
<tr>
<td>81002 81003 81005 81015 81025 82947 82948 84443 84702 84703</td>
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<tr>
<td>85013 85014 85018 85025 85027 86318 86580 86592 86689 86695</td>
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<tr>
<td>86696 86701 86702 86703 86762 86763 86800 86900 86911 87070</td>
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<tr>
<td>87088 87102 87110 87205 87210 87220 87252 87389 87480 87490</td>
<td></td>
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<tr>
<td>87491 87510 87535 87590 87591 87624 87625 87660 87797 87800</td>
<td></td>
</tr>
<tr>
<td>87801 87810 87850 88150 88164 88175 90460 90471 90649 90650</td>
<td></td>
</tr>
<tr>
<td>90651 96372</td>
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<table>
<thead>
<tr>
<th><strong>Behavioral Health and Mental Health Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>97802 97803 97804 99000 99078 99406 99407 90791 90792</td>
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<table>
<thead>
<tr>
<th><strong>Supplies and Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A4261 A4264 A4266 A4267 A4268 A4269 A9150 H1010 J0696 J1050</td>
</tr>
<tr>
<td>J3490 J7300 J7301 J7302 J7303 J7304 J7307 S4993 S5000</td>
</tr>
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<table>
<thead>
<tr>
<th><strong>Evaluation and Management</strong></th>
</tr>
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<tbody>
<tr>
<td>99201 99202 99203 99204 99205 99211 99212 99213 99214 99215</td>
</tr>
<tr>
<td>99241 99242 99243 99244 99384 99385 99386 99394 99395 99396</td>
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<table>
<thead>
<tr>
<th><strong>Breast Cancer Screening</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>00400 10022 19000 19081 19082 19083 19084 19100 19101 19102</td>
</tr>
<tr>
<td>19125 19126 19281 19282 19283 19284 19285 19286 71010 71020</td>
</tr>
<tr>
<td>76098 76604 76642 76942 77051 77052 77053 77055 77056 77057</td>
</tr>
<tr>
<td>77058 77059 80048 80053 85730 88305 88307 93000 G0202 G0204</td>
</tr>
</tbody>
</table>
2.3.1 Family Planning History Check

HTW clients must receive family planning services annually, but no later than the third visit as an established client. These services must include family planning counseling and education, including natural family planning and abstinence. In order to receive reimbursement, all existing HTW clients must have received family planning services and/or counseling within the past rolling year.

The following HTW clients do not require a family planning history check:

- New clients
- Women who are sterilized
- Women who have a long-acting reversible contraception (LARC)

2.3.2 Family Planning Annual Exams

Family planning providers must bill one of the following E/M visit procedure code based on the complexity of the annual family planning examination provided:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>99201</td>
</tr>
<tr>
<td>99241</td>
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</table>

Procedure Codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>G0206</td>
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</table>

Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>00940</td>
</tr>
<tr>
<td>57522</td>
</tr>
<tr>
<td>88173</td>
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</table>

Problem-Focused Gynecological Services

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>56405</td>
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<tr>
<td>57421</td>
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Immunizations and Vaccinations

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<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>90460</td>
</tr>
<tr>
<td>90673</td>
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<tr>
<td>90736</td>
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</tbody>
</table>

Other Preventative Services

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>76700</td>
</tr>
<tr>
<td>82465</td>
</tr>
<tr>
<td>85007</td>
</tr>
<tr>
<td>87270</td>
</tr>
<tr>
<td>88172</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: Most appropriate E/M procedure code</td>
<td>One new patient E/M code 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</td>
</tr>
</tbody>
</table>

### 2.3.2.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination for HTW clients, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous tables in Subsection 2.3.2, “Family Planning Annual Exams” in this handbook.

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

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

### 2.3.3 Other Family Planning Office or Outpatient Visits

HTW does not cover office visits during which HTW clients are referred for elective abortions.

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

Refer to: Subsection 1.6.9.1, “Client Acknowledgment Statement” in “Section 1: Provider Enrollment and Responsibilities” (Vol. 1. General Information) for the requirements for billing clients.

### 2.3.3.1 * FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three encounters per HTW client, per year. Procedure codes J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the contraceptive device along with the procedure code for the encounter. The contraceptive device is not subject to FQHC limitations. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

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

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

### 2.3.4 * Laboratory Procedures

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.

More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Note: When a provider who renders HTW laboratory services obtains a specimen but does not perform the laboratory procedure, the provider who obtains the specimen may be reimbursed one lab handling fee per day, per client.
Handling fees are not paid for Pap smears or cultures. When billing for Pap smear interpretations, the claim must indicate that the screening and interpretation were actually performed in the office by using the modifier SU (procedure performed in physician’s office).

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

**Note:** Providers must code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797.

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

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

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

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


### 2.3.5 Contraceptive Devices

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

An E/M procedure code will not be reimbursed when it is billed with the same date of service as procedure code 58301, unless the E/M visit is a significant, separately identifiable service from the removal of the IUD. If the E/M visit occurs on the same date of service as the removal of the IUD, modifier 25 may be used to indicate that the E/M visit was a significant, separately identifiable service from the procedure.

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

### 2.3.6 Drugs and Supplies

#### 2.3.6.1 Prescriptions and Dispensing Medication

Providers may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill HTW.
- 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 HTW. Only providers with an appropriate pharmacy license may be reimbursed for dispensing family planning drugs and supplies. Provider types with an appropriate pharmacy license 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.

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.
2.3.6.1.1 Long-Acting Reversible Contraception Products

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

2.3.7 Sterilization and Sterilization-Related Procedures

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

The sterilization services that are available to HTW clients include surgical or nonsurgical sterilization, follow-up office visits related to confirming the sterilization, and any necessary short-term contraception.

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

2.3.7.1 Sterilization Consent

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

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

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

2.3.8 Treatment for Sexually Transmitted Infections (STIs)

HTW covers treatment for the following conditions:

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

2.3.9 Immunizations and Vaccinations

HTW covers the following immunizations and vaccinations:

- HPV
- Hep A
- Hep B
- Chicken pox
- MMR
• Tdap
• Flu

2.3.10 Prior Authorization
Prior authorization is not required for HTW services.

2.4 Documentation Requirements
All services require documentation to support the medical necessity of the service rendered, including HTW services.

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

2.5 HTW Claims Filing and Reimbursement

2.5.1 Claims Information
Providers must use the appropriate claim form to submit HTW claims to TMHP.

Refer to: Subsection 2.4, “Claims Filing and Reimbursement” in the Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks) for more information about filing family planning claims.

2.5.1.1 HTW and Third Party Liability
Federal and state regulations mandate that family planning client information be kept confidential.

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

2.5.2 Reimbursement
Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

2.5.3 National Drug Code

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

2.5.4 NCCI and MUE Guidelines
The Health Care Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the Texas Medicaid Provider Procedures Manual are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manual. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.
3 Health and Human Services Commission (HHSC) Family Planning Program Services

3.1 Provider Enrollment for HHSC Family Planning Program Contractors

Agencies that submit claims for HHSC Family Planning Program Services must have a contract with HHSC. The HHSC Family Planning Program determines client eligibility and services policy. Refer to the HHSC Family Planning Policy Manual for specific eligibility and policy information at www.dshs.texas.gov/famplan.

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


Subsection 1.1, “Family Planning Overview” in the Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks) for more information about family planning funding sources, guidelines for family planning providers, and family planning services for undocumented aliens and legalized aliens.

3.2 Services, Benefits, Limitations, and Prior Authorization

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

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

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

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

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

An annual family planning exam consists of a comprehensive health history and physical examination, including medical laboratory evaluations as indicated, an assessment of the client’s problems and needs, and the implementation of an appropriate contraceptive management plan.

HHSC 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:

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>Procedure Codes</th>
<th>Billing Criteria</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 99202 99203 99204 99211 99212 99213 99214</td>
<td><strong>New patient:</strong> Appropriate E/M procedure code with modifier FP</td>
<td>One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td></td>
<td><strong>Established patient:</strong> Appropriate E/M procedure code with modifier FP</td>
<td>Once per state fiscal year*</td>
</tr>
</tbody>
</table>

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

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

Refer to: Subsection 3.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

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

3.2.1.1  FQHC Reimbursement for Family Planning Annual Exams

To receive the encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in Subsection 3.2.1, “Family Planning Annual Exams” in this handbook and must use modifier FP.

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

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

Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.
3.2.2 Family Planning Office or Outpatient Visits

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

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

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

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

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>Procedure Codes</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>New patient: Appropriate E/M procedure code One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group</td>
</tr>
<tr>
<td>99202</td>
<td>Established patient: Appropriate E/M procedure code As needed*</td>
</tr>
<tr>
<td>99203</td>
<td>* 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.</td>
</tr>
<tr>
<td>99204</td>
<td></td>
</tr>
<tr>
<td>99211</td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td></td>
</tr>
</tbody>
</table>

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

Refer to: Subsection 3.2, “Services, Benefits, Limitations, and Prior Authorization” in this handbook for the list of family planning diagnosis codes.

3.2.2.1 FQHC Reimbursement for Family Planning Office or Outpatient Visits

To receive the encounter rate for a general family planning visit, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated previously in the tables in Subsection 2.5.3, “National Drug Code” in this handbook.

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

The new patient procedure codes will be limited to one new patient E/M procedure code three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.
Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

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

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

### 3.2.3 Laboratory Procedures

**3.2.3.1 HHSC Family Planning Program**

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

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80061</td>
</tr>
<tr>
<td>81025</td>
</tr>
<tr>
<td>85027</td>
</tr>
<tr>
<td>86703</td>
</tr>
<tr>
<td>87205</td>
</tr>
<tr>
<td>87535</td>
</tr>
<tr>
<td>87850</td>
</tr>
</tbody>
</table>

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

Refer to: Subsection 2.3.4, “Laboratory Procedures” in this handbook for more information about family planning laboratory services requirements.


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


### 3.2.4 Immunization Administration

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

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

**3.2.4.1 Human Papilloma Virus (HPV) Vaccine**

Procedure codes 90649 and 90650 may be reimbursed for the Human papilloma virus (HPV) vaccine.
3.2.5 Radiology
The following radiology services may be reimbursed for services performed for the purpose of localization of an IUD:

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

Procedure codes 76881 and 76882:
- Must be submitted with the most appropriate family planning diagnosis code
- Will be denied if they are submitted with the same date of service as procedure codes 55250 or 58600

3.2.6 Contraceptive Devices and Related Procedures
3.2.6.1 External Contraceptives
The following procedure codes may be reimbursed separately from the fitting and instruction (procedure code 57170):

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>57170</td>
</tr>
</tbody>
</table>

3.2.6.2 IUD
IUD services may be reimbursed using the following:

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

3.2.6.2.1 Insertion of an IUD
The IUD and the insertion of the IUD may be reimbursed using procedure codes J7297, J7298, J7300, J7301, and 58300.

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

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

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

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

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

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

3.2.6.4 Medroxyprogesterone Acetate/Estradiol Cypionate

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

3.2.7 Drugs and Supplies

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

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

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

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

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

3.2.7.1 Prescriptions and Dispensing Medication

Providers may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill HTW.
- 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 HTW. Only providers with an appropriate pharmacy license may be reimbursed for dispensing family planning drugs and supplies. Provider types with an appropriate pharmacy license 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.

HHSC Family Planning Program clients may have their prescriptions filled at the clinic pharmacy. HHSC Family Planning Providers can refer to the HHSC Family Planning Policy and Procedure Manual for additional guidance on dispensing medication.

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

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

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

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

3.2.8 Family Planning Education

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

3.2.8.1 Medical Nutrition Therapy

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

3.2.8.2 Instruction in Natural Family Planning Methods

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

3.2.9 Sterilization and Sterilization-Related Procedures

3.2.9.1 Sterilization Consent

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

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

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

3.2.9.2 Incomplete Sterilizations

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

3.2.9.3 Tubal Ligation and Hysteroscopic Occlusion

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

3.2.9.4 Vasectomy

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

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

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

3.3 Documentation Requirements

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

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

3.4 Claims Filing and Reimbursement

3.4.1 Claims Information

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

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

**Refer to:** Subsection 2.4, “Claims Filing and Reimbursement” in the Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks) for more information about filing family planning claims.

3.4.1.1 Filing Deadlines

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

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

**Note:** As stated in the HHSC Family Planning Policy and Procedure Manual, all claims and appeals must be submitted and processed within 60 days after the end of the contract period.

3.4.1.2 Third Party Liability

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

3.4.2 Reimbursement

Reimbursement for family planning procedures is available in the TMHP Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

3.4.2.1 Funds Gone

HHSC family planning providers are contracted to provide services for a specific time period, either the state fiscal year or a contract period within the fiscal year. The providers receive a specific budget amount for their contract period. When their claims payments have reached their budget allowance, providers must continue to submit claims. The amount of funds that they would have received had the funds been available will be tracked as "funds gone."
Providers may receive additional funds for a contract period at a later time. Claims identified as “funds gone” may be reimbursed at that time.

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

### 3.4.3 NCCI and MUE Guidelines

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

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

### 3.4.4 National Drug Code

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

### 4 Claims Resources

<table>
<thead>
<tr>
<th>Resources</th>
<th>“Appendix A: State, Federal, and TMHP Contact Information” (Vol. 1, General Information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix D: Acronym Dictionary</td>
<td></td>
</tr>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>Appendix F (Vol. 1, General Information)</td>
</tr>
<tr>
<td>Subsection 6.8 (Vol. 1, General Information)</td>
<td></td>
</tr>
</tbody>
</table>

### 5 Contact TMHP

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

### 6 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at [www.tmhp.com](http://www.tmhp.com):

<table>
<thead>
<tr>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization Consent Form Instructions</td>
</tr>
<tr>
<td>Sterilization Consent Form (English)</td>
</tr>
<tr>
<td>Sterilization Consent Form (Spanish)</td>
</tr>
<tr>
<td>2017 Claim Form</td>
</tr>
<tr>
<td>Healthy Texas Women Certification</td>
</tr>
</tbody>
</table>