Texas Medicaid

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Gynecological, Obstetrics, and Family Planning Title XIX 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.

GYNECOLOGICAL, OBSTETRICS, AND FAMILY PLANNING TITLE XIX SERVICES

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1 General Information

The information in this handbook is intended for gynecological, obstetrics, and Texas Medicaid Title XIX family planning 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" (Vol. 1, General Information). 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 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 health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

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

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

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

The *Healthy Texas Women Program Handbook* (*Vol. 2, Provider Handbooks*) for information about women's health services.

The *Health and Human Services Commission Family Planning Program Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Health and Human Services Commission (HHSC) programs that provide family planning services.

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, providers can refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in the Medicaid Managed Care Handbook.

Refer to: Section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.1 Family Planning Overview

TMHP processes family planning claims and encounters for two different funding sources:

- The HHSC Family Planning program funding for HHSC-contracted providers
- The Title XIX family planning funding for Texas Medicaid providers

HHSC awards contracts to agencies across Texas to provide services to low-income individuals who may not qualify for Texas Medicaid services. These awards are granted through a competitive procurement process. HHSC contracts with a variety of providers, including local health departments, universities, medical schools, private nonprofit agencies, FQHCs, RHCs, and hospital districts. All HHSC-contracted providers must first be enrolled in Title XIX Texas Medicaid.

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Client eligibility requirements, reimbursement methodologies, client copayment guidelines, and covered services may differ for each funding source. Family planning funding cannot be used for elective abortion services.

- Title XIX funds are available for family planning services provided to Texas Medicaid clients. TMHP processes Title XIX claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.
- HHSC Family Planning Program contracts annually with family planning providers. TMHP processes claims and reimburses providers for services to eligible clients according to the individually granted funds.
- Funds are also available for women's health and family planning services provided to Healthy Texas Women (HTW) clients. TMHP processes HTW claims and reimburses eligible services on a fee-for-service basis for family planning providers and a prospective payment system basis for FQHC and RHC providers.

1.1.1 Guidelines for Family Planning Providers

The following guidelines apply for all family planning services:

- Family planning services may be provided by a physician or under the direction of a physician, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physicians assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or certified nurse midwife (CNM).
- Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- Texas Medicaid clients, including limited care clients, are allowed to choose any enrolled family planning service provider.
- Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate.
- Family planning clients must be allowed the freedom to accept or reject services without coercion.
- Only family planning clients may consent to the provision of family planning services. Counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.
- Sterilization services cannot be provided to any person who is 20 years of age or younger. For more information, HHSC providers may refer to the HHSC website at www.healthytexaswomen.org.

1.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.

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- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

2 Medicaid Title XIX Family Planning Services

2.1 Title XIX Provider Enrollment

Physician, FQHC, and RHC providers may provide Title XIX family planning services for Texas Medicaid clients under the provider's Texas Medicaid provider number. No additional enrollment is required to provide Title XIX family planning services.

Refer to: Subsection 7.1, "Provider Enrollment" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about physician provider enrollment.

Subsection 4.1, "Enrollment" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about FQHC provider enrollment.

Subsection 8.1, "Enrollment" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about RHC provider enrollment.

Family planning agencies must apply for enrollment with TMHP. To be enrolled in Texas Medicaid, family planning agencies must meet the following requirements:

- Complete an agency enrollment application.
- Ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician in accordance with the Texas Medical Board or Texas BON.
- Have a medical director who is a physician currently licensed to practice medicine in Texas, and submit a current copy of the medical director's physician license.
- Have an established record of performance in the provision of both medical and educational counseling of family planning services as verified through client records, established clinic hours, and clinic site locations.
- Provide family planning services in accordance with HHSC standards of client care for family planning agencies.
- Be approved for family planning services by the HHSC Family Planning Program.

Note: *An RHC can also apply for enrollment as a family planning agency.*

The effective date for participation is the date an approved provider agreement with Medicaid is established.

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

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

Subsection 6.3.6, "Benefit Code" in the *Section 6: Claims Filing* (*Vol. 2, Provider Handbooks*) for more information about benefit codes.

2.2 Services, Benefits, Limitations, and Prior Authorization

This section includes information on family planning services funded through Title XIX Medicaid.

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Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Title XIX services include:

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

Providers must use one of the following diagnosis codes in conjunction with all family planning procedures and services:

Diagnosis Codes							
Z30011	Z30013	Z30014	Z30015	Z30016	Z30017	Z30018	Z3002
Z3009	Z302	Z3040	Z3041	Z3042	Z30430	Z30431	Z30432
Z30433	Z3044	Z3045	Z3046	Z3049	Z308	Z309	Z9851
Z9852							

One of the diagnosis codes in this table must be included in Block 24 E of the CMS-1500 claim form referencing the appropriate procedure code. The choice of diagnosis code must be based on the type of family planning service performed.

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

2.2.1 Family Planning Annual Exams

An annual family planning exam consists of a comprehensive health history and physical examination, which includes the following:

- Medical laboratory evaluations as indicated
- An assessment of the client's problems and needs
- The implementation of an appropriate contraceptive management plan

Family planning providers must bill the most appropriate evaluation and management (E/M) visit procedure code for the complexity of the annual family planning examination provided. To bill an annual family planning examination, one of the following procedure codes must be billed with modifier FP and a family planning diagnosis code:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

Important: *Only the annual family planning examination requires modifier FP. All other family planning office visits do not. One annual family planning examination is allowed per year. Claims filed incorrectly may be denied.*

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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 with modifier FP and a family planning diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with modifier FP and a family planning diagnosis code	Once a year*
*** The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.**	

An annual family planning examination (billed with modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit.

If another condition requiring an E/M office visit beyond the required components for the annual examination is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client's condition required a significant, separately identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

2.2.1.1 FQHC Reimbursement for Family Planning Annual Exams

To receive their encounter rate for the annual family planning examination, FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the previous table in subsection 2.2.1, "Family Planning Annual Exams" in this handbook.

The annual exam is allowed once per fiscal year, per client, per provider. Two additional family planning office or outpatient visits may be reimbursed to the FQHC within the same year for the same client.

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

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

2.2.2 Other Family Planning Office or Outpatient Visits

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

New and established patient E/M services for general family planning visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) may be provided via a telemedicine service delivered using synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

New and established patient E/M services delivered using synchronous audiovisual technology must be billed using the 95 modifier.

Refer to: The *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about E/M services and The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for restrictions for services delivered using synchronous audiovisual technology.

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Documentation requirements for a telemedicine service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the service delivery method when provided via telemedicine.

Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine documentation requirements, including requirements for informed consent.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

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

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

Title XIX family planning providers must use one of the following procedure codes based on the complexity of the visit with a family planning diagnosis for other family planning office or outpatient visits:

Procedure Codes								
99202	99203	99204	99205	99211	99212	99213	99214	99215

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

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

Billing Criteria	**Frequency**
New patient: Most appropriate E/M procedure code with a family planning diagnosis code	One new patient E/M code every 3 years following the last E/M visit provided the client by that provider or a provider of the same specialty in the same group
Established patient: Most appropriate E/M procedure code with a family planning diagnosis code	As needed*
*** The established patient procedure code will be denied if a new patient procedure code has been billed in the same year.**	

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

A general family planning office or outpatient visit (billed without modifier FP) will not be reimbursed when submitted with the same date of service as a surgical procedure or an additional E/M visit. If another condition requiring an E/M office visit beyond the required components for an office visit, family planning visit, or surgical procedure is discovered, the provider may submit a claim for the additional visit using modifier 25 to indicate that the client's condition required a significant, separately

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identifiable E/M service. Documentation supporting the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

2.2.2.1 FQHC Reimbursement for Other Family Planning Office or Outpatient Visits

FQHCs may be reimbursed for three family planning encounters per year, per client, same provider, regardless of the reason for the encounter. The three encounters may include any combination of general family planning, annual family planning exams, or services. Procedure codes J7296, J7297, J7298, J7300, J7301, and J7307 may be reimbursed in addition to the FQHC encounter payment. When seeking reimbursement for an intrauterine device (IUD) or implantable contraceptive capsule, providers must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. 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.

A family planning diagnosis code must be billed along with the most appropriate informational procedure codes for the services that were rendered. Reimbursement for services payable to an FQHC is based on an all-inclusive rate per visit.

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

2.2.2.2 RHC Reimbursement for Other Family Planning Office or Outpatient Visits

RHC's may receive an encounter rate when submitting claims with procedure code T1015, in addition to a flat "add on" fee for a LARC device (procedure codes J7296, J7297, J7298, J7300, J7301, and J7307).

Refer to: Subsection 8.2.1.4, "Family Planning Services" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about family planning services performed by an RHC.

2.2.3 Laboratory Procedures

All family planning laboratory services must be billed with a family planning diagnosis code.

2.2.3.1 Clinical Laboratory Improvement Amendments (CLIA) Requirement

All providers of laboratory services must comply with the rules and regulations of the CLIA. Providers who are not in compliance with CLIA will not be reimbursed for laboratory services. Only the office or lab that holds the appropriate CLIA certificate and that actually performs the laboratory test procedure may be reimbursed for the procedure.

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

2.2.3.2 Medical Record Documentation

Medicaid family planning service providers must document in the client's medical record the medical necessity of all ordered laboratory services. The medical record documentation must also reference an appropriate diagnosis.

2.2.3.3 Lab Specimen Handling and Testing

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

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If the provider that obtains the specimen does not perform the laboratory procedure, the provider that obtains the specimen may be reimbursed one lab handling fee per day, per client, using procedure code 99000 and a family planning diagnosis code for the handling or conveyance of the specimen from the provider's office to a laboratory. More than one lab handling fee may be reimbursed per day if multiple specimens are obtained and sent to different laboratories.

Handling fees are not paid for Pap smears or cultures. The appropriate procedure code may be reimbursed for Pap smear interpretations when billed with modifier SU indicating that the screening and interpretation were actually performed in the office.

2.2.3.4 Providing Information to the Reference Laboratory

When sending any specimen, including Pap smears, to the reference laboratory, the family planning provider must provide the reference laboratory with the client's name, address, Texas Medicaid number, and a family planning diagnosis so the laboratory may bill Texas Medicaid for its family planning lab services.

2.2.4 Radiology Services

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

2.2.5 External Contraceptives, Long Acting Reversible Contraceptives (LARCs), and Related Procedures

2.2.5.1 External Contraceptives

Procedure codes A4261 (cervical cap) and A4266 (diaphragm) may be reimbursed separately from the fitting and instruction (procedure code 57170).

Procedure codes A4261 and A4266 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30012	Z30018	Z3009	Z302	Z3040	Z3041	Z3042
Z30431	Z30432	Z3049	Z308	Z309	Z641		

2.2.5.2 Long Acting Reversible Contraception: Intrauterine Devices

2.2.5.2.1 Insertion of the LARC IUD

The IUD and the insertion of the IUD may be reimbursed using procedure code J7296, J7297, J7298, J7300, J7301, and 58300.

Procedure codes J7296, J7297, J7298, J7300, and J7301 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis codes							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

2.2.5.2.2 Removal of the LARC IUD

Procedure code 58301 may be reimbursed when an IUD is extracted from the uterine cavity. An office visit will not be reimbursed when billed on the same date of service as procedure code 58301.

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When a vaginal, cervical, or uterine surgery procedure code is submitted with the same date of service as the IUD removal procedure code or the IUD replacement procedure code, the following reimbursement may apply:

- The other vaginal, cervical, or uterine surgical procedure may be reimbursed at full allowance.
- The removal or the replacement of the IUD will be denied.

2.2.5.3 Long Acting Reversible Contraception: Implantable Contraceptive Capsules

The contraceptive capsule and the implantation of the contraceptive capsule may be reimbursed using procedure code J7307. Providers must use modifier U8 when submitting claims for a contraceptive device purchased through the 340B Drug Pricing Program.

Procedure code 11981 may be reimbursed for the insertion of the contraceptive capsule when it is billed with a family planning diagnosis code.

Procedure code 11983 may be reimbursed for the removal with reinsertion of the contraceptive capsule when it is billed with a family planning diagnosis code. Progesterone-containing subdermal contraceptive capsules (Norplant) were previously used for birth control. Although subdermal contraceptive capsules are no longer approved by the Food and Drug Administration (FDA), the removal of the implanted contraceptive capsule may be considered for reimbursement with procedure code 11976 or 11982.

2.2.5.4 Immediate Postpartum Insertion of LARCs: IUDs and Implantable Contraceptive Capsules

Procedure codes for LARCs may be reimbursed in addition to the hospital Diagnosis related group (DRG) payment when insertion is performed immediately postpartum. "Immediately postpartum" refers to the following:

- Insertion within 10–15 minutes of placental delivery for IUDs
- Insertion prior to discharge for implantable contraceptive capsules.

Medicaid MCOs must adopt claim processing procedures to reimburse hospital and facility providers for immediate postpartum LARC devices in addition to the rate for delivery services.

For claims submitted to TMHP, hospital and facility providers must submit an outpatient claim with the appropriate procedure code for the contraceptive device in addition to the inpatient claim for the delivery services.

For claims submitted to a Texas Medicaid managed care organization (MCO), providers must follow the MCO's claim processing procedures for reimbursement of immediate postpartum LARC devices in addition to the rate for delivery services.

2.2.6 Contraceptive Drugs, Supplies, and Prophylactics

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

Procedure Codes								
A4267	A4268	A4269	J1050	J3490*	J7294	J7295	J7304	S4993
96372								
*** Procedure code J3490 may be reimbursed when a prescription medication to treat a genital infection is provided to the client.**								

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

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Procedure code J1050 (no modifier) may be reimbursed for services rendered to male and female clients of any age for other indications as appropriate. Providers must bill the appropriate quantity based on the amount used in milligrams (mg).

For Texas Medicaid Title XIX services, procedure code J1050 is not diagnosis-restricted. For Title XIX family planning services, procedure code J1050 must be billed with a valid family planning diagnosis code.

Procedure codes A4268, A4269, and S4993 may be reimbursed when they are billed with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30012	Z30018	Z3009	Z302	Z3040	Z3041	Z3042
Z30431	Z30432	Z3049	Z308	Z309	Z641		

Procedure code A9150 is not reimbursed through Title XIX Medicaid for the medication to treat a monilia infection. The drug is available through the Texas Vendor Drug Program with a prescription.

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

Refer to: Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

2.2.6.1 Prescriptions and Dispensing Medication

Family planning agencies may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill accordingly.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to TMHP for Texas Medicaid fee-for-service clients. Only family planning agencies may be reimbursed for dispensing family planning drugs and supplies. Family planning agencies may be reimbursed for dispensing up to a 1-year supply of contraceptives in a 12-month period using procedure code J7294, J7295, J7304, or S4993. The appropriate family planning diagnosis code must be included on the claim.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook.

Title XIX clients may have prescriptions filled at the clinic pharmacy or at another pharmacy. Pharmacies under the Vendor Drug Program are allowed to fill all prescriptions as prescribed. Family planning drugs and supplies are exempt from the three prescriptions-per-month rule for up to a six-month supply.

2.2.6.2 Pharmacy Benefit for Long-Acting Reversible Contraception Products

Certain LARC products are available as a pharmacy benefit of Family Planning and are available through a limited number of specialty pharmacies that work with LARC manufacturers. Providers can refer to the Long-Acting Reversible Contraception Products section of the Outpatient Drug Services Handbook for additional information, including a list of covered products and participating specialty pharmacies.

2.2.6.3 Medroxyprogesterone Acetate (Depo-Provera)

Medroxyprogesterone acetate injectable suspension (Depo-Provera) has been approved by the FDA as a method of contraception. Intramuscular injections of medroxyprogesterone acetate given at 90-day intervals has been proven to be a long-term method of preventing pregnancy. Medroxyprogesterone acetate injectable suspension is reimbursed by Texas Medicaid to providers of family planning services. Medroxyprogesterone acetate must be billed using procedure code J1050 with modifier U1 and a valid family planning diagnosis codes.

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2.2.6.4 Injection Administration

Injection administration billed by a provider is reimbursed separately from the medication. If billed without procedure code J1050 and modifier U1, procedure code 96372 must be billed with a family planning diagnosis and a description of the medication in the Remarks field of the claim. Injection administration is not payable to outpatient hospitals.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for a list of family planning diagnosis codes.

2.2.7 Medical Counseling and Education

Procedure code H1010 for the instruction in natural family planning methods may be reimbursed once per day, per person or per couple, when billed by any provider with one of the following diagnosis codes:

Diagnosis Codes							
Z30011	Z30018	Z3002	Z3009	Z302	Z3040	Z3041	Z3042
Z30430	Z30431	Z30432	Z30433	Z3049	Z308	Z309	Z9851
Z9852							

Procedure code H1010 is intended to instruct a couple or an individual in methods of natural family planning. Two sessions (one per client) may be billed for separate, individual sessions, or one session may be billed for counseling and education if provided in a joint session. Each session may be billed separately or the two sessions may be billed together with a total charge for both sessions.

2.2.8 Sterilization and Sterilization-Related Procedures

For a complete list of Title XIX sterilization procedures, providers can refer to the Texas Medicaid fee schedules located on the TMHP website at public.tmhp.com/FeeSchedules/Default.aspx.

2.2.8.1 Sterilization Consent

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

Note: *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.

2.2.8.2 Anesthesia for Sterilization

Procedure codes 00840, 00851, and 00940 may be reimbursed for anesthesia for sterilization services in accordance with standard anesthesia billing requirements. Providers must include a valid family planning diagnosis code on the claim.

Refer to: Subsection 6.2.5.2, "Anesthesia" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about anesthesia modifiers.

2.2.8.3 Occlusive Sterilization Device

Procedure code A4264 may be reimbursed for the occlusive sterilization system (micro-insert), and may be reimbursed separately from the surgery (procedure code 58565) to place the device.

Providers must bill procedure code A4264 on the same date of service by the same provider as the occlusive sterilization system (micro-insert).

Procedure code 58565 is considered bilateral and is limited to once per lifetime, any provider.

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2.2.8.4 Tubal Ligation

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

2.2.8.5 Vasectomy

Procedure code 55250 may be reimbursed for any sterilization procedure that is performed on a male by a family planning agency. This procedure code may be reimbursed as a global fee to include preoperative, intra-operative, and postoperative services by all parties involved. Vasectomies are considered to be permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the client, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

2.2.8.6 Facility Fees for Sterilization

Hospital-based and freestanding ambulatory surgical centers (HASCs/ASCs) may be reimbursed for procedure code 55250, 58260, 58262, 58565, 58600, 58615, 58670, or 58671. An appropriate family planning diagnosis code must be billed when reporting facility fees for procedure codes 58565 or 58670.

Refer to: Ambulatory Surgical Center on the TMHP website at www.tmhp.com for a claim form example.

Subsection 6.2.13, "Gynecological and Reproductive Health and Family Planning Services" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional gynecological, reproductive health, and family planning services procedure codes that may be reimbursed to ASC and HASC providers.

2.2.9 Prior Authorization

Prior authorization is not required for family planning services, including sterilization and sterilization-related procedures.

2.2.10 Non-covered Services

2.2.10.1 Family Planning Services for Undocumented Aliens

Undocumented aliens are identified on the client eligibility card as having limited Medicaid eligibility by the classification of Type Program (TP) 30, 31, 34, and 35. Under Texas Medicaid, these clients are only eligible for emergency services, including emergency labor and delivery. Texas Medicaid emergency-only services do not cover Title XIX family planning services.

2.3 Documentation Requirements

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

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

Documentation requirements for a telemedicine service are the same as for an in-person visit and must accurately reflect the services rendered. Documentation must identify the service delivery method when provided via a telemedicine service.

Refer to: Subsection 3.4, "Telemedicine Services" in the *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about telemedicine documentation requirements, including requirements for informed consent.

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2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Providers may use the following claim forms to submit claims to TMHP:

Providers	Forms
Medicaid Fee-For-Service Claims Submitted to TMHP	
All family planning services provided by physicians, PAs, NPs, CNSs, CNMs, and family planning agencies who also contract with HHSC	2017 claim form or approved electronic format
Medicaid family planning providers who do not contract with HHSC	2017 claim form, CMS-1500 claim form, or approved electronic format of either form
Hospitals	UB-04 CMS-1450 claim form or approved electronic format
FQHCs not contracted with HHSC	UB-04 CMS-1450, 2017 claim form, or approved electronic format of either form
FQHC also contracts with HHSC	2017 claim form or approved electronic format

The following applies when filing claims:

- All claims and Sterilization Consent Forms submitted by family planning agencies must be submitted with benefit code FP3.
- Family planning services billed by RHCs must include modifier AJ, AM, SA, or U7. These services must be billed using the appropriate national place of service (72) for an RHC setting.
- When completing a 2017, CMS-1500, or UB-04 CMS-1450 claim form, all required information must be included on the claim, as TMHP does not key any information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.
- All claims must be filed within approved filing deadlines.
- Denied claims may be appealed.

Providers may copy 2017 Claim Form on the TMHP website at www.tmhp.com.

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

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

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.9, "Family Planning Claim Form (Paper Billing)" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.9.1, "2017 Claim Form" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.5.4, "CMS-1500 Instruction Table" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.6.3, "UB-04 CMS-1450 Instruction Table" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about filing deadlines.

"Section 7: Appeals" (*Vol. 1, General Information*) for information about appealing claims.

Blocks that are not referenced are not required for processing by TMHP and may be left blank.

RHCs must use their National Provider Identifier (NPI), the appropriate benefit code as applicable, and the appropriate modifier and place of service as outlined in this section.

2.4.1.1 Family Planning and Third Party Liability

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

2.4.2 Billing Procedures for Non-Family-Planning Services Provided During a Family Planning Visit (Title XIX Only)

When a non-family-planning service is provided during a family planning visit or the client is offered family planning services during a medical visit, the following billing process must be used:

- A family planning clinic must bill for non-family-planning services using the performing provider's NPI and taxonomy code. The clinic NPI and taxonomy code is used to bill family planning services only.
- The performing provider must bill both family planning services and non-family-planning services, using the correct NPI and taxonomy code.
- The FQHC must bill both family planning services and non-family-planning services, using the correct NPI and taxonomy code.
- An RHC may bill a rural health encounter for a non-family-planning medical condition or use the physician's or NP's NPI and taxonomy code to bill for family planning services. If the RHC also is enrolled as a family planning agency, the family planning services may be billed using the agency's family planning NPI and taxonomy code and the appropriate national place of service (72) for an RHC setting.

2.4.3 National Drug Code

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

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2.4.4 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals and bulletins. Providers should refer to the 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 Breastfeeding Support Services

Breast pumps facilitate an infant's ability to receive their mother's own breast milk when it would be difficult to do so without equipment. Breast pump equipment is a benefit when provided by durable medical equipment (DME) suppliers and medical supply companies in the home. DME suppliers may deliver breast pump equipment to a client who is still in the hospital, but for claims purposes, the place of service should indicate the home setting.

Durable medical equipment (DME) is defined as medical equipment/appliances that are manufactured to withstand repeated use, ordered by a physician or an allowed practitioner for use in the home, and required to correct or ameliorate the client's disability, condition, or illness. Since there is no single authority (such as a federal agency) that confers the official status of "durable medical equipment" on any device or product, the Health and Human Services Commission (HHSC) retains the right to make such determinations with regard to DME provided by Texas Medicaid. DME provided by Texas Medicaid must either have a well-established history of efficacy, or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment corrects or ameliorates a Medicaid-eligible medical condition or functional disability.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or a clinical nurse specialist (CNS).*

A breast pump may be obtained under an eligible mother's Medicaid client number; however, if a mother is no longer eligible for Texas Medicaid and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Any provider who is familiar with the mother's or infant's health may order a breast pump. The ordering provider may include, but is not limited to, obstetricians, gynecologists, neonatologists, and pediatricians. Providers in the hospital setting or the community setting may write the order for breast pump equipment.

DME providers are not precluded from releasing equipment to infants with a Medicaid pending status when they have an order from the direct care provider. A Medicaid identification number is typically assigned to an infant within 24 hours, but it may take longer. During this time, DME providers are expected to release equipment to the client as ordered by the direct care provider who is familiar with the infant.

Note: *For clients who are 21 years of age or older, requests for breast pumps that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.*

Note: *Medicaid providers should supply breast pump equipment to qualifying clients. If clients do not meet criteria as outlined, mothers should also be informed that breast pumps may be available through the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC), contingent upon WIC's issuance criteria.*

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The American Academy of Pediatrics (AAP) recommends that infants exclusively breastfeed for the first six months and continue to breastfeed through 12 months of age or longer.

Breastfeeding refers to both the infant's feeding of breast milk directly from the breast as well as the feeding of mother's own expressed breast milk to the infant.

Breast milk provides unsurpassed nutrition and immune protections, influencing the growth and development of infants, and is a significant primary prevention strategy for improving infant health outcomes.

Breastfeeding is encouraged as a means to prevent various illnesses and conditions and to promote the health and wellness of mothers and infants. In some circumstances, breast pumps may be necessary for breastfeeding.

Breastfeeding reduces the infant's risk for illness, including ear infections, gastrointestinal and bacterial infections, respiratory infections, asthma, diabetes, obesity, and leukemia; and reduces the premature infant's risk of necrotizing enterocolitis. Breastfeeding also reduces the mother's risk of developing conditions including breast and ovarian cancers, diabetes, and cardiovascular disease. With proper breastfeeding support and management, breastfeeding may also be protective against post-partum depression.

Infant health can be directly impacted by the ability of the infant's mother to provide her own breast milk. Therefore, it is beneficial to enhance the opportunities for infants to receive their mother's milk through the use of equipment when needed.

The American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) advise that mothers who are infected with human immunodeficiency virus (HIV), Human T-lymphotropic virus (HTLV)-1, and HTLV-2 infection should not breastfeed as the virus may be passed to their infant.

All breast pumps must meet the following specifications:

- Comply, be registered, and be cleared with the Federal Drug Administration (FDA)
- Allow for pumping sessions to be efficiently completed within 30 minutes
- Be adaptable for several sizes of breast shields (flanges), including larger sizes, so as to accommodate different sizes of breasts and nipples
- Have an adjustable and wide-range of suction pressure at the breast shield during use, typically from 30 millimeters of mercury up to 250 millimeters of mercury (mm Hg)
- Have a mechanism or written guidelines to prevent or instruct the user from achieving a vacuum level over 250 mm Hg
- Be portable

The following breast pump procedure codes are a benefit of Texas Medicaid with the listed limitations:

Procedure Codes	Additional Information	Limitations
A4281, A4282, A4283, A4284, A4285, A4286, A4288	Breast pump parts for use with a pump that has been purchased. All parts must be submitted with modifier U8.	Each part - up to 2 times within 12 months from the breast pump date of purchase
E0602*	Purchase of a personal-use, manual breast pump	Once within 12 months from the date of birth
E0603*	Purchase of a personal-use, electric breast pump	
***Only one of these procedure codes may be reimbursed when submitted for the same date of service by any provider**		

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Procedure Codes	Additional Information	Limitations
E0604*	Rental of a multiple-user, hospital-grade electric breast pump	Initial 60-day rental, followed by up to three 90-day rentals within 12 months from the date of birth
***Only one of these procedure codes may be reimbursed when submitted for the same date of service by any provider**		

Modifier	Description
U8	U8 denotes the replacement of a part for durable medical equipment and must be used when submitting claims for any breast pump parts

The rental or purchase of a breast pump, as well as any replacements or parts, must be billed using the mother's Medicaid identification number, or if she is no longer eligible, using the infant's Medicaid identification number.

Personal-use breast pump is for use by only one individual. Personal-use pumps are not to be shared, or used by anyone other than the original owner. Use by more than one individual may pose a risk of cross-contamination, may result in infection or illness of mother and infant, and may void the equipment warranty.

A manual or electrical (AC and/or DC) personal-use breast pump may be considered for purchase only.

A multiple-user electric breast pump is also known as a hospital-grade electric breast pump. Hospital-grade electric breast pumps are designed for repeated uses throughout the pump's lifetime, by more than one woman and infant. The risk of cross-contamination is eliminated via a closed system. Pumped breast milk must not reach the motor. Hospital grade pumps are durable, heavy-duty breast pumps.

A hospital-grade breast pump may be considered for rental only.

Pump kits, which are specific to each breast pump manufacturer's requirements, provide the necessary supplies and accessories to allow expression of breast milk.

Procedure codes E0602 and E0603 will be denied when submitted within the same calendar month as procedure code E0604.

Procedure code E0602 will be denied when submitted within one year from procedure code E0603, any provider.

Claims for parts will not be reimbursed when billed for the same day as the purchase of breast pump equipment. Reimbursement is for purchase or rental, with documented medical necessity and prior authorization when appropriate, as outlined in this handbook.

Refer to: Subsection 2.3.2.3, "Breast Pump Claims Filing for MCO Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*) for more information related to breast pump coverage for newborns.

3.1 Breast Pump Kit Specifications

A breast pump kit is included in the purchase or rental of a breast pump, and is not separately reimbursed. Kits should include the following:

- Breast shields (flanges) that are adjustable and flexible, or flanges that are available in several different sizes if rigid, including larger sizes
- All accessories necessary for pumping two breasts simultaneously for electric pumps, or at least one breast manually for manual handle-squeeze pumps
- All parts necessary to easily convert an electric pump to a manual pump
- At least one extra set of membranes and valve replacements

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- At least one extra diaphragm replacement for closed-system pumps
- At least two collection bottles with spill-proof standard size caps, that are bisphenol-A (BPA) and DEHP-free
- Accessories and supplies must be compatible with the pump provided. Materials must be of durable quality for withstanding repeated boiling, washing, and pumping use.

3.2 Replacement Parts

Breast pump replacement parts (procedure codes A4281, A4282, A4283, A4284, and A4285) must be billed with modifier U8.

Replacement parts will be denied when submitted for the same date of service as a breast pump.

If the breast pump was not purchased by Texas Medicaid and requires replacement parts, the following documentation of a client-owned device must be submitted:

- Purchase date
- Serial number
- Purchasing entity of the device
- Copy of the receipt, if available

Note: *Parts for a hospital-grade electric breast pump (procedure code E0604), and routine servicing and all necessary repairs to ensure the unit remains functional for the client's needs, are included in the rental of the pump and is the responsibility of the DME supplier.*

Refer to: Subsection 6.4.1, "National Correct Coding Initiative (NCCI) Guidelines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about NCCI MUE guidelines.

3.3 Personal-Use Manual Breast Pump Medical Necessity Criteria

Manual breast pumps (procedure code E0602) are personal-use, hand-operated, handle-squeeze pumps that are appropriate for short-term or occasional uses related to, but not limited to, any of the following:

- Infrequent separation from infants; such as mothers who work or go to school part-time for less than 10 hours per week, and who do not meet criteria for electric or hospital-grade pumps.
- Resolving brief uncomplicated periods of plugged duct
- Short-term concerns of mild engorgement
- Flat, retracted, or inverted nipples, and the mother does not meet the criteria for electric or hospital-grade pumps
- Cracked or fissured nipples, and the mother does not meet the criteria for electric or hospital-grade pumps

Note: *Manual breast pumps are not recommended for pumping on a regular basis, or for attempting to establish a milk supply.*

3.3.1 Specifications

Manual breast pumps must include an independent milk collection bottle. The pump cylinder must not be the milk-collecting container.

3.4 Personal-Use Electric Breast Pump Medical Necessity

Electric Breast Pumps (procedure code E0603) have a motor and are electrically (AC and/or DC) operated. Personal-use double-collection electric breast pumps are recommended for their functionality and efficiency; they allow expression of breast milk from both breasts simultaneously.

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Personal use double-collection electric breast pumps are for mothers and infants who are breastfeeding with limited, minor, or no complications. Personal-use double-collection electric breast pumps are recommended for pumping and maintaining a milk supply related to, but not limited to, any of the following:

- Regular separation from infants; such as mothers returning to work or school for 10 or more hours per week
- Infants detained in the hospital, who do not meet the criteria for a multiple-user electric breast pump
- Significant breast engorgement
- Breast abscess
- Mastitis
- If the mother is to receive short-term treatment with medication or therapies that may be transmitted through breast milk, but she wishes to maintain her milk supply by pumping and discarding her milk in the interim

3.4.1 Specifications

Electric breast pumps must meet the following specifications:

- Be adaptable for simultaneous pumping of both breasts (double-collection)
- Have an adjustable suction pressure range necessary for preventing nipple trauma
- Automatically cycle with an adjustable variable cycling rate, typically 30 to 60 or more cycles per minute
- Include a battery option or adapter to be used as an alternate power source when electricity is not immediately available

Note: *Personal-use, single-collection electric pumps cannot simultaneously pump both breasts. Single-collection pumps are not recommended, as they are neither effective in maintaining a long-term milk supply nor efficient when pumping during short periods, such as work breaks. Double-collection breast pumps are the standard personal-use electric pump recommended by Texas Medicaid for breastfeeding infants and mothers.*

3.5 Hospital-Grade Electric Breast Pump Medical Necessity Criteria

Multiple-user, hospital-grade electric breast pumps (procedure code E0604) are heavy-duty, durable, closed-system pumps designed to be loaned multiple times throughout the pump's lifespan.

Rental of a multiple-user, hospital-grade electric breast pump is recommended for moderate to significant breastfeeding complications. Hospital-grade electric breast pumps are recommended for pumping related to, but not limited to, any of the following:

- Infants who cannot suck well, or have an uncoordinated swallow/suck reflex, due to respiratory disease or congenital disorder
- Infants diagnosed with failure to thrive, cardiac problems, or other special needs
- Infants who are chronically ill
- Infants of low birth-weight with increased nutritional needs
- Infants with severe feeding or digestive problems, as described by the provider in documentation
- Prematurity (less than 37 weeks gestation)
- Multiple births (e.g., twins, triplets, etc.)

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- Long-term separation of mother and infant due to hospitalization
- Mothers experiencing conditions affecting their milk production, or low-milk supply, as described in documentation by the prescribing provider familiar with the client
- Mothers needing to induce lactation for establishing their milk supply, but are unable to do so without a hospital-grade breast pump

Note: *A closed-system pump requires a personal-use milk collection pump kit, included in the rental, but to be kept by the individual and not for return with the pump.*

3.5.1 Specifications

Use of a hospital-grade breast pump may be covered when the use of a hospital-grade breast pump is determined to be medically necessary and appropriate, as documented by the provider.

A hospital-grade electric breast pump must meet the following specifications:

- Be adaptable for simultaneous pumping of both breasts with an adjustable suction for preventing nipple trauma
- Automatically cycle with adjustable or variable cycling that closely mimics the suckling action of an infant
- Electrical (AC and/or DC)
- Include an adapter to be used as an alternate power source when electricity is not immediately available
- Must not allow milk to contact the housing unit or internal pump-motor at any time when the multiple-user pump is used per manufacturer's instructions

3.6 Prior Authorization

A completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form prescribing the DME and/or supplies must be signed and dated by a physician or an allowed practitioner familiar with the client, before requesting prior authorization for all DME equipment and supplies. The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form must include the procedure codes and quantities for services requested.

The completed Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form with the original dated signature must be maintained by the prescribing physician or allowed practitioner in the client's medical record. A copy of the completed, signed, and dated form must be maintained by the DME provider in the client's medical record.

To complete the prior authorization process by paper, the DME provider must fax or mail the completed form to the Home Health Services Prior Authorization Department. To complete the prior authorization process electronically, the DME provider must submit the prior authorization requirements through any approved electronic methods.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician or allowed practitioner must provide correct and complete information, including documentation for medical necessity of the medical equipment and/or supplies requested and is subject to retrospective review. The physician or allowed practitioner must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for breastfeeding equipment.

3.6.1 Replacement Parts

Prior authorization is not be required for up to 2 replacements of each part within 12 months from the breast pump's date of purchase.

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Prior authorization is required for parts that exceed the limitations outlined in this handbook.

Requests must be submitted with appropriate documentation to support the need for additional replacement parts. The following documentation must be included under "If applicable" in section B of the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form:

- The provider must attest that the mother continues to use the equipment for breastfeeding.
- The provider must indicate that the requested part is required for improved pumping efficiency (e.g., larger flanges), or is damaged or lost and affecting the function of the pump.

3.6.2 Personal-Use Manual or Electric Breast Pumps

Prior authorization is not required for the purchase of a manual or electric personal-use breast pump, within 12 months from the date of birth. Prior authorization is required for the replacement of a manual or electric personal-use breast pump due to damage or loss, within 12 months from the purchase date.

Requests for the replacement of a Texas Medicaid purchased personal-use breast pump (procedure code E0602 or E0603) must include the following documentation:

- A statement from the provider describing the loss or damage and what measures will be taken to prevent reoccurrence
- A copy of the police or fire report, when appropriate. The report must also be maintained in the client's medical record.

Note: *HHSC or its designee reserves the right to request additional documentation about the need for replacement when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. Requests for replacement when there is documented proof of abuse or neglect will not be approved.*

3.6.3 Hospital-Grade Breast Pump

The initial 60-day rental of a hospital-grade pump does not require prior authorization.

The subsequent rental of a hospital-grade breast pump does require prior authorization. Subsequent rental requests may be considered for 90-day increments only. A maximum of 3 prior-authorized 90-day increments will be allowed within the 12 months following birth.

If an infant with medical necessity requires the extended rental of a hospital-grade electric breast pump, beyond these limitations, the claim may be considered for reimbursement upon appeal with documentation.

The prescribing provider familiar with the client must identify pumping as the mother's primary method for expressing her breast milk, and must include a statement that clearly describes the infant's medical necessity. Medically necessary conditions may include the following:

- Short-bowel syndrome
- Severe malabsorption syndromes
- Severe feeding intolerances or immunological deficiencies

Clients who no longer qualify for the continued rental of a hospital-grade breast pump may still qualify for the purchase of a breast pump as outlined in this handbook.

Purchase of a manual breast pump will not be reimbursed during the rental of a hospital-grade pump or if a personal-use electric breast pump was already purchased within the frequency limitations outlined in this handbook.

Purchase of a personal-use electric breast pump will not be reimbursed during the rental of a hospital-grade breast pump.

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A hospital-grade electric breast pump will be considered purchased and owned by the client when the monthly payments for rental, through the same provider, equals the purchase cost for the equipment.

The following is required:

- The DME provider must notify the client when the rental equipment is considered purchased due to an extended rental. Proof of ownership must be provided to the client by the DME provider.
- Proof of client ownership of the device is required for reimbursement of replacement parts
- A statement from the DME provider indicating the make and model of the client-owned device, along with proof of client ownership, must be submitted with claim appeals for reimbursement of parts.

A hospital-grade breast pump that has been purchased due to extended rental is anticipated to last the minimum time frame indicated by the manufacturer's warranty.

3.7 Documentation Requirements

Direct care providers must maintain the following documentation in the client's medical record:

- Client's specific medical necessity regarding the specific type of breast pump equipment ordered
- Anticipated duration of need regarding the circumstances or conditions related to the type of equipment ordered
- Infant's age (or gestational age, if premature)
- Documentation of the mother's intent to breastfeed

3.7.1 DME Certification Form

The DME Certification and Receipt Form must be submitted by DME claims and appeals when:

- A single item meets or exceeds a billed amount of $2,500
- Multiple items submitted on the same date of service meet or exceed a total billed amount of $2,500

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the following:

- Name of the item
- Date the client received the DME
- Date signature of the DME provider and the client or client's primary caregiver

The signed and dated form must be maintained by the DME provider in the client's record.

Claims submitted without the DME Certification and Receipt Form will be denied.

Clients who receive DME meeting or exceeding a total billed amount of $2,500 may be contacted to verify receipt of the equipment. If receipt of the equipment cannot be verified, the claim payment is eligible for recoupment.

3.8 Services that are not a Benefit

The following breastfeeding support services are not benefits of Texas Medicaid:

- Personal-use electric breast pumps that are only capable of single-collection pumping, one breast at a time
- Breastfeeding support services in the preconception or prenatal period
- Breastfeeding support services for infants who are not breastfeeding and the mother has no intent to breastfeed

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4 Obstetric Services

4.1 Services, Benefits, Limitations, and Prior Authorization

Antepartum care, antenatal surveillance, perinatal procedures, infant deliveries, and postpartum care are a benefit of Texas Medicaid.

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by TMHP within 95 days of the date of service.

Medicaid may reimburse only one delivery or Cesarean section procedure code per client in a seven-month period; reimbursement includes multiple births. Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except when it is decided a cesarean delivery is required following neuraxial labor analgesia. Procedure code 01967 may be reimbursed separately with cesarean procedure codes 59514, 59515, 59620 and 59622.

Refer to: Subsection 9.2.7.3, "Anesthesia for Labor and Delivery" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information related to anesthesia reimbursement.

Procedure code 99140 is not considered for reimbursement when submitted with diagnosis code O80 for a normal delivery or with diagnosis code O82 for a Cesarean delivery when one of these diagnosis codes is documented on the claim as the referenced diagnosis. The referenced diagnosis must indicate the complicating condition. An emergency is defined as a situation when delay in treatment of the client poses a significant health threat to a client's life, bodily organ, or body part.

Hospital admissions resulting from conditions or comorbidities complicating labor should be billed using the appropriate E/M procedure codes. These codes are not subject to the three-day pre-care period but are not payable on the date of delivery or the following six-week post-care period.

The procedure codes listed in the tables below may be reimbursed by Texas Medicaid. Providers can refer to the Texas Medicaid Static Fee Schedules and the Online Fee Look-up for rate and coverage information about specific procedure codes.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures. Medical record documentation must include assessment findings that substantiate the medical necessity for each diagnostic test performed.

4.1.1 Antepartum and Fetal Invasive Procedures

The following procedure codes may be submitted for antepartum and fetal invasive procedures:

Procedure Codes									
36460	59000	59001	59012	59015	59020	59025	59030	59050	59051

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Procedure Codes									
59070	59074	59076	82731	84112					

Antenatal surveillance includes fetal contraction stress test (procedure code 59020), fetal nonstress test (procedure code 59025), and fetal biophysical profile with or without nonstress testing (procedure code 76818 or 76819).

The American Congress of Obstetricians and Gynecologists (ACOG) states "because antepartum fetal surveillance results have not been definitively demonstrated to improve perinatal outcome, all indications for antepartum testing must be considered somewhat relative. In general, antepartum fetal surveillance has been employed in pregnancies in which the risk of antepartum fetal demise is increased." Accordingly, some of the conditions under which testing may be appropriate, include but are not limited to the following:

- Maternal conditions:
  - Antiphospholipid syndrome
  - Hyperthyroidism (poorly controlled)
  - Hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
  - Cyanotic heart disease
  - Systemic lupus erythematosus
  - Chronic renal disease
  - Type I diabetes mellitus
  - Hypertensive disorders
- Pregnancy-related conditions:
  - Pregnancy-induced hypertension
  - Decreased fetal movement
  - Oligohydramnios
  - Polyhydramnios
  - Intrauterine growth restriction
  - Postterm pregnancy
  - Isoimmunization (moderate to severe)
  - Previous fetal demise (unexplained or recurrent risk)
  - Multiple gestation (with significant growth discrepancy)

Procedure codes 59020 and 59025 billed with revenue code 729 for outpatient facilities may be reimbursed on the same day by a different provider without appeal; however, if billed more than once per day by the same provider, it will be denied. The provider may appeal with documentation supporting the performance of the test more than once on the same day by the same provider.

A fetal fibronectin (fFN) enzyme immunoassay (procedure code 82731) may be considered for reimbursement through Texas Medicaid when performed between 22 0/7 and 34 6/7 weeks for women with risk factors for preterm labor with or without symptoms of preterm labor.

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Fetal intrauterine transfusion (procedure code 36460) and cordocentesis (procedure code 59012) are restricted to the diagnoses listed in the following table:

Diagnosis Codes							
O353XX0	O353XX1	O353XX2	O353XX3	O353XX4	O353XX5	O353XX9	O358XX0
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999
O368210	O368211	O368212	O368213	O368214	O368215	O368219	O368220
O368221	O368222	O368223	O368224	O368225	O368229	O368230	O368231
O368232	O368233	O368234	O368235	O368239	O368290	O368291	O368292
O368293	O368294	O368295	O368299	O4690	O4691	O4692	O4693

FIUT (procedure code 36460) is reimbursed as a global fee and, therefore, includes all other services provided by the same physician, including umbilical blood sampling or cordocentesis (procedure code 59012).

Appeals for cordocentesis performed for a diagnosis other than the ones listed in the appropriate table in the policy will be reviewed on a case by case basis.

In addition to the physician performing the FIUT (procedure code 36460), another physician may assist with echography control.

Therapeutic amniocentesis (procedure code 59001) is restricted to the following diagnosis codes:

Diagnosis Codes							
O401XX0	O401XX1	O401XX2	O401XX3	O401XX4	O401XX5	O401XX9	O402XX0
O402XX1	O402XX2	O402XX3	O402XX4	O402XX5	O402XX9	O403XX0	O403XX1
O403XX2	O403XX3	O403XX4	O403XX5	O403XX9	O409XX0	O409XX1	O409XX2
O409XX3	O409XX4	O409XX5	O409XX9				

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Transabdominal amnioinfusion (procedure code 59070), fetal fluid drainage (e.g., vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance (procedure code 59074), and fetal shunt placement, including ultrasound guidance (procedure code 59076) are restricted to one of the following diagnosis codes:

Diagnosis Codes							
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999

4.1.2 Vaginal and Cesarean Deliveries

The following procedure codes submitted with the appropriate modifier may be a benefit for vaginal or Cesarean deliveries:

Procedure Codes									
59409	59410	59514	59515	59612	59614	59620	59622	S8415*	
*** Procedure code S8415 is for home delivery supplies**									

One of the following modifiers must be billed with the procedure codes indicated above for vaginal and cesarean deliveries:

Modifiers	
U1	Prior to 39 Weeks and Medically Necessary
U2	39 Weeks or Later
U3	Prior to 39 Weeks and Not Medically Necessary

Claims will deny if submitted for a delivery prior to 39 weeks of gestation and not medically necessary, or for a delivery service with no modifier.

Claims will deny or recoupment will occur for associated claims for deliveries that are performed prior to 39 weeks and are determined to be not medically necessary including:

- Claims for the provider performing the vaginal or Cesarean delivery
- Inpatient and outpatient hospital claims inclusive of the delivery, planned Cesarean section, induction with vaginal delivery or failed induction with subsequent Cesarean section
- Birthing center claims inclusive of induction with vaginal delivery

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- Claims for medical or surgical admission, including ICU, due to the complications of the delivery for the mother

Home deliveries must be billed with procedure code 59409 or 59410; including postpartum care.

Licensed midwives will not be reimbursed for home deliveries.

4.1.2.1 Home Deliveries

Home deliveries and the home supplies for the delivery (S8415) require submitting a written prior authorization request during the client's third trimester of pregnancy. Home deliveries will not be prior authorized to a licensed midwife.

Documentation must include:

- A statement signed by a licensed physician who examined the client during the third trimester and determined at the time of examination the client is not at high risk for complications and is suitable for a home delivery
- A plan for access to emergency transport for mother and neonate, if needed

4.1.3 Elective Deliveries Prior to 39 Weeks

Texas Medicaid restricts any Cesarean section, labor induction, or any delivery following labor induction to one of the following criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery

Note: *Records are subject to retrospective review. Payments made for Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria (as determined by review of medical documentation), are subject to recoupment. Recoupment may apply to all services related to the delivery, including additional physician fees, birthing center, and inpatient and outpatient hospital fees.*

4.1.4 Other Vaginal and Cesarean Delivery Procedures

The following vaginal and Cesarean delivery procedures do not require vaginal and Cesarean delivery modifiers:

Procedure Codes	
59414	59525

Refer to: Subsection 4.1.8, "Obstetric Ultrasound" in this handbook for information about ultrasound limitations.

4.1.5 Surgical Treatment of Early Intrauterine Failed Pregnancy

A provider must conduct an evaluation to make a definitive diagnosis of early intrauterine failed pregnancy; this may include a comprehensive medical history and examination, serum human chorionic gonadotropin (hCG) testing, other lab tests, and ultrasound examination.

The following procedure codes may be submitted for surgical management of early intrauterine failed pregnancy. The provider must choose the most appropriate code:

Procedure Codes		
59812	59820	59821

Performing providers must maintain appropriate documentation in the medical record of the client's early intrauterine failed pregnancy and the surgical treatment provided for the individual circumstances.

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Surgical treatment of early intrauterine failed pregnancy (procedure codes 59812, 59820, and 59821) must include one of the following diagnosis codes as the reference or primary diagnosis on the claim. The provider must choose the most appropriate code:

Diagnosis Codes					
O021	O0339	O034	O071	O0730	O0739

4.1.6 Abortion

The following procedure codes may be submitted for abortion services:

Procedure Codes								
59830	59840	59841	59850	59851	59852	59855	59856	59857

Abortion services are benefits of Texas Medicaid if submitted with the following modifier:

Modifier	Description
G7	Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening

In accordance with federal directives, abortions may be reimbursed when performed to save the life of the mother or for pregnancies resulting from rape or incest.

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

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

One of the following statements, signed by the physician is mandatory for any abortion performed. Substitute wording will not be accepted. One of these statements must accompany any claim for abortion in order for reimbursement to be made:

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure is necessary because (client's full name, Medicaid number, and complete address) suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place her in danger of death unless an abortion is performed."

  Signature

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name, Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of rape. I have counseled the client concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities."

  Signature

- "I, (physician's name), certify that on the basis of my professional judgment, an abortion procedure for (client's full name Medicaid number, and complete address) is necessary to terminate a pregnancy that was the result of incest. I have counseled the client concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities."

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Signature

A stamped or typed physician signature on the original certification statement is not acceptable. The physician signature must be an original signature. A copy of the signed certification statement must be submitted with each claim for reimbursement. Faxes are not acceptable at this time. The physician must maintain the original certification statement in the client's file.

Abortion services must be billed with modifier G7.

Performing physicians, facilities, anesthesiologists, and certified respiratory nurse anesthetist (CRNA) providers must submit modifier G7 with the appropriate procedure code when requesting reimbursement for abortion procedures that are within the scope of the rules and regulations of Texas Medicaid. Modifier G7 must be submitted with the procedure code that identifies abortion services.

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

4.1.6.1 Services Related to Abortion Procedures

An anesthesia service that is provided for an abortion procedure may be reimbursed if the abortion procedure meets medical necessity criteria and complies with the Texas Medicaid guidelines in the section above.

All other services that are related to abortion services are also subject to medical necessity review. All services that are related to a non-covered abortion procedure will be denied or recouped.

4.1.7 Other Maternity Care and Delivery Services

The following procedure codes may be submitted for other maternity care and delivery services:

Procedure Codes									
59100	59160	59200	59300	59320	59325	59350	59412	59870	59871
59897	59898	59899							

4.1.8 Obstetric Ultrasound

The following procedure codes may be submitted for obstetric ultrasound services:

Procedure Codes									
76801	76802	76805	76810	76811	76812	76813	76814	76815	76816
76817									

Texas Medicaid requires providers to follow the documentation requirements as set forth in the Diagnostic Ultrasound section of the Current Procedural Terminology (CPT) manual for the diagnostic studies of the fetus, including when ultrasound is used to guide a procedure.

Documentation requirements set forth in the CPT manual include, but are not limited to:

- Permanently recorded images with measurements, when measurements are clinically indicated
- Final written report included in the client's medical record (includes written interpretation)
- Report must include description of elements that comprised a "complete" or "limited" exam and the reasons an element could not be visualized
- Permanently recorded images are also required for ultrasound guidance procedures of the site to be localized. In addition, description of the localization process, either separately or within the report of the procedure when the guidance is utilized.

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Permanently recorded images must be available on request by the Texas Health and Human Services Commission (HHSC).

Prior authorization is required for greater than three obstetrical ultrasounds per pregnancy. Requests for additional obstetric ultrasounds may be considered when submitted with documentation of medical necessity on the Obstetric Ultrasound Prior Authorization Request Form.

Refer to: Obstetric Ultrasound Prior Authorization Request Form on the TMHP website at www.tmhp.com.

Authorization is not required for obstetric ultrasounds performed in the emergency department, outpatient observation, or inpatient hospital setting.

Texas Medicaid follows the American Congress of Obstetricians and Gynecologists (ACOG) indications for sonography.

First trimester ultrasounds may be medically necessary for, but not limited to, the following conditions:

- Confirm the presence of an intrauterine pregnancy
- Evaluation of a suspected ectopic pregnancy
- Evaluation of vaginal bleeding
- Evaluation of pelvic pain
- Estimation of gestational age
- Diagnosis or evaluation of multiple gestations
- Confirmation of cardiac activity
- Adjunct to chorionic villus sampling or localization and removal of an intrauterine device
- Assessment of certain fetal anomalies, such as anencephaly, in clients at high risk
- Evaluation of maternal pelvic or adnexal masses or uterine abnormalities
- Screening for fetal aneuploidy
- Evaluation of suspected hydatidiform mole

Second- and third-trimester ultrasounds may be medically necessary for the following conditions:

- Estimation of fetal age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal and pelvic pain
- Determination of fetal presentation
- Adjunct to amniocentesis or other procedure
- Evaluation of suspected multiple gestation
- Evaluation of a significant discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Evaluation of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of a suspected ectopic pregnancy

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- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation for fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Adjunct to external cephalic version
- Evaluation for premature rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa
- Evaluation for clients with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment of findings that may increase the risk of aneuploidy
- Screening for fetal anomalies

A request for retroactive authorization must be submitted no later than 14 calendar days, beginning the day after the study is completed.

Requests for prior authorization or retroactive authorization may be submitted by mail or an approved electronic method.

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, dated, and maintained in the client's medical record by the provider requesting the test. The form must include information related to medical necessity of the test including all of the following:

- Procedure requested (CPT code) and quantity requested
- The trimester(s) during which the requested ultrasounds will be performed
- The date range during which the procedure(s) will be performed
- Client's estimated date of confinement (EDC) at the time the request is submitted
- Diagnosis

Additional documentation to support medical necessity may include any of the following:

- Treatment history
- Treatment plan
- Medications
- Previous imaging results

The Obstetric Ultrasound Prior Authorization Request Form must be completed, signed, and dated by the ordering provider (physician, nurse practitioner/clinical nurse specialist, certified nurse midwife [CNM], or physician assistant) when requesting prior authorization for obstetric ultrasounds, regardless of the method of request for authorization.

Residents may order obstetric ultrasounds; however, the attending physician must sign the authorization form and provide the group or supervising provider's NPI

Providers may be requested to provide additional documentation.

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Obstetric ultrasounds provided in the emergency department or outpatient observation must be submitted with Modifier U6 when submitted on the professional claim form in order to be considered for reimbursement.

Obstetric ultrasounds provided in the emergency department or hospital observation must be submitted with the appropriate corresponding emergency services or hospital observation revenue code in order to be considered for reimbursement.

Note: *Any obstetric ultrasound performed in the emergency department or hospital observation will not count toward the limit of three per pregnancy.*

Any obstetric ultrasound claims submitted with or without prior authorization for the initial three will count toward the limit of three per pregnancy.

For transvaginal obstetric ultrasound performed in addition to one of the transabdominal examinations, documentation is required to substantiate the need to perform both tests on the same day.

Reimbursement for obstetric ultrasounds may be considered on appeal when submitted with documentation of any one of the following:

- Ultrasound was performed for a different pregnancy
- The provider was unable to obtain the previous ultrasound records from a different provider
- The provider was new to treating the client and was not aware the client had received three obstetric ultrasounds

Only one appeal will be considered per client for the same provider. Providers must obtain prior authorization for additional obstetric ultrasounds performed after the appealed service.

Add-on procedure codes (76802, 76810, 76812, and 76814) when billed with the primary procedure code for obstetric ultrasounds do not count toward the limit of three per pregnancy.

Claims for add-on codes for multiple fetuses should be billed with Modifier 76 if greater than one additional fetus. Claims for multiple fetuses greater than two will be considered on appeal with documentation indicating number of fetuses.

Three dimensional (3-D) rendering of obstetric ultrasound (procedure code 76376 or 76377) is not a benefit of Texas Medicaid.

Procedure code 76810 must be billed in conjunction with primary procedure code 76805, by the same provider.

Procedure code 76812 must be billed in conjunction with primary procedure code 76811, by the same provider.

Procedure code 76814 must be billed in conjunction with primary procedure code 76813, by the same provider.

4.1.9 Diagnostic Ultrasound and Ultrasonic Guidance

The following procedure codes may be submitted for diagnostic ultrasound and ultrasonic guidance services:

Procedure Codes			
76818	76819	76941	76946

Ultrasonic guidance (procedure code 76941) is restricted to the diagnoses listed in the following table:

Diagnosis Codes							
O353XX0	O353XX1	O353XX2	O353XX3	O353XX4	O353XX5	O353XX9	O358XX0

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Diagnosis Codes							
O360110	O360111	O360112	O360113	O360114	O360115	O360119	O360120
O360121	O360122	O360123	O360124	O360125	O360129	O360130	O360131
O360132	O360133	O360134	O360135	O360139	O360190	O360191	O360192
O360193	O360194	O360195	O360199	O360910	O360911	O360912	O360913
O360914	O360915	O360919	O360920	O360921	O360922	O360923	O360924
O360925	O360929	O360930	O360931	O360932	O360933	O360934	O360935
O360939	O360990	O360991	O360992	O360993	O360994	O360995	O360999
O361110	O361111	O361112	O361113	O361114	O361115	O361119	O361120
O361121	O361122	O361123	O361124	O361125	O361129	O361130	O361131
O361132	O361133	O361134	O361135	O361139	O361190	O361191	O361192
O361193	O361194	O361195	O361199	O361910	O361911	O361912	O361913
O361914	O361915	O361919	O361920	O361921	O361922	O361923	O361924
O361925	O361929	O361930	O361931	O361932	O361933	O361934	O361935
O361939	O361990	O361991	O361992	O361993	O361994	O361995	O361999
O368210	O368211	O368212	O368213	O368214	O368215	O368219	O368220
O368221	O368222	O368223	O368224	O368225	O368229	O368230	O368231
O368232	O368233	O368234	O368235	O368239	O368290	O368291	O368292
O368293	O368294	O368295	O368299	O4690	O4691	O4692	O4693

Ultrasonic guidance for intrauterine fetal transfusion (procedure code 76941) will be reimbursed separately when billed by a different physician.

Fetal biophysical profile (procedure code 76818 or 76819), when billed with 76805, 76810, 76811, 76812, 76813, 76814, 76815, or 76816, will be reimbursed separately.

4.1.10 Doppler Studies

The following procedure codes may be submitted for doppler study services:

Procedure Codes	
76820	76821

As supported by ACOG, umbilical artery doppler (procedure code 76820) is limited to suspected intrauterine growth restriction (IUGR), post-term gestation, diabetes mellitus, systemic lupus erythematosus, or antiphospholipid antibody syndrome.

Middle cerebral artery doppler (procedure code 76821) is indicated, but not limited to fetuses who are alloimmunized.

4.1.11 Echocardiography

The following procedure codes may be submitted for echocardiography services:

Procedure Codes			
76825	76826	76827	76828

Fetal echocardiography (procedure codes 76825, 76826, 76827, and 76828) may be reimbursed for the following factors/syndromes:

- Fetal Risk Factors

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- Extracardiac anomalies
  - Chromosomal
  - Anatomic
- Fetal cardiac dysrhythmia
  - Irregular rhythm
  - Tachycardia
  - Bradycardia
- Nonimmune hydrops fetalis
- Suspected cardiac anomaly on ultrasound
- Abnormal fetal situs

- Maternal Risk Factors
  - Congenital heart disease
  - Cardiac teratogen exposure
    - Lithium
    - Alcohol
    - Phenytoin
    - Trimethadione
    - Isoretinoin
  - Maternal Metabolic Disorders
    - Diabetes mellitus
    - Phenylketonuria
- Familial Risk Factors for congenital heart disease
  - Previous sibling
  - Paternal
- Syndromes
  - Marfan's
  - Noonan's
  - Tuberous sclerosis

4.1.12 Fetal Surgery

The following procedure codes may be submitted for fetal surgery:

Procedure Codes						
59072	S2401	S2402	S2403	S2405	S2409	S2411

Fetal surgery procedures require prior authorization.

Prior authorization requests must be submitted on a Special Medical Prior Authorization (SMPA) Request Form to the SMPA department.

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Refer to: Special Medical Prior Authorization (SMPA) Request Form on the TMHP website at www.tmhp.com.

Procedure codes S2401, S2402, S2403, S2405 and S2409 may be authorized for Texas Medicaid only when the hospital is a member of the North American Fetal Therapy Network (NAFTNet).

The pediatric surgeon for procedure codes S2401, S2402, S2403, S2405, or S2409 must submit documentation which includes:

- A clear description of the fetal malformation(s). The malformation(s) must interfere with the in utero organ development and fetal survival and have potential fatal consequences before or after birth
- Evidence that in utero correction of the fetal congenital malformation(s) results in a clinical outcome that is better than that which would be seen in expectant management

Note: *Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.*

Umbilical cord occlusion (procedure code 59072) may be considered when all the following is documented:

- Diagnosis of monoamniotic-monochorionic twins is present
- Spontaneous fetal death of one of the twins with the presence of hydrops
- The ratio of the acardia twin weight to the pump twin weight is greater than 50 percent
- The abdominal circumference of the twin with reversed arterial perfusion fetus is greater than or equal to the abdominal circumference of the pump twin

Note: *Elective abortions are not benefits of Texas Medicaid*

Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome (procedure code S2411) may be considered when all the following are documented:

- Fetal gestational age of less than 26 weeks
- Evidence of polyhydramnios in the recipient fetus
- Donor fetus is oligohydramniotic
- Evidence of abnormal blood flow documented by Doppler studies in one or both fetuses

4.1.13 Antenatal and Postnatal Care Visits

The following procedure codes may be submitted for antenatal and postnatal care visits:

Procedure Codes									
59430	99202	99203	99204	99205	99211	99212	99213	99214	99215
99341	99342	99344	99345	99347	99348	99349	99350		

Texas Medicaid reimburses prenatal care, deliveries, and postpartum care as individual procedures.

Prenatal and postpartum care visits billed in an inpatient hospital (place of service 3), will be denied as part of another procedure when billed within the three days before delivery or the six weeks after delivery. The inpatient intrapartum and postpartum care are included in the fee for the delivery or Cesarean section and should not be billed separately.

Physicians (obstetricians, family practice physicians, and maternal-fetal medicine specialists), CNMs, and maternity service clinics (MSCs) are limited to 20 prenatal care visits per pregnancy and one postpartum care visit after discharge from the hospital.

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Licensed midwives (LMs) are limited to 20 outpatient antepartum care visits per pregnancy to be performed in a birthing center; postpartum visits are not separately reimbursed. Routine pregnancies are anticipated to require around 11 visits per pregnancy and high-risk pregnancies are anticipated to require around 20 visits per pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk obstetrical visits are not limited to 20 visits per pregnancy. The provider can appeal with documentation supporting a complication of pregnancy. Documentation reflecting the need for increased visits must be maintained in the physician's files and is subject to retrospective review.

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

New patient and established patient evaluation and management services for antenatal and postnatal visits (procedure codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215) may be provided via a telemedicine service delivered using synchronous audiovisual technology if clinically appropriate and safe, as determined by the provider, and agreed to by the person receiving services. Whenever possible, HHSC encourages face-to-face interaction, such as an in-person visit.

New and established patient evaluation and management services delivered using synchronous audio-visual technology must be billed using modifier 95.

Refer to: *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) and the *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) restrictions for services delivered using synchronous audiovisual technology.

During a Declaration of State of Disaster, HHSC may issue direction to providers regarding the use of a telemedicine or telehealth services to include the use of a synchronous telephone (audio-only) platform to provide covered services outside of the allowances described herein. A Declaration of State of Disaster is when an executive order or proclamation by the governor declaring a state of disaster in accordance with Section 418.014 of the Texas Government Code.

Refer to: Subsection 9.2.60.1.1, "New and Established Patient Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about established patient E/M services.

When billing for prenatal services, use modifier TH with the appropriate E/M procedure code to the highest level of specificity.

Note: *Failure to use the TH modifier may result in recoupment of payment rendered.*

LMs are not reimbursed for postpartum visits.

One postpartum care procedure code may be reimbursed per pregnancy. The claim for the postpartum visit may be submitted with either procedure code 59430 or with a delivery procedure code (59410, 59515, 59614, or 59622) that includes postpartum care. The reimbursement amount for the submitted procedure code covers all postpartum care per pregnancy regardless of the number of postpartum visits provided.

Postpartum depression screening is a benefit at the infant's Texas Health Steps medical checkup or follow-up visit, as a separately reimbursed service in the 12 months following the infant's birth.

Refer to: Section 4.3.12.1.4, "Postpartum Depression Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information regarding postpartum depression screening for mothers during the infant's Texas Health Steps medical checkup or follow-up visit.

Any other E/M office visit will not be reimbursed when billed on the same date of service, by the same provider, as any antenatal or postpartum office visit. Modifier 25 may be used to identify a significant separately identifiable E/M service by the same physician on the same date of service as the procedure

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or other service. Documentation that supports the provision of a significant, separately identifiable E/M service must be maintained in the client's medical record and made available to Texas Medicaid upon request.

Note: *All unlisted surgical procedure codes have a 42 global period assigned by Texas Medicaid.*

4.1.13.1 Maternity Service Clinic (MSC)

MSCs are limited provider clinics, unrelated to a hospital, that only provide maternity services. An MSC will be reimbursed for antepartum and/or postpartum care visits only. Hemoglobin, hematocrit, and urinalysis procedures are included in the charge for antepartum care and not separately reimbursed. Services other than antepartum and postpartum care visits will be denied.

4.1.14 Birthing Centers—Professional Services

The following procedures may be performed by professionals in the birthing center setting:

Procedure Codes				
59409	59410***	99221	99222	99223
***Licensed Midwives may not use code 59410.				

The following table includes procedure codes that may be benefits for licensed midwife (LM) services rendered in the birthing center setting:

Procedure Codes						
59409	99202	99211	99212	99221	99222	99223

Note: *Licensed Midwives may not use code 59410.*

Antenatal services provided by LMs may be a benefit when billed with modifier TH. If the client is discharged prior to delivery, procedure codes 99221, 99222, or 99223 may be billed by the professional for labor services only. Clinical documentation that clearly demonstrates level of medical decision making (i.e., moderate or complex) must be included in the client's medical record. All medical documentation is subject to retrospective review. Those services not supported by the documentation in the client's medical record are subject to recoupment.

Refer to: Subsection 9.2.47, "Newborn Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information related to the care of the newborn.

4.1.15 Birthing Centers—Facility Services

The following procedures may be performed by birthing center facilities:

Procedure Codes	
59409	S4005

Deliveries at a facility licensed as a birthing center by the Department of State Health Services (DSHS) must be billed with procedure code 59409.

If the client is discharged prior to delivery, procedure code S4005 may be billed by the facility for labor services only.

4.1.16 Smoking and Tobacco Use Cessation Counseling

Counseling for cessation of the habit of using tobacco products by pregnant women is a benefit of Texas Medicaid.

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The following procedure codes listed may be billed for smoking and tobacco use cessation counseling using an applicable diagnosis code:

Procedure Codes	
99406	99407

One of the following diagnosis codes must be submitted for tobacco use cessation with the appropriate procedure code:

Diagnosis Codes					
O99330	O99331	O99332	O99333	O99334	O99335

Refer to: Subsection 9.2.60.4.3, "Smoking and Tobacco Use Cessation Counseling" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for additional information related to smoking and tobacco use cessation counseling and additional covered diagnoses.

Procedure codes 99406 and 99407 are limited to once per day, same or different procedure code, any provider.

Smoking and tobacco use cessation counseling delivered by group modality are limited to a maximum of 8 individuals and must be billed with modifier HQ.

Procedure codes 99406 and 99407 may be billed in any combination, individual or group, by the same or different provider, and are limited to eight services per rolling year. Additional services require documentation of medical necessity to exceed the established limit.

4.1.17 Zika Virus Testing

Refer to: Subsection 2.2.11.1, "Zika Virus Testing" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for information about Zika virus testing.

5 Noninvasive Prenatal Screening (NIPS)

Noninvasive prenatal screening (NIPS) is a benefit of Texas Medicaid when medically necessary for the advanced screening of fetal chromosomal abnormalities in pregnant women who meet specific screening criteria. Genetic screening results, when informative, may influence clinical management decisions.

NIPS may be performed as early as ten weeks gestation for specific fetal aneuploidy screening, restricted to Trisomy 13, Trisomy 18, Trisomy 21, and fetal sex chromosome aneuploidy (SCA). To determine NIPS appropriateness, a baseline ultrasound, if not previously performed, is strongly recommended to confirm viability, the number of fetuses, and gestational dating.

If NIPS provides an abnormal screening result, invasive prenatal confirmatory diagnostic testing is strongly encouraged due to the potential risk of a false-positive result from NIPS. Confirmatory diagnostic tests include chorionic villus sampling (CVS) or amniocentesis.

It is recommended that clients who receive an indeterminate result be offered further genetic counseling, comprehensive evaluation with ultrasound, and diagnostic testing due to the increased risk of aneuploidy. Higher body mass index (BMI) may affect NIPS results. Clients weighing more than 250 pounds are at risk of having an inconclusive result from NIPS.

NIPS does not assess the risk for fetal anomalies such as neural tube defects or ventral wall defects. Ultrasound evaluation and maternal serum alpha-fetoprotein screening should be offered for these risk assessments.

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If a fetal structural anomaly (e.g., hydrops, cystic hygroma, cardiac malformations, abdominal wall defects, or skeletal abnormalities) is identified upon ultrasound examination, it is recommended that diagnostic testing be offered rather than NIPS.

NIPS is a benefit for a confirmed intrauterine singleton pregnancy when serum analyte testing with any of the following screening tests were previously elected for the current pregnancy instead of NIPS, the results indicate an increased risk of Trisomy 13, Trisomy 18, or Trisomy 21, and the client wishes to postpone invasive diagnostic testing:

- First trimester screen
- Sequential screen
- Integrated screen
- Quadruple screen

NIPS must be ordered by the medical provider rendering direct care to the client. The provider must order the most appropriate screening based on the client's medical history and the results of previous screenings, if available. The provider must clarify for the client the option to decline, and the provider must document that the option to decline was clearly provided in the client's medical record.

Note: *Some noninvasive prenatal screenings include an extended panel that screens for microdeletions and additional trisomies, such as T16 and T22. However, this use has not been validated, and the "opt-out" box on the requisition form should be checked.*

5.1 Screening for Fetal Sex Chromosome Aneuploidy

In addition to trisomy (e.g., T13, T18, T21), NIPS may also screen for fetal SCA (e.g., 45, X; 47, XXX; 47, XXY; 47, XYY).

Note: *Currently, clinical evidence is unclear for concluding the net health benefits when using cell-free fetal DNA to screen for fetal sex chromosome aneuploidy (SCA). The potential benefit of early detection for management must be balanced against potential harms, stigmatization, and distorted perceptions of the child.*

Sex chromosome aneuploidy of maternal origin should be considered when NIPS results suggest fetal sex chromosome aneuploidy (e.g., 45, X; 47, XXX, 47, XXY; 47, XYY). Other considerations include the risk for incidental findings with NIPS. Appropriate client counseling is encouraged.

5.1.1 Screening Criteria

NIPS is a benefit for clients with a confirmed intrauterine singleton pregnancy dated at least ten weeks gestation.

5.2 Genetic Counseling Requirement

Genetic counseling must be provided by a trained genetic counselor, nurse specialist in genetics, maternal-fetal medicine specialist, or other medical provider (e.g., obstetrician) possessing expertise in genetic counseling. Genetic counseling must provide the depth of content and time for the client to make an informed decision.

The client must be provided with information about the purpose and nature of the screenings. Documentation in the medical record must reflect that the client has been given information on the benefits, risks, and limitations of advanced screening; as well as the nature, inheritance, and implications of genetic disorders. Documentation requirements include all of the following:

- Genetic counseling includes all of the following:
  - The date(s) that formal genetic counseling was provided, with the name and qualifications of the counseling professional

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- The explanation of risks, benefits, and limitations that was discussed with the client
- The client's ability to understand the risks, benefits, and limitations and the client's informed choice to proceed with NIPS as evidenced by the client's signature on a consent form specific to the NIPS to be performed
- The client's other prenatal radiological or lab results, if available, to support medical necessity of NIPS
- The client's NIPS results
- The clear, non-directive explanation provided to the client concerning the findings and implications of the NIPS results
- The client's ability to understand the results and explanation provided

The genetic counseling must be nondirective. The purpose of the provider's information is not to direct the client, but to allow the client to make informed medical and personal decisions.

Clients should be informed that a negative NIPS result does not ensure an unaffected pregnancy.

5.3 Prior Authorization

Prior authorization is not required for NIPS procedure codes 81420 and 81507.

A no-call or inconclusive result is possible and further diagnostic testing is strongly recommended in these cases.

NIPS procedure codes 81420 and 81507 are limited to once per pregnancy. Additional tests will not be reimbursed.

Note: *Providers may appeal denied claims with documentation of a new pregnancy.*

5.3.1 Additional Documentation Requirements

In addition to the documentation of genetic counseling, and the option to decline NIPS provided to the client, the following NIPS documentation must also be maintained in the client's medical record and is subject to retrospective review:

- The appropriateness and benefit of NIPS specific to the client

5.4 NIPS Limitations

Procedure codes 81507 and 81420 are restricted to female clients only who are 10 through 55 years of age. Procedure code 81420 will be denied when billed during the same pregnancy as procedure code 81507, by any provider. Claims that have been paid for procedure code 81420 are subject to recoupment if procedure code 81507 is submitted later for the same pregnancy.

5.5 Non-Covered Services

The following NIPS services are not a benefit of Texas Medicaid:

- NIPS as part of a routine prenatal laboratory assessment
- NIPS if performed without informed patient choice and genetic counseling from a qualified professional
- NIPS for women who do not meet the criteria outlined above
- NIPS for women with multiple gestations (e.g., twins, triplets, etc.)
- NIPS for screening of chromosomal microdeletion syndromes
- NIPS for screening of trisomy other than T13, T18, or T21

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- NIPS for sex determination, paternity determination, or non-medical reasons
- NIPS is not reimbursed with procedure code 81599

6 Gynecological Health Services

6.1 Services, Benefits, Limitations, and Prior Authorization

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

The following gynecological procedures and services may be benefits of Texas Medicaid:

- Gynecological and family planning examinations
- Contraceptives
- Diagnostic tests
- Surgical procedures
- Gynecological treatments

Refer to: Section 2, "Medicaid Title XIX Family Planning Services" in this handbook for information about contraception, sterilizations, and family planning annual examinations.

6.2 Surgical and Laparoscopic Treatment of Ectopic Pregnancy

Surgical and laparoscopic treatment of ectopic pregnancy (procedure codes 59120, 59121, 59130, 59136, 59140, 59150, and 59151) is a benefit of Texas Medicaid.

6.3 Laparoscopic Procedures

Laparoscopic procedures (procedure codes 58545, 58546, 58578, and 58674) are a benefit of Texas Medicaid.

6.4 Endometrial Cryoablation

Endometrial cryoablation (procedure codes 58353 and 58356) is a benefit of Texas Medicaid.

6.5 Uterine Suspension

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

6.6 Vulvectomy

Vulvectomy (procedure code 56620) is a benefit of Texas Medicaid.

6.6.1 Prior Authorization for Vulvectomy

Prior Authorization is required for vulvectomy.

The prior authorization request must include documentation of one of the following conditions:

- Vulvar intraepithelial neoplasia (VIN)
- Labial enlargement that results in abrasion, irritation, or intractable skin infection

Note: *A vulvectomy will not be considered for cosmetic reasons.*

6.7 Salpingostomy

Salpingostomy (procedure codes 58673 and 58770) is a benefit of Texas Medicaid.

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6.7.1 Prior Authorization for Salpingostomy

Prior authorization is required for salpingostomy.

The prior authorization request must include documentation of one or more of the following conditions:

- Ectopic pregnancy
- Hydrosalpinx unrelated to infertility
- Salpingitis unrelated to infertility
- Torsion of the fallopian tube
- Abscess of the fallopian tube
- Peritubal adhesions unrelated to infertility
- Cyst or tumor of the fallopian tube unrelated to infertility
- Hematosalpinx

6.8 Ovarian Wedge Resection

Ovarian wedge resection (procedure code 58920) is a benefit of Texas Medicaid.

6.8.1 Prior Authorization for Ovarian Wedge Resection

Prior Authorization is required for ovarian wedge resection.

The prior authorization request must include documentation of polycystic ovarian syndrome (PCOS).

Note: *Ovarian wedge resection will not be considered to improve chances of conceiving if the PCOS lead to infertility.*

6.9 Assays for the Diagnosis of Vaginitis

Vaginitis assay procedure codes 87478, 87480, 87484, 87510, 87660, 87661, 87797, 87798, and 87800 are benefits of Texas Medicaid.

Providers are reminded to code to the highest level of specificity with a diagnosis to support medical necessity when submitting procedure code 87797.

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

If a positive test result was not treated, documentation must be present indicating why treatment was not rendered.

6.10 Hysteroscopy

Hysteroscopy (procedure codes 58555, 58558, 58559, 58560, 58561, 58562, 58563, and 58579) is a benefit of Texas Medicaid.

6.11 Examination Under Anesthesia

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

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

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6.12 Laminaria Insertion

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

6.13 Hysterectomy Services

Texas Medicaid reimburses hysterectomies when they are medically necessary. Texas Medicaid does not reimburse hysterectomies performed for the sole purpose of sterilization.

Providers can use any of the following procedure codes to submit claims for hysterectomy procedures:

Procedure Codes									
51925	58150	58152	58180	58200	58210	58240	58260	58262	58263
58267	58270	58275	58280	58285	58290	58291	58292	58294	58541
58542	58543	58544	58548	58550	58552	58553	58554	58570	58571
58572	58573	58575	59525						
Providers can refer to the Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for components and fees that may be reimbursed.									

6.13.1 Hysterectomy Acknowledgment

Hysterectomy services are considered for reimbursement when a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is faxed to TMHP, the claim is filed with a signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form, or documentation supporting that the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form could not be obtained or was not necessary.

All Texas Medicaid clients (including those in a STAR or STAR+PLUS Program health plan) receiving hysterectomy services must sign a Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. The acknowledgment must be submitted to TMHP with the claim or to the client's health plan.

The Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form must be signed and dated by the client. The statement must indicate that the client was informed both orally and in writing before the surgery that the hysterectomy would leave her permanently incapable of bearing children.

Note: *A client representative's signature will be required for mentally incompetent clients.*

The client's eligibility file is updated upon receipt of the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form. Claims for services related to the hysterectomy cannot be reimbursed unless the signed Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is on file; therefore to avoid claim denials, each individual provider involved in the hysterectomy procedure is encouraged to submit a copy of the valid Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form rather than relying on another provider to do so.

The provider is responsible for maintaining the original, signed copy of the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form in the client's medical record when a claim is submitted for consideration of payment. These records are subject to retrospective review.

When a hysterectomy, whether abdominal or vaginal, is performed without a client's acknowledgement form:

- The hysterectomy procedure code is denied.
- The other surgical procedures are evaluated for their clinical relevance.
- Multiple procedures are processed according to the multiple surgery guidelines.

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A Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the performing physician certifies that at least one of the following circumstances existed before the surgery:

- The patient was already sterile before the hysterectomy, and the cause of the sterility is stated (e.g., congenital disorder, sterilized previously, or postmenopausal). Providers must use a post menopause or sterilization diagnosis code on the claim form. If the provider submits a claim and does not attach the acknowledgment, the provider must maintain the signed statement in the client's records, and the physician's signature will not be required on the claim form. These records are subject to retrospective review.
- The patient requires a hysterectomy on an emergency basis because of a life-threatening situation. The physician must state the nature of the emergency and certify that it was determined that prior acknowledgment was not possible. Because the acknowledgment may be signed the day of or an hour before surgery, an emergency situation requires that the patient be unconscious or under sedation and unable to sign the acknowledgment.

Although the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form is not required if the criteria previously listed are met, the performing physician must certify that one or more of the circumstances existed prior to the surgery. This certification may be submitted before the claim is submitted or attached to the claim and signed by the performing provider.

Refer to: Title 42 of CFR 441.255 and 25 TAC Part 1, Chapter 29, Subchapter F, section 25.501 for more information.

Refer to: Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information on the TMHP website at www.tmhp.com.

For clients with retroactive Medicaid coverage, one of the following must be submitted with the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form:

- A copy of the client's Your Texas Benefits Medicaid card, which covers the date of the hysterectomy.
- A copy of the retroactive approval notice for Medicaid coverage.

Faxing Forms

All Medicaid providers may fax the Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information form to 1-512-514-4218. The form must include the client's Texas Medicaid number. All consent forms should be faxed with a cover sheet that identifies the provider and includes the telephone number and address. If the fax is incomplete or the consent form is invalid, the form is returned by mail or fax for correction. Completed consent forms that are faxed for adjustments or appeals are validated in the TMHP system. However, claims associated with the consent forms must be appealed through the mail to Appeals/Adjustments at the following address:

Texas Medicaid & Healthcare Partnership
Attn: Appeals/Adjustments
PO Box 200645
Austin, TX 78720-0645

6.14 Pap Smear (Cytopathology Studies)

Pap smears are benefits of Texas Medicaid for early detection of cancer. Family planning clients are eligible for annual Pap smears. Procurement and handling of the Pap smear are considered part of the E/M of the client and are not reimbursed separately.

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The following procedure codes are reimbursed only to pathologists and CLIA-certified laboratories (whose directors providing technical supervision of cytopathology services are pathologists):

Procedure Codes									
88142	88143	88147	88148	88150	88152	88153	88155	88164	88165
88166	88167	88174	88175						

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

Procedure code 88141 is reimbursed in addition to and when billed with the cytopathology procedure codes in the table above.

Procedure code 88155 will only be reimbursed when billed in conjunction with one of the following procedure codes on the same date of service by the same provider:

Procedure Codes									
88142	88143	88147	88148	88150	88152	88153	88164	88165	88166
88167	88174	88175							

Note: *Pap smear procedures will not be reimbursed separately to either the physician or a laboratory when billed on the same day as a THSteps medical check-up visit.*

6.15 Clitoroplasty and Vaginoplasty

Clitoroplasty and vaginoplasty are performed for clients who possess ovaries and are female by genetic sex, but the external genitalia are not those of a normal female. Surgical correction of abnormalities of the external genitalia is the only indicated treatment for this disorder. Clitoroplasty and vaginoplasty procedure codes 56805 and 57335 may be considered for reimbursement for female clients who are 20 years of age and younger when submitted for reimbursement with one of the following diagnosis codes:

Diagnosis Codes							
E250	E258	E259	E271	E272	E2740	E2749	E3450
E3451	E3452	Q560	Q561	Q562	Q563	Q564	

6.16 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including gynecological services.

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

6.17 Claims Filing and Reimbursement

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

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

Subsection 6.1, "Claims Information" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in the *Section 6: Claims Filing* (*Vol. 2, Provider Handbooks*).

Texas Medicaid rates for physicians and other practitioners are calculated in accordance with TAC §355.8085. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2.1.1, "Non-emergent and Non-urgent Evaluation and Management (E/M) Emergency Department Visits" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

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

6.17.1 NCCI and MUE Guidelines

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

6.18 National Drug Code

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

7 Claims Resources

Resource	Location
2017 Claim Form Instructions	Subsection 6.8, "Family Planning Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

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Resource	Location
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)
UB-04 CMS-1450 Paper Claim Filing Instructions	Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

8 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.

9 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)
Abortion Certification Statements Form
Texas Medicaid - Title XIX Acknowledgment of Hysterectomy Information
2017 Claim Form

10 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Family Planning Claim Form
Nurse Practitioner/Clinical Nurse Specialist (Family Planning)

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