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Health and Human Services Family Planning Program 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.

HEALTH AND HUMAN SERVICES COMMISSION FAMILY PLANNING PROGRAM SERVICES HANDBOOK

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1 * Provider Enrollment for HHSC Family Planning Program Contractors

[Revised] Agencies that submit claims for HHSC Family Planning Program Services must have a contract with HHSC. The HHSC Family Planning Program determines client eligibility and benefits. Refer to the HHSC Family Planning Program Policy Manual for specific eligibility, services, and policy information at https://hhs.texas.gov/laws-regulations/handbooks/family-planning-program-policy-manual.

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

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

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

2 * Services, Benefits, Limitations, and Prior Authorization

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

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

Providers are encouraged to include the appropriate diagnosis codes on the claim in conjunction with all family planning procedures and services.

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual*.

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

2.1 * Family Planning Annual Exams

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

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

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual*.

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

Billing Criteria	Frequency
New patient: Appropriate E/M procedure code with modifier FP	One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group
Established patient: Appropriate E/M procedure code with modifier FP	Once per state fiscal year*
*** The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.**	

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

Refer to: Subsection 2 *, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

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

2.1.1 * FQHC Reimbursement for Family Planning Annual Exams

[Revised] FQHCs must use the most appropriate E/M procedure code for the complexity of service provided as indicated in the *HHSC Family Planning Program Policy Manual.*

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

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

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual*.

2.2 * Family Planning Office or Outpatient Visits

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

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

- An update of the client's relevant history

- Physical exam, if indicated
- Laboratory tests, if indicated
- Treatment or referral, if indicated
- Education and counseling, or referral, if indicated
- Scheduling of office or clinic visit, if indicated

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about general family planning office or outpatient visits.

The following table summarizes the uses for the E/M procedure codes and the corresponding billing requirements for general family planning office or outpatient visits:

Billing Criteria	Frequency
New patient: Appropriate E/M procedure code	One new patient E/M code every three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group
Established patient: Appropriate E/M procedure code	As needed*
*** The established patient procedure code will be denied if a new patient procedure code has been billed for the annual examination in the same year.**	

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

Refer to: Subsection 2 *, "Services, Benefits, Limitations, and Prior Authorization" in this handbook for the list of family planning diagnosis codes.

2.2.1 * FQHC Reimbursement for Family Planning Office or Outpatient Visits

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

The new patient procedure codes will be limited to one new patient E/M procedure code three years following the last E/M visit provided to the client by that provider or a provider of the same specialty in the same group. The annual examination must be billed as an established patient visit if E/M services have been provided to the client within the last three years.

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

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual*.

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

2.2.1.1 * Laboratory Procedures

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about laboratory procedures.

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

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

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

Refer to: The Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov/CLIA/10_Categorization_of_Tests.asp for information about procedure code and modifier QW requirements.

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

2.3 * Immunization Administration

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for medications, immunizations, and vaccines.

2.3.1 * Human Papilloma Virus (HPV) Vaccine

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for medications, immunizations, and vaccines for HPV.

2.4 * Radiology

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for radiology services performed for the purpose of localization of an IUD.

2.5 Contraceptive Devices and Related Procedures

2.5.1 * Barrier Contraceptives

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for barrier contraceptives separately from fitting and instruction.

2.5.2 * IUD

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for IUDs and the insertion of IUDs.

2.5.2.1 * Removal of the IUD

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for the removal of an IUD.

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

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

2.5.3 * Contraceptive Implants

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

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

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for the appropriate contraceptive implant removal procedure code.

2.6 * Drugs and Supplies

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for specific procedure codes that may be reimbursed for providing contraceptive methods.

2.6.1 * Prescriptions and Dispensing Medication

Providers may do one or both of the following:

- Dispense family planning drugs and supplies directly to the client and bill the HHSC Family Planning Program.
- Write a prescription for the client to take to a pharmacy.

Family planning drugs and supplies that are dispensed directly to the client must be billed to the HHSC Family Planning Program. Only providers with an appropriate pharmacy license may be reimbursed for dispensing family planning drugs and supplies. Provider types with an appropriate pharmacy license may be reimbursed for dispensing up to a one-year supply of contraceptives in a 12-month period.

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about dispensing contraceptives.

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

2.6.2 * Oral Medication Reimbursement

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about oral medication.

2.7 * Family Planning Education

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for the procedure codes that may be reimbursed for providing Contraceptive Method Instruction.

2.7.1 * Medical Nutrition Therapy

For clients requiring intensive nutritional guidance, medical nutritional therapy can be provided as an allowable and billable service. Medical nutritional therapy, however, must be provided by a registered dietician in order to be reimbursed.

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about medical nutritional therapy.

2.7.2 * Instruction in Natural Family Planning Methods

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

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about natural family planning.

2.8 Sterilization and Sterilization-Related Procedures

2.8.1 Sterilization Consent

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

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.

2.8.2 Incomplete Sterilizations

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

2.8.3 * Tubal Ligation and Hysteroscopic Occlusion

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about tubal ligation and hysteroscopic occlusion.

2.8.4 * Vasectomy

Refer to: ***[Revised]*** The *HHSC Family Planning Program Policy Manual* for more information about vasectomies.

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

2.9 Prior Authorization

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

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.

4 Claims Filing and Reimbursement

4.1 Claims Information

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

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

4.1.1 Filing Deadlines

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

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

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

4.1.2 Third Party Liability

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

4.2 Reimbursement

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

4.2.1 Funds Gone

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

Providers may receive additional funds for a contract period at a later time. Claims identified as "funds gone" may be reimbursed at that time.

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

4.3 NCCI and MUE Guidelines

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

In instances when Texas Medicaid limitations are more restrictive than NCCI Medically Unlikely Edit (MUE) guidance, Texas Medicaid limitations prevail.

4.4 National Drug Code

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