



Texas Medicaid Provider Procedures Manual

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Provider Handbooks

Women's Health Services Handbook

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

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 Program 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 health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. 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.*

Referto: 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*). "Texas Medicaid Administration" in the *Preliminary Information (Vol. 1, General Information)*.

The Healthy Texas Women website at www.healthytexaswomen.org 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.

Referto: 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 Medicaid card to verify the client’s HTW eligibility on the Your Texas Benefits Medicaid website at www.yourtexasbenefitscard.com.

Client eligibility may also be verified using the following sources:

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

Referto: 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.healthytexaswomen.org/bccs-program.

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.

Referto: 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.

Referto: “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:

Procedure Codes									
Contraceptive and STI Services									
00851	11976	11981	11982	11983	57170	58300	58301	58340	58562
58565	58600	58611	58615	58670	58671	73060	74740	76830	76856
76857	76881	76882	80061^	81000	81001	81002*	81003^	81005	81015
81025*	82947^	82948	84443^	84702	84703^	85013*	85014^	85018^	85025^
85027	86318^	86580	86592	86689	86695	86696	86701^	86702	86703
86762	86803^	86900	86901	87070	87086	87088	87102	87110	87205
87210^	87220	87252	87389^	87480	87490	87491	87510	87535	87590
87591	87624	87625	87660	87797	87800	87801	87810	87850	88150
88164	88175	90460	90471	90649	90650	90651	96372	G0433	
Behavioral Health and Mental Health Services									
90791	90792	97802	97803	97804	99000	99078	99406	99407	
Supplies and Services									
A4261	A4264	A4266	A4267	A4268	A4269	A9150	H1010	J0696	J1050
J3490	J7296	J7297	J7298	J7300	J7301	J7303	J7304	J7307	S4993
Evaluation and Management									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99241	99242	99243	99244	99384	99385	99386	99394	99395	99396
G0466	G0467	G0468	G0469	G0470	T1015				
Breast Cancer Screening									
00400	10022	19000	19081	19082	19083	19084	19100	19101	19120
19125	19126	19281	19282	19283	19284	19285	19286	71045	71046
74018	74019	76098	76641	76642	76942	77053	77058	77059	77065
* CLIA waived test									
^ QW Modifier									

Procedure Codes									
77066	77067	80048^	80053^	85730	88305	88307	93000		
Cervical Cancer Screening									
00940	57452	57454	57455	57456	57460	57461	57500	57505	57520
57522	58110	71045	71046	74018	74019	80048^	80053^	85730	88141
88142	88143	88173	88174	88305	88307	93000			
Problem-Focused Gynecological Services									
56405	56420	56501	56515	56605	56606	56820	57023	57061	57100
57421	57511	58100							
Immunizations and Vaccinations									
90460	90471	90472	90632	90633	90636	90654	90656	90660	90670
90673	90686	90688	90707	90710	90714	90715	90716	90732	90733
90734	90736	90743	90744	90746					
Other Preventative Services									
76700	76705	76770	80050	80051^	80053^	80069^	80074	80076	82270*
82465^	82950^	82951^	83020	83021	83036^	84450^	84460^	84478^	84479
85007	85610^	85660	85730	86631	86677	86704	86706	86780^	86885
87270	87512	87529	87530	87661	88155	88160	88161	88165	88167
88172	94760	J0558	J0561	J0690	J2010				
* CLIA waived test									
^ QW Modifier									

Procedure code G0433 will deny if billed on the same day by the same provider as procedure code 86703.

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

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:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99241	99242	99243	99244	99384	99385	99386	99394	99395	99396
G0466	G0467	G0468	G0469	G0470	T1015				

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

Billing Criteria	Frequency
New patient: Most appropriate E/M procedure code	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

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.

Referto: 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 family planning encounters per HTW client, per year. Procedure codes J7296, 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 implant, 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.

Referto: 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.

Referto: 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.

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

For waived tests, providers must use modifier QW as indicated on the CMS website.

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.

Referto: "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.

Referto: [Sterilization Consent Form \(English\)](http://www.tmhp.com) on the TMHP website at www.tmhp.com.

[Sterilization Consent Form \(Spanish\)](http://www.tmhp.com) on the TMHP website at www.tmhp.com.

[Sterilization Consent Form Instructions](http://www.tmhp.com) 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.

Referto: 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

Referto: 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 benefits. Refer to the HHSC Family Planning Program Policy Manual for specific eligibility, services, and policy information at www.healthytexaswomen.org.

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

Subsection 2.1, “Title XIX Provider Enrollment” in the *Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook (Vol. 2, Provider Handbooks)*.

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 the appropriate diagnosis codes on the claim in conjunction with all family planning procedures and services.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#).

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 program providers must bill the most appropriate E/M with modifier FP visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, providers must include the appropriate E/M procedure codes and must be billed with modifier FP on the claim in conjunction with all family planning procedures and services.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#).

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

Billing Criteria	Frequency
New patient: Appropriate E/M procedure code with modifier FP	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
Established patient: Appropriate E/M procedure code with modifier FP	Once per state fiscal year*
* 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.

Referto: 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

FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the HHSC Family Planning Program Services Policy and Procedure Manual.

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.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#).

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

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about general family planning office or outpatient visits.

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:

Billing Criteria	Frequency
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
Established patient: Appropriate E/M procedure code	As needed*
* 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.

Referto: 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

FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated previously in the tables in the HHSC Family Planning Program Services Policy and Procedure Manual.

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.

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.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#).
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

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about laboratory procedures.

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

Referto: Subsection 2.1.1, "Clinical Laboratory Improvement Amendments (CLIA)" in the *Radiology and Laboratory Services Handbook (Vol. 2, Provider Handbooks)*.

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

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

For waived tests, providers must use modifier QW as indicated on the CMS website.

3.2.4 Immunization Administration

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for specific procedure codes that may be reimbursed for medications, immunizations, and vaccines.

3.2.4.1 Human Papilloma Virus (HPV) Vaccine

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for specific procedure codes that may be reimbursed for medications, immunizations, and vaccines for HPV.

3.2.5 Radiology

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for specific procedure codes that may be reimbursed for radiology services performed for the purpose of localization of an IUD.

3.2.6 Contraceptive Devices and Related Procedures

3.2.6.1 Barrier Contraceptives

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for specific procedure codes that may be reimbursed for barrier contraceptives separately from fitting and instruction.

3.2.6.2 IUD

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for specific procedure codes that may be reimbursed for IUDs and the insertion of IUDs.

3.2.6.2.1 Removal of the IUD

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for specific procedure codes that may be reimbursed for the removal of an IUD.

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 Implants

The contraceptive implant, procedure code J7307, and the implantation of the contraceptive implant, procedure code 11981, may be reimbursed.

Progesterone-containing subdermal contraceptive implants (Norplant) were previously used for birth control. Although subdermal contraceptive implants are no longer approved by the FDA, the removal of the implanted contraceptive implant may be considered for reimbursement.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for the appropriate contraceptive implant removal procedure code.

3.2.7 Drugs and Supplies

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for specific procedure codes that may be reimbursed for providing contraceptive methods.

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 the HHSC Family Planning Program.
- 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 the HHSC Family Planning Program. 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.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about dispensing contraceptives.

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.

3.2.7.2 Oral Medication Reimbursement

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about oral medication.

3.2.8 Family Planning Education

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for the procedure codes that may be reimbursed for providing Contraceptive Method Instruction.

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. Medical nutritional therapy, however, must be provided by a registered dietician in order to be reimbursed.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about medical nutritional therapy.

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.

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about natural family planning.

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.

Referto: [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.

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

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about tubal ligation and hysteroscopic occlusion.

3.2.9.4 Vasectomy

Referto: The [HHSC Family Planning Program Services Policy and Procedure Manual](#) for more information about vasectomies.

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.*

3.4.1.1 Filing Deadlines

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

Deadline	Appeals
95 days from the date of service on the claim or date of any third party insurance explanation of benefits (EOB)	120 days from the date of the Remittance and Status (R&S) Report on which the claim reached a finalized status
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 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

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

4 Claims Resources

Resource	Location
Acronym Dictionary	"Appendix D: Acronym Dictionary" (<i>Vol. 1, General Information</i>)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (<i>Vol. 1, General Information</i>)
2017 Claim Form Instructions	Subsection 6.8, "Family Planning Claim Filing Instructions" in "Section 6: Claims Filing" (<i>Vol. 1, General Information</i>)

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:

Forms
Sterilization Consent Form Instructions
Sterilization Consent Form (English)
Sterilization Consent Form (Spanish)
2017 Claim Form
Healthy Texas Women Certification