

FISCAL YEAR 2017

**POLICY
and
PROCEDURE
MANUAL**

For

**HHSC
Family Planning Program
Services**

July 2016



Health and Human Services Commission
Women's Health Services Division

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Introduction

General Information

PROGRAM AUTHORIZATION AND SERVICES

PURPOSE OF PROGRAM

The purpose of the Health and Human Services Commission's (HHSC) Family Planning Program is to provide comprehensive family planning services to reduce unintended pregnancies, positively affect future pregnancies, and improve health status of women and men.

PROGRAM BACKGROUND

HHSC Family Planning Program – State funds to provide family planning services to low-income women and men.

Title XIX – Medicaid (Title XIX of the Social Security Act) was created by Congress in 1965. All agencies that receive HHSC Family Planning Program funding are required also to be enrolled providers of services to Medicaid-eligible women and men. (Federal regulation citation: Title XIX, Social Security Act, [42 USC § 1396-1396v et. seq.] Grants to States for Medical Assistance Programs).

Funding Sources – Family Planning Program services are funded by State General Revenue. HHSC Family Planning Program funds are allocated through a competitive application process, after which, selected applicants negotiate contracts with HHSC to provide services. A variety of types of organizations provide Family Planning Program services, such as local health departments, medical schools, hospitals, private non-profit agencies, community-based clinics, federally qualified health centers (FQHCs), and rural health clinics. Providers must enroll with the Texas Medicaid and Healthcare Partnership (TMHP) in order to provide HHSC Family Planning Program. Reimbursements are managed by TMHP. State and federal law prohibits the use of contracted funds awarded by HHSC to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures.

Rules

The state rules that apply most specifically to family planning services in Texas are found in the [Texas Administrative Code \(TAC\), Title 1, Part 15, Chapter 382](#), Subchapter B.

PURPOSE OF THE MANUAL

The *HHSC Family Planning Program Policy and Procedure Manual* is a guide for contractors who deliver HHSC Family Planning Program services in Texas. Providers of family planning services who are also reimbursed by Title XIX (Medicaid), must follow policies and procedures as established by the Texas Medicaid Program in the Texas Medicaid Provider Procedures Manual (TMPPM).

Federal and state laws related to reporting of child abuse, operation of health facilities, professional practice, insurance coverage, and similar topics also impact family planning services. Contractors are required to be aware of and comply with existing laws.

Family planning contractors also must be in compliance with the [DSHS Standards for Public Health Clinic Services](#).

For additional information about HHSC family planning services, access the [HHSC Family Planning Program website](#).

DEFINITIONS

The following words and terms, when used in this manual, have the following meanings:

Barrier to Care – A factor that hinders a person from receiving health care (i.e., proximity (or distance), lack of transportation, documentation requirements, co-payment amount, etc.).

Class D (Clinic) Pharmacy License – A pharmacy license issued to a pharmacy to dispense a limited type of drug or devices under a prescription drug order (e.g., XYZ Health Clinic). Information to apply for a Class D Pharmacy License may be found at:

http://www.tsbp.state.tx.us/files_pdf/INSTRUCTIONS_CLASS_D_PHY.pdf.

Client – An individual who has been screened and has successfully completed the eligibility process. The terms “client” and “patient” may be used interchangeably in this manual.

Compass 21 – Automated system used by Texas Medicaid and Healthcare Partnership to process claims for services delivered to Medicaid and HHSC Family Planning Program; also performs data collection and report functions for HHSC.

Consultation – A type of service provided by a physician with expertise in a medical or surgical specialty, and who, upon request of another appropriate healthcare provider, assists with the evaluation and/or management of a patient.

Contraception – The means of pregnancy prevention, including permanent and temporary methods.

Contractors – Any entity that the Health and Human Services Commission has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who actually implements the services.

Co-Payments – Monies collected directly from clients for services.

Core Tool – A standardized instrument used to review all Community Health Services contractors to ensure compliance with basic requirements for operating a clinic providing health services as reflected in the DSHS Standards for Public Health Clinic Services

Cost Reimbursement – Funding used to develop and maintain contractor infrastructure for the provision of family planning services.

Elective Abortion – The intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably

likely to cause the death of the fetus. The tem does not include the use of any such means to terminate a pregnancy that resulted from an act of rape or incest; in a case which a female suffers from a physical disorder, physical disability, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the female in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or in a case in which a fetus has a life-threatening physical condition that, in reasonable medical judgement, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

Eligibility Date – Date the contractor determines an individual eligible for the program. The eligibility expiration date will be twelve months after the eligibility date.

Family Planning Services – Services that assist women and men in planning their families, whether it is to achieve, postpone, or prevent pregnancy. Family planning services should include the following: pregnancy test (if indicated), health history, physical examinations, basic infertility services, lab tests, STD services (including HIV/AIDS), and other preconception health services (e.g. screening for obesity, smoking, and mental health), counseling/education, and contraceptive supplies.

Federal Poverty Level (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid, define eligibility income limits as some percentage of FPL.

Fee-for-service – Payment mechanism for services that are reimbursed on a set rate per unit of service (also known as unit rate).

Fiscal Year – State fiscal year from September 1 - August 31.

Health and Human Services Commission (HHSC) – State agency with administration and oversight responsibilities for designated Health and Human Services agencies.

Health Service Region (HSR) – Counties grouped within specified geographic service areas throughout the state.

Healthy Texas Women – HTW is a state-funded program administered by HHSC to provide eligible uninsured women with women’s health and family planning services such as woman’s health exams, health screenings, and birth control. HTW will begin July 1, 2016. HTW providers must provide client services on a fee-for-service basis, and may also, but are not required to, contract with HHSC to provide support services that enhance HTW fee-for-service client service delivery on a cost reimbursement basis.

Household (for the purpose of eligibility determination) – The household consists of a person living alone, or a group of two or more persons related by birth, marriage (including common law), or adoption, who reside together and are legally responsible for the support of the other person. If an unmarried applicant lives with a partner, ONLY count the partner’s income and children as part of the household group IF the applicant and his/her partner have mutual children together. Unborn children should also be

included. Treat applicants who are 18 years of age as adults. No children aged 18 and older or other adults living in the home should be counted as part of the household group.

Informed Consent – The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other appropriate options, and the benefits and risks of taking no action are explained to a patient in a manner that is understandable to that patient and allows the patient to participate and make sound decisions regarding his or her own medical care.

Intended pregnancy – Pregnancy a woman reports as timed well or desired at the time of conception.

Long-acting Reversible Contraceptives (LARC) – Methods of birth control that provide effective contraception for an extended period without requiring user action. LARC include intrauterine devices (IUDs), and subdermal contraceptive implants.

Medicaid – The Texas Medical Assistance Program, a joint federal and state program provided for in Texas Human Resources Code Chapter 32 and subject to Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Minor – In Texas, a minor is a person under 18 years of age who has never been married and never been declared an adult by a court (emancipated). See Texas Family Code Sections 101.003, 31.001-31.007, 32.003-004, 32.202.

Nutritional Services – The provision of services to identify the nutritional status of an individual, and instruction which includes appropriate dietary information based on the client's needs, i.e. age, sex, health status, culture. Information may be provided on an individual basis, one-on-one basis, or to a group of individuals.

Outreach – Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of clients.

Patient – An individual receiving medical care, treatment, or services. The terms “patient” and “client” are used interchangeably in this manual.

Program Income – Monies collected directly by the contractor/provider for services provided under the contract award (i.e., reimbursements from the fee-for-service contract, patient co-pay fees, and client donations).

Provider – An individual clinician or group of clinicians who provide services.

Referral – The process of directing or redirecting (as a medical case or a client) to an appropriate specialist or agency for definitive treatment. To direct to a source for help or information.

Reproductive Life Plan – A plan that outlines a client's personal goals regarding whether or not to have children, the desired number of children, and the optimal timing and spacing of children. Counseling should include the importance of developing a reproductive life plan and information about reproductive health, family planning methods and services, and obtaining preconception health services, as appropriate.

Texas Medicaid and Healthcare Partnership (TMHP) – The Texas Medicaid Claims and Primary Care Case Management (PCCM) Administrator. HHSC contracts with TMHP to process claims for providers.

Title XIX Family Planning Program – Family planning services provided under Title XIX (Medicaid) of the Social Security Act, 42 United States Code §1396 *et seq.*

ACRONYMS

ADA	Americans with Disabilities Act
AMA	American Medical Association
BCCS	Breast and Cervical Cancer Services
CBE	Clinical Breast Exam
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CHT	Center For Health Training
CLIA	Clinical Laboratory Improvement Amendments
CMB	Contracts Management Branch
CMS	Centers For Medicare and Medicaid
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
DHHS	U.S. Department of Health and Human Services
DES	Diethylstilbestrol
EOB	Explanation of Benefit
EDI	Electronic Data Interchange
EHR	Electronic Health Records
EMR	Electronic Medical Records
E/M	Evaluation and Management Services
FDA	Federal Drug Administration
FP	Family Planning
FPL	Federal Poverty Level
FQHC	Federal Qualified Health Center
FSR	Financial Status Report
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
HTW	Healthy Texas Women
IRB	Institutional Review Board
IUC	Intrauterine Contraception

IUD	Intrauterine Device
LARC	Long Acting Reversible Contraceptive
LEP	Limited English Proficiency
NPI	National Provider Identifier
NPPES	National Plan and Provider Numeration System
PDPT	Patient-Delivered Partner Therapy
QA	Quality Assurance
QM	Quality Management
QMB	Quality Management Branch
PAA	Prescriptive Authority Agreement
R & S	Remittance and Status (Reports)
SDO	Standing Delegation Orders
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TMHP	Texas Medicaid Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TPI	Texas Provider Identifier
UPSTF	The United States Preventive Services Task Force
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Section I

Administrative Policies

Purpose: Section I assists the contractor in conducting administrative activities such as assuring client access to services and managing client records.

CLIENT ACCESS

The contractor must ensure that male and female clients are provided services in a timely and nondiscriminatory manner. The contractor must:

- Have a policy in place that delineates the timely provision of services.
 - Family Planning Program clients should be given an appointment as soon as possible - no later than 30 days - from initial request.
 - Appointments for adolescents age 17 and younger should be seen as soon as possible - with every effort made to provide an appointment within two weeks of the request. (See also Section 1 Chapter 3 – Client Rights)
- Comply with all applicable civil rights laws and regulations including [Title VI of the Civil Rights Act of 1964](#), the [Americans with Disabilities Act](#) of 1990, the Age Discrimination Act of 1975, and [Section 504 of the Rehabilitation Act of 1973](#), and ensure services are accessible to persons with [Limited English Proficiency](#) (LEP) and speech or sensory impairments at no cost to client.
- Have a policy in place that requires qualified staff to assess and prioritize clients' needs.
- Provide referral resources for individuals that cannot be served or cannot receive a specific service.
- Manage funds to ensure that established clients continue to receive services throughout the budget year.
- Inform clients of HTW services and encourage them to bring required documentation to the initial visit for eligibility processing.

ABUSE AND NEGLECT REPORTING

HHSC expects contractors to comply with state laws governing the reporting of abuse and neglect. Contractors must have an agency policy regarding abuse and neglect. It is mandatory to be familiar with and comply with adult and child abuse and neglect reporting laws in Texas.

To report abuse or neglect, call the Texas Abuse Hotline **800-252-5400**, use the [secure website](#), or call any local or state law enforcement agency for cases that pose an imminent threat or danger to the client.

CHILD ABUSE REPORTING

Child Abuse Compliance and Monitoring

Chapter 261 of the Texas Family Code requires child abuse reporting. Contractors/providers are required to develop policies and procedures that comply with the child abuse reporting guidelines and requirements set forth in Chapter 261.

The following outlines the review process for contract compliance.

Policy – Contractors must develop an internal policy specific to:

- how child abuse reporting requirements will be implemented throughout their agency,
- how staff will be trained, and
- how internal monitoring will be done to ensure timely reporting.

Procedures – During site monitoring, the following procedures will be utilized to evaluate compliance:

- 1) The contractor's process used to ensure that staff is reporting according to Chapter 261. . To verify compliance, monitors must review that the contractor:
 - a) has an internal policy which details how the contractor will determine, document, report, and track instances of abuse, sexual or non-sexual, for all clients under the age of 17 in compliance with the Texas Family Code, Chapter 261;
 - b) followed their internal policy; and
 - c) documented staff training on child abuse reporting requirements and procedures.
- 2) The contractor's internal policy must clearly describe the reporting process for minors. All records of clients under 14 years of age who are a) pregnant, or b) have a confirmed diagnosis of an STI/STD acquired in a manner other than through perinatal transmission or transfusion, will be reviewed for appropriate screening and reporting documentation as required in the clinic or site being visited during a site monitoring visit. The review of the records will involve reviewing that a report was made, and the report was made within the proper timeframes required by law.

3) If it is found during routine record review that a report should have been made as evidenced by the age of the client and evidence of sexual activity, the failure to appropriately screen and report will be identified as lack of compliance. Failure to report will be brought to the attention of the staff person who should have made the report or the appropriate supervisor with a request to report immediately. This failure to report will also be discussed with the agency director and during the exit conference with the contractor.

4) The monitoring report that is sent to the contractor will indicate the number of applicable records reviewed in each clinic and the number of records that were found to be out of compliance. This report will be sent to the contractor approximately 4 weeks from the date of the review, which is the usual process for site monitoring reports.

5) The contractor will have a determined length of time to respond with written corrective actions to all findings. If the contractor does not provide corrective actions during the required time period, the contractor will be sent a past due letter with a time period of 10 days to submit the corrective actions. If the corrective actions are not submitted during the time period given, failure to submit the corrective action is considered a subsequent finding of noncompliance with Chapter 261.

If the contractor has other findings that warrant technical assistance or accelerated monitoring review, either regional or central office staff will make the necessary contacts. Records and/or policies will again be reviewed to ensure compliance with Chapter 261 requirements. If any subsequent finding of noncompliance is identified during a subsequent monitoring or technical assistance visit, the contractor will be referred for financial sanctioning.

6) If a contractor is found to have minimal findings overall but did have findings of noncompliance with Chapter 261, an additional accelerated monitoring visit solely to review child abuse reporting will not be conducted. For agencies that receive technical assistance visits as a result of a quality assurance review, the agency child abuse reporting processes will be reviewed again for compliance. In all cases, the corrective actions submitted by the contractor will be reviewed to ensure that the issues have been addressed.

HUMAN TRAFFICKING

HHSC mandates that contractors comply with state laws governing the reporting of abuse and neglect. Additionally, as part of the requirement that contractors comply with all applicable federal laws, family planning contractors must comply with the federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000 (Pub.L.No. 106-386), as amended, and 19 U.S.C. 1591.

Contractors must have a written policy on human trafficking which includes the provision of annual staff training.

INTIMATE PARTNER VIOLENCE (IPV)

[Intimate partner violence \(IPV\)](#) describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

Contractors must have a written policy related to assessment and prevention of IPV, including the provision of annual staff training.

CONFIDENTIALITY

All contracting agencies must be in compliance with the [U.S. Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) established standards for protection of client privacy.

Employees and volunteers must be made aware during orientation that violation of the law in regard to confidentiality may result in civil damages and criminal penalties. All employees, volunteers, sub-contractors, and board members and/or advisory board must sign a confidentiality statement during orientation.

The client's preferred method of follow-up for clinic services (cell phone, email, work phone) and preferred language must be documented in the client's record (See Client Health Record - Section II, Chapter 3).

Each client must receive verbal assurance of confidentiality and an explanation of what confidentiality means (kept private and not shared without permission) and any applicable exceptions such as abuse reporting (See Abuse and Neglect Reporting - Section I, Chapter 2).*

***Minors and Confidentiality**

Except as permitted by law, a provider is legally required to maintain the confidentiality of care provided to a minor. Confidential care does not apply when the law requires parental notification or consent or when the law requires the provider to report health information, such as in the cases of contagious disease or abuse. The definition of privacy is the ability of the individual to maintain information in a protected way. Confidentiality in health care is the obligation of the health-care provider to not disclose protected information. While confidentiality is implicit in maintaining a patient's privacy, confidentiality between provider and patient is not an absolute right.

The HIPAA privacy rule requires a covered entity to treat a "personal representative" the same as the individual with respect to uses and disclosures of the individual's protected health information. In most cases, parents are the personal representatives for their minor children, and they can exercise individual rights, such as access to medical records, on behalf of their minor children. (Code of Federal Regulations [45CFR164.504]).

NON-DISCRIMINATION

HHSC contractors must comply with state and federal anti-discrimination laws, including and without limitation:

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681- et seq.); and
- Administrative rules for HHS agencies, as set forth in the Texas Administrative Code.

More information about non-discrimination laws and regulations can be found on the [HHSC Civil Rights website](#).

Contract Terms and Conditions

To ensure compliance with non-discrimination laws, regulations, and policies, contractors must:

- Have a written policy that states the agency does not discriminate on the basis of race, color, national origin, including limited English proficiency (LEP), sex, age, religion, disability, or sexual orientation;
- Have a policy that addresses client rights and responsibilities that is applicable to all clients requesting family planning services;
- Sign a written assurance to comply with applicable federal and state non-discrimination laws and regulations;
- Notify all clients and applicants of the contractor's non-discrimination policies and complaint procedures;
- Ensure that all contractor staff is trained in the contractor's non-discrimination policies, including policies for serving clients with LEP, and HHSC complaint procedures; and
- Notify the HHSC Civil Rights Office of any discrimination allegation or complaint related to its programs and services no later than ten (10) calendar days after receipt of the allegation or complaint.
- Send notices to:

HHSC Civil Rights Office
701 W. 51st Street, Mail Code W206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone (512) 438-4313
TTY Toll Free: (877) 432-7232
Fax: (512) 438-5885

Limited English Proficiency (LEP)

To ensure compliance with civil rights requirements related to LEP, contractors must:

- Take reasonable steps to ensure that LEP persons have meaningful access to programs and services, and not require a client with LEP to use friends or family members as interpreters. However, a family member or friend may serve as a client's interpreter, if requested, if the family member or friend does not compromise the effectiveness of the service nor violate client confidentiality.

- Make clients and applicants with language service needs, including persons with LEP and disabilities, aware that the contractor will provide an interpreter free of charge.

Civil Rights Posters

The contractor must prominently display in client common areas, including lobbies and waiting rooms, front reception desk, and locations where clients apply for services, the following posters:

- [“Know Your Rights” \[English\] \[Spanish\]](#)

Size: 8.5” x 11” (standard size sheet of paper).

Posting Instructions: Post the English and Spanish versions of this poster next to each other.

Questions: Contact the HHSC Civil Rights Office.

- [“Need an Interpreter” \[Language Translation\] \[American Sign Language\]](#)

Size: 8.5” x 11” (standard size sheet of paper).

Posting Instructions: Post the “Language Translation” version and “American Sign Language” version next to each other.

Questions: Contact the HHSC Civil Rights Office.

- [Americans with Disabilities Act \[English A\] \[Spanish A\] \[English B\] \[Spanish B\]](#)

Size: 8.5” x 11” and 11” x 13”

Posting instructions: Post with other civil rights posters.

Questions: Contact the HHSC Civil Rights Office.

Questions concerning this section and civil rights matters can be directed to the HHSC Civil Rights Office.

TERMINATION OF SERVICES

Clients must never be denied services due to an inability to pay.

Contractors have the right to terminate services to a client if the client is disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the contractor’s ability to provide services or if the client’s behavior jeopardizes his or her own safety, clinic staff, or other clients.

Any policy related to termination of services must be included in the contractor’s policy and procedures manual.

RESOLUTION OF COMPLAINTS

Contractors must ensure that clients have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner. Contractors’

policy and procedure manuals must explain the process clients will follow if they are not satisfied with the care received. If an aggrieved client requests a hearing, a contractor shall not terminate services to the client until a final decision is rendered.

Any client complaint must be documented in the client's record.

PROMPT SERVICES

Contractors are responsible for ensuring that family planning services are provided to clients in a timely manner, preferably within 30 days of the request for services.

Clients who request contraception but cannot be immediately provided a clinical appointment must be offered a nonprescription method.

Adolescents age 17 and younger must be provided family planning counseling and medical services as soon as possible of request - with every effort made to provide an appointment within two weeks of the request.

Clinic/reception room wait times should be reasonable so as not to represent a barrier to service.

FREEDOM OF CHOICE

HHSC Family Planning Program clients are guaranteed the right to choose family planning providers and methods without coercion or intimidation. Acceptance of family planning services must not be a prerequisite to eligibility for or receipt of any other service or assistance.

Medicaid clients are free to receive services from any Medicaid-enrolled family planning provider, even in managed care areas.

Personnel at contractors' clinics must be informed that they may be subject to prosecution under federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure. [Section 205 of Public Law 94-63. Contractors must have a written policy to this effect. (See TAC § 56.11)]

RESEARCH (HUMAN SUBJECT CLEARANCE)

Any HHSC Family Planning Program contractor that wishes to participate in any proposed research that would involve the use of HHSC Family Planning Program clients as subjects, the use of HHSC Family Planning Program clients' records, or any data collection from HHSC Family Planning Program clients, must obtain prior approval from the HHSC Family Planning Program and be approved by the Institutional Review Board (IRB).

Contractors should first contact the HHSC Family Planning Program (famplan@hhsc.state.tx.us) to initiate a research request. Next, the Program will assist contractors to find the most current version of the IRB application to complete and submit to famplan@hhsc.state.tx.us. The IRB will review the materials and approve or deny the application.

The contractor must have a policy in place that indicates that prior approval will be obtained from the HHSC Family Planning Program, as well as the IRB, prior to instituting any research activities. The contractor must also ensure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained.

CLIENT RECORDS MANAGEMENT

HHSC contractors must have an organized and secure client record system. The contractor must ensure that the record is organized, readily accessible, and available to the client upon request with a signed release of information. The record must be kept confidential and secure, as follows:

- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use and inaccessible to unauthorized persons; and
- Maintained in a secure environment in the facility, as well as during transfer between clinics and in between home and office visits.

The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. If the client is 15 through 17 years of age, the client's parent, managing conservator, or guardian, as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations, must authorize the release. HIV information should be handled according to [law](#).

When information is requested, contractors should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form that does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable as medical records.

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by HHSC all records pertaining to client services, contracts, and payments. Record retention requirements are found in Title 1, Part 15 TAC §354.1003 (relating to Time Limits for Submitted Claims) and Title 22, Part 9 TAC §165 (relating to Medical Records). Contractors must follow contract provisions, maintain medical records for at least seven years after the close of the contract, and follow the retention standards of the appropriate licensing entity. All records relating to services must be accessible for examination at any reasonable time to representatives of HHSC and as required by law.

PERSONNEL POLICY AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately for their job position. Personnel policies and procedures must include:

- job descriptions,
- a written orientation plan for new staff to include skills evaluation and/or competencies appropriate for the position, and
- a performance evaluation process for all staff.

Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

Contractors must show evidence that employees meet all required qualifications and are provided annual training. Job evaluations should include observation of staff/client interactions during clinical, counseling, and educational services.

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain. All employees and board members must complete a conflict of interest statement during orientation. All medical care must be provided under the supervision, direction, and responsibility of a qualified Medical Director. The Family Planning Program Medical Director must be a licensed Texas physician.

Contractors must have a documented plan for organized staff development. There must be an assessment of:

- training needs;
- quality assurance indicators; and
- changing regulations/requirements.

Staff development must include orientation and in-service training for all personnel and volunteers. (Non-profit entities must provide orientation for board members and government entities must provide orientation for their advisory committees). Employee orientation and continuing education must be documented in agency personnel files.

FACILITIES AND EQUIPMENT

HHSC contractors are required to maintain a safe environment at all times. Contractors must have written policies and procedures that address the handling of hazardous materials, fire safety, and medical equipment.

Hazardous Materials – Contractors must have written policies and procedures that address:

- the handling, storage, and disposing of hazardous materials and waste according to applicable laws and regulations;
- the handling, storage, and disposing of chemical and infectious waste, including sharps; and
- an orientation and education program for personnel who manage or have contact with hazardous materials and waste.

Fire Safety – Contractors must have a written fire safety policy that includes a schedule for testing and maintenance of fire safety equipment. Evacuation plans for the premises must be clearly posted and visible to all staff and clients.

Medical Equipment – Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment, including automated external defibrillators (AED). Documentation must include:

- assessments of the clinical and physical risks of equipment through inspection, testing, and maintenance;
- reports of any equipment management problems, failures, and use errors;
- an orientation and education program for personnel who use medical equipment; and
- manufacturer recommendations for care and use of medical equipment.

Radiology Equipment and Standards – All facilities providing radiology services must:

- possess a current Certificate of Registration from the Texas Department of State Health Services, Radiation Control Program,
- have operating and safety procedures as required by Title 25, Texas Administrative Code Chapter 289, Texas Regulations for Control of Radiation,
- post NOTICE TO EMPLOYEES, Texas Regulations for Control of Radiation.

For information on x-ray machine registration, see the [Texas Department of State Health Services, Radiation Control Program](#).

Smoking Ban – Contractors must have written policies that prohibit smoking in any portion of their indoor facilities. If a contractor subcontracts with another entity for the provision of health services, the subcontractor must comply with this policy.

Disaster Response Plan – Written and oral plans that address how staff are to respond to emergency situations (i.e., fires, flooding, power outage, bomb threats, etc.). The disaster plan must identify the procedures and processes that will be initiated during a disaster and the staff (position/s) responsible for each activity. A disaster response plan must be in writing, formally communicated to staff, and kept in the workplace available to employees for review. For an employer with ten or fewer employees the plan may be communicated orally to employees.

For additional resources on facilities and equipment, see the [Occupational Safety and Health Administration website](#).

QUALITY MANAGEMENT

Organizations that embrace [Quality Management](#) (QM) concepts and methodologies and integrate them into the structure of the organization and day-to-day operations discover a powerful management tool. Quality Management programs can vary in structure and organization and will be most effective if they are individualized to meet the needs of a specific agency, services and the populations served.

Contractors are expected to develop quality processes based on four core Quality Management principles that focus on:

- the client,
- systems and processes,
- measurement, and
- teamwork.

Contractors must have a Quality Management program individualized to their organizational structure and based on the services provided. The goals of the quality program should ensure availability and accessibility of services, and quality and continuity of care.

A Quality Management program must be developed and implemented that provides for ongoing evaluation of services. Contractors should have a comprehensive plan for the internal review, measurement and evaluation of services, the analysis of monitoring data, and the development of strategies for improvement and sustainability. Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with HHSC policies and basic standards will be assessed with the subcontracting entities.

The Quality Management Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical Director, and any other appropriate staff where applicable, annually reviews and approves the quality work plan for the organization. The Medical Director must be a licensed Texas physician.

The Quality Management Committee must meet at least quarterly to:

- receive reports of monitoring activities;
- make decisions based on the analysis of data collected;
- determine quality improvement actions to be implemented; and
- reassess outcomes and goal achievement.

Minutes of the discussion, actions taken by the committee, and a list of the attendees must be maintained.

The quality work plan at a minimum must:

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- include clinical and administrative standards by which services will be monitored;
 - include process for credentialing and peer review of clinicians;
 - identify individuals responsible for implementing monitoring, evaluating and reporting;
 - establish timelines for quality monitoring activities;
 - identify tools/forms to be used; and
 - outline reporting to the Quality Management Committee.

Although each organization’s quality management program is unique, the following activities must be undertaken by all agencies providing client services:

- On-going eligibility, billing, and clinical record reviews to assure compliance with program requirements and clinical standards of care;
- Tracking and reporting of adverse outcomes;
- Annual review of facilities to maintain a safe environment, including an emergency safety plan;
- Annual review of policies, clinical protocols, standing delegation orders (SDOs), and immunization status to ensure they are current; and
- Performance evaluations to include primary license verification, DEA, and immunization status to ensure they are current.

HHSC contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with policies and basic standards will be assessed with the subcontracting entities including:

- Annual license verification (primary source verification);
- Clinical record review;
- Eligibility and billing review;
- On-site facility review;
- Annual client satisfaction evaluation process; and
- Child abuse training and reporting – subcontractor staff.

Data from these activities must be presented to the Quality Management Committee. Plans to improve quality should result from the data analysis and reports considered by the committee and should be documented.

PHARMACY

In order to facilitate client access to and compliance with contraceptive methods and related medications, **it is required that all contractors have at least a Class D pharmacy at each HHSC Family Planning Program clinic site.**

Pharmacies must be operated in accordance with federal and state laws relating to security and record-keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations. It is essential that each facility maintain an adequate supply and variety of drugs and devices on-site to effectively manage the contraceptive needs of its patients.

Class D Pharmacy Exemption

Contractors may request an exemption to the requirement to have at least a Class D pharmacy on-site, if such an exemption would facilitate client access to contraceptive methods and related medications. Requests for exemptions must be made in writing to the HHSC Women's Preventive Service Branch and will be considered on a case-by-case basis. Exemption requests must 1) describe the process through which a patient obtains medication from the referral pharmacy/pharmacies, and 2) include justification wherein referring clients to an off-site pharmacy benefits the agency and/or clients. The following criteria must be met in order to potentially qualify for an exemption:

1. A signed and fully executed Memorandum of Understanding (MoU) with referral pharmacy/pharmacies, which includes the purpose of cooperation and details coordination with between the contractors and the referral pharmacy/pharmacies to provide the following medications:
 - non-clinician administered hormonal contraceptive methods [oral contraceptives; transdermal hormonal contraceptives (patch); and vaginal hormonal contraceptives (ring)];
 - anti-infectives for the treatment of STIs and other infections; and
 - other medications necessary to treat health care needs of the family planning patient population.
2. The agreement made with referral pharmacy/pharmacies must not create barriers to the client receiving the prescribed medication.
3. The referral pharmacy/pharmacies is/are located within a reasonable distance to participating clients.
4. Clients do not incur additional costs to obtain medications.
5. The contractor has a written policy that ensures clients can obtain prescribed medication refills from the cooperating pharmacy/pharmacies without an additional clinic visit (unless medically indicated/necessary).

Section II

Eligibility, Client Services, and Community Activities

Purpose: Section II provides policy requirements for providing client services and community activities.

CLIENT ELIGIBILITY SCREENING PROCESS

HHSC Family Planning Program contracted agencies must screen all potential family planning clients for eligibility in the following programs that provide family planning services: Medicaid, Healthy Texas Women (HTW), and then the HHSC Family Planning Program. Eligibility screening criteria and processes are described below.

SCREENING FOR MEDICAID

If the client has a Medicaid card, it can be used to document Medicaid eligibility.

How to know if a person is covered by Medicaid:

- He/she will be issued a ‘Your Texas Benefits’ card.
- He/she should show his/her ‘Your Texas Benefits’ card at the point of service delivery.

Even with this card, providers must verify the person’s Medicaid eligibility. Providers can log on to www.YourTexasBenefitsCard.com or call TMHP at 1-800-925-9126. Providers can also log on to TexMedConnect to check the member’s Medicaid ID number (PCN).

SCREENING FOR HEALTHY TEXAS WOMEN

All women 15-44 years of age who are not eligible for full Medicaid services must be screened for HTW. HTW is a state-funded program administered by HHSC to provide eligible uninsured women with women’s health and family planning services such as woman’s health exams, health screenings, and birth control. HTW providers must provide client services on a fee-for-service basis, and may also, but are not required to, contract with HHSC to provide support services that enhance HTW Fee-for-Service client service delivery on a cost reimbursement basis. Family Planning Program contractors must be HTW providers.

HTW is for women who meet the following qualifications:

- ages 15-44
 - applicants ages 15-17 must have a parent or legal guardian apply, renew, and report changes to her case on her behalf (an applicant is considered 15 years of age the first day of the month of her 15th birthday and 17 years of age through the day before her 18th birthday);
 - an applicant is considered 18 years of age on the day of her 18th birthday and 44 years of age through the last day of the month of her 45th birthday;
- U.S. citizens and eligible immigrants;
- reside in Texas;

- do not currently receive full Medicaid benefits, Children’s Health Insurance Program (CHIP), or Medicare Part A or B;
- are not pregnant;
- do not have private health insurance that covers family planning services, unless filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person; and
- have a countable household income at or below 200 percent of the federal poverty level.

How to know if a person is covered by the HTW:

- She will be issued a ‘Your Texas Benefits’ card with “Healthy Texas Women” printed in the upper right corner.
- She should show her ‘Your Texas Benefits’ card at the point of service delivery.

Even with this card, providers must verify the person’s eligibility. Providers can log on to www.YourTexasBenefitsCard.com or call TMHP at 1-800-925-9126. Providers can also log on to [TexMedConnect](#) to check the member’s Medicaid ID number (PCN).

Contractors must assist individuals who screen eligible for HTW to complete the HTW Application Form #H1867 and verify the person’s income, identity, and citizenship in accordance with HTW policies. An applicant may qualify as adjunctively eligible if she or a member of her family participates in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], Supplemental Nutrition Assistance Program [SNAP], Temporary Assistance for Needy Families [TANF], or Children’s Medicaid). For more information on documents that are acceptable as proof of adjunctive eligibility see the [HTW website](#).

The HTW Application, HHSC Form # H1867 is used to apply for HTW if the screening form indicates that a woman is likely to be determined eligible. Note: a HTW Screening Tool or [HTW Application Form #H1867](#) must be maintained in the client record for all potentially eligible HTW clients.

After ensuring that the application is completed and signed, the contractor must fax the application to the toll-free number included on the application to HHSC for processing. Verification of income, expenses, or adjunctive eligibility, identity, and citizenship must also be faxed with the application. Contractors must fax the application to the eligibility office even if all required documentation is not provided by the client. The eligibility office will contact the client for any missing information. To minimize paperwork and the chance that verification will be lost, the documents should be photocopied to fit on one sheet, if possible. A woman’s enrollment in HTW will be effective from the first day of the month the State receives her application for the program. For example, if a woman applies for HTW on January 20 and she is certified, her enrollment will be effective starting January 1.

SCREENING FOR FAMILY PLANNING PROGRAM ELIGIBILITY

Contractors must determine Family Planning Program eligibility. Contractors must use one of the following eligibility screening tools to assess client eligibility for Family Planning Program services:

- DSHS Individual Eligibility Form (EF05-14215); DSHS Household Eligibility Screening Form (EF05-14214) with Household Eligibility Screening Form Worksheet (EF05-13227) (See Appendix B) or
- Any other eligibility screening form substitute (e.g., in-house form, electronic/automated form, phone interview, etc.), that contains the required information for determining eligibility, and is approved by the Family Planning Program.

The eligibility assessment may be completed over the phone or in the office. The completed eligibility form must be maintained in the client record, indicating the client's poverty level and the co-pay amount he or she may be charged. Client eligibility must be assessed on an annual basis.

DETERMINING FAMILY PLANNING PROGRAM ELIGIBILITY

Eligibility Requirements

- Eligible clients must be:
 - females and males age 64 years and younger;
 - Texas residents. Residency is self-declared. Contractors may require residency verification, but such verification should not jeopardize delivery of services;
 - at/or under 250% of the federal poverty level (FPL). Contractors must require income verification. If the methods used for income verification jeopardize the client's right to confidentiality or impose a barrier to receipt of services, the contractor must waive this requirement. Reasons for waiving verification of income must be noted in the client record.
 - For un-emancipated, unmarried individuals under 18 years of age, if parental consent is required for the receipt of services per Section 32 of the Texas Family Code, the family's income must be considered in determining the charge for the service.
 - If parental consent is not required to provide services to an individual under 18 years of age, per Section 32 of the Texas Family Code, only the individual's income is used to assess eligibility, not the income of other

family members. In this case, the minor's own income is applied and the size of the family should be recorded as one.

If a barrier to receiving Family Planning Program services exists, the contractor may waive the requirement and approve full eligibility.

Clients who were deemed eligible for the Expanded Primary Health Care Program from July 1, 2015 to June 30, 2016 will not have to be rescreened for Family Planning Program eligibility; however, their eligibility must be documented in the client record.

For the purpose of determining Family Planning Program eligibility, the following definitions will be used:

- **Household** -- The household consists of a person living alone or a group of two or more persons related by birth, marriage including common-law, or adoption, who reside together and are legally responsible for the support of the other person. Household is self-declared.
 - For example: If an unmarried applicant lives with a partner, **ONLY** count the partner's income and children as part of the household **IF** the applicant and his/her partner have mutual children together. Unborn children should also be included. Treat applicants who are 18 years of age as adults. No children aged 18 and older or other adults living in the household should be counted as part of the household group.
- **Income** -- All income received must be included. Income is calculated before taxes (gross). Include sources of income as defined in the HHSC Family Planning Program Definition of Income (See Appendix D).
 - For individuals who are married or who are 18 years of age or older, the income of all family members must be used.
 - For un-emancipated, unmarried individuals **UNDER** 18 years of age, if parental consent is required for the receipt of services per Section 32 of the Texas Family Code, the family's income must be considered in determining the charge for the service.
 - If parental consent is not required to provide services to an individual **UNDER** 18 years of age, per Section 32 of the Texas Family Code, only the individual's income is used to assess eligibility, not the income of other family members. In this case, the minor's own income is applied and the size of the family should be recorded as one.
- **Income Deductions** - Dependent care expenses shall be deducted from total income in determining eligibility. Allowable deductions are actual expenses up to \$200.00 per child per month for children under age 2 and \$175.00 per child per month for each

dependent age 2 or older.

Legally obligated child support payments made by a member of the household group shall also be deducted. Payments made weekly, every two weeks or twice a month must be converted to a monthly amount by using one of the conversion factors listed below.

Monthly Income Calculation

- If income is received in lump sums or at longer intervals than monthly, such as seasonal employment, the income is prorated over the period of time the income is expected to cover.
- Weekly income is multiplied by 4.33.
- Income received every two weeks is multiplied by 2.17.
- Income received twice monthly is multiplied by 2.

Subsidized services must be made available to clients up to 250% of the current FPL.

RE-SCREENING FOR HTW

- An applicant must be re-screened at subsequent visits if her eligibility for HTW has not been determined after 45 calendar days from the application submission date.
 - If the applicant seeks services within the 45 days from the application submission date, and the client has undetermined HTW eligibility, then contractors are not required to re-screen for HTW.
- Applicants who were initially screened ineligible for HTW because of their citizenship or immigration status must be re-screened annually or when the client reports a change in their citizenship or immigration status.
- If the applicant has been deemed ineligible for HTW, a copy of the denial letter must be maintained in the client record. Applicants who do not provide a copy of denial letter must be re-screened at subsequent visits.
- Individuals who refuse to apply for HTW must be re-screened at subsequent visits.

ADJUNCTIVE ELIGIBILITY

An applicant is considered adjunctively (automatically) eligible for HHSC Family Planning Program services at an initial or renewal eligibility screening, if she/he is currently enrolled in one of the following programs:

- Children's Health Insurance Program (CHIP), Supplement Nutrition Assistance Program (SNAP),
- Temporary Assistance for Needy Families (TANF), and/or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The applicant must be able to provide proof of active enrollment in the adjunctively eligible program. Acceptable eligibility verification documentation may include:

PROGRAM	DOCUMENTATION
CHIP	<i>'Your Texas Benefits' card*</i>
SNAP	<i>SNAP eligibility letter</i>
TANF	<i>TANF verification of certification letter</i>
WIC	<i>WIC verification of certification letter, printed WIC-approved shopping list, or recent WIC purchase receipt with remaining balance</i>

*NOTE: Presentation of the 'Your Texas Benefits' card does not completely verify current eligibility. To verify eligibility, contractors can go to www.YourTexasBenefitsCard.com, call TMHP at 1-800-925-9126, or access [TexMedConnect](#) to enter or give the applicant's Medicaid ID number (PCN) as listed on the card.

If the client or the client's child (must be considered part of the household) is enrolled in the Children's Health Insurance Program (CHIP), she/he may be considered adjunctively eligible.

If the applicant's current enrollment status cannot be verified during the eligibility screening process, adjunctive eligibility would not be granted. Contractor would then determine eligibility according to usual protocols.

CALCULATION OF APPLICANT'S FEDERAL POVERTY LEVEL PERCENTAGE

Household FPL Calculation

If a contractor collects a client co-pay, the contractor must determine the applicant's exact household Federal Poverty Level (FPL) percentage. The steps to do so include:

1. Determine the applicant's household size.
2. Determine the applicant's total monthly income amount.
3. Divide the applicant's **total monthly income** amount by the **maximum monthly income** amount at 100% FPL, for the appropriate **household size**.
4. Multiply by 100%

The maximum monthly income amounts by household size are based on the Department of Health and Human Services [federal poverty guidelines](#). The guidelines are subject to change around the beginning of each calendar year. For more information see Appendix E.

Example:

Applicant has a total monthly income of \$2,093 and counts three (3) family members in the household.

Total Monthly Income	Maximum Monthly Income (Household Size of 3)	Actual Household FPL%
\$2,093	÷ \$1,674	= 1.25 x 100% = 125% FPL

DATE ELIGIBILITY BEGINS

An individual is eligible for services beginning the date the contractor determines the individual eligible for the program and signs the completed application.

CLIENT FEES/CO-PAYS

All Family Planning Program services provided at an HHSC Family Planning Program funded clinic, including non-reimbursable services, must be offered on a sliding fee scale. (See Example co-pay schedule in Appendix E.)

Please note the following:

- Medicaid-eligible clients must never be charged a fee for services covered by Medicaid.
- HTW-eligible clients must never be charged a fee for services covered by HTW.
- HHSC Family Planning Program-eligible clients at or under 100% FPL must never be charged a fee for services covered by the program.
- Clients must never be denied services because of inability to pay current fees or any fees owed. Signs indicating this policy should be visibly posted at contractor clinic sites.

CO-PAY GUIDELINES:

- Clients between 101% and 250% FPL *may* be assessed a co-pay for Family Planning Program services. If a client is charged a co-pay, the co-pay amount must be reflected on the client's account.
- Clients who are assessed a co-pay should be presented with the bill at the time of service.

- Contractors must maintain records regarding client co-pays paid and any balance owed. Contractors must also have a system for aging accounts receivable. This system must be documented in the contractor's policy and procedures and must clearly indicate a timeframe for removing balances from a client's account due to inability to pay.

A co-pay schedule must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service. Individuals whose household income is at or below 100% of the FPL must not be charged a co-pay. Individuals whose household income is between 101% and 250% of FPL *may* be charged a co-pay, but it is not required.

- Appendix E is an example of a co-pay schedule. Contractors can adopt the example or develop their own. The co-pay schedule must have proportional FPL increments and co-pay amounts. The maximum co-pay amount must not exceed \$30.00. If a contractor does not use the HHSC Family Planning Program example, the scale must be submitted to and approved by the HHSC Family Planning Program staff.
- The co-pay schedule must be updated when the revised Federal Poverty Income Guidelines are released. Contractors must have policies and procedures regarding co-pay collection, which must be approved by the contractor's Board of Directors.
- Services may be provided to clients with third-party insurance if the confidentiality of the client is a concern or if the client's insurance deductible is 5% or greater of their monthly income.
- Client co-pays collected by the contractor are considered program income and must be used to support the delivery of HHSC Family Planning Program services.

OTHER FEES

Clients shall not be charged administrative fees for items such as processing and/or transfer of medical records, copies of immunization records, etc.

Contractors are allowed to bill clients for services outside the scope of Family Planning Program reimbursable services, if the service is provided at the client's request, and the client is made aware of his/her responsibility for paying the charges.

CONTINUATION OF SERVICES

Contractors who have expended their awarded Family Planning Program funds are required to continue to serve their existing Family Planning Program clients.

If other funding sources are used to provide Family Planning Program services, the funds must be reported as non-HHSC funds on the monthly State Purchase Voucher (Form B-13) and the quarterly Financial Status Report (FSR or Form 269A).

GENERAL CONSENT

Contractors must obtain the patient’s written, informed, voluntary general consent to receive services prior to receiving any clinical services. A general consent explains the types of services provided and how client/patient information may be shared with other entities for reimbursement or reporting purposes. If there is a period of time of three years or more during which a patient does not receive services, a new general consent must be signed prior to reinitiating delivery of services.

Consent information must be effectively communicated to every patient in a manner that is understandable. This communication must allow the patient to participate, make sound decisions regarding her/his own medical care, and address any disabilities that impair communication (in compliance with Limited English Proficiency regulations). Only the patient may consent. For situations when the patient is legally unable to consent (e.g., a minor or an individual with development disability), a parent, legal guardian, or caregiver must consent on his/her behalf. Consent must never be obtained in a manner that could be perceived as coercive.

In addition, as described below, the contractor must obtain the informed consent of the client for procedures as required by the Texas Medical Disclosure Panel.

HHSC contractors should consult a qualified attorney to determine the appropriateness of the consent forms utilized by their health care agency.

PROCEDURE-SPECIFIC INFORMED CONSENTS**Sterilization Procedures:**

There are two consent forms required for sterilization procedures:

- the Sterilization Consent Form, and
- the Texas Medical Disclosure Panel Consent.

The Sterilization Consent Form

The Sterilization Consent Form is a federally mandated consent form and is necessary for both abdominal and trans-cervical sterilization procedures in women and vasectomy in men. It is provided in the Texas Medicaid Provider Procedures Manual (TMPPM), and is the only acceptable consent form for sterilizations funded by regular Medicaid (Title XIX), HTW, or the HHSC Family Planning Program. An electronic copy of the Sterilization Consent Forms (in English and Spanish) may be found on the [TMHP website](#). It is important that contractors use the most recent Sterilization Consent Form available. Additionally, it is the contractor’s responsibility to ensure that the form is complete and accurate prior to submission to TMHP.

In brief, the individual to be sterilized must:

- be at least **21 years old** at the time the consent is obtained;
- be mentally competent;
- voluntarily give his or her informed consent;
- sign the consent form **at least 30 days but not more than 180 days prior** to the sterilization procedure*; and
- may choose a witness to be present when the consent is obtained.

**An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after the client gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.*

The consent form must be signed and dated by the:

- individual to be sterilized;
- interpreter, if one is provided;
- person who obtains the consent; and
- physician who will perform the sterilization procedure.

Informed consent may **not** be obtained while the individual to be sterilized is:

- in labor or in the process of delivering an infant or infants;
- seeking to obtain or obtaining an abortion; or
- under the influence of alcohol or other substances that affect the individual's state of awareness.

Texas Medical Disclosure Panel Consent

The [Texas Medical Disclosure Panel \(TMDP\)](#) was established by the Texas Legislature to 1) determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients, and 2) establish the general form and substance of such disclosure. TMDP has developed a List A (informed consent requiring full and specific disclosure) for certain procedures, which can be found in the [Texas Administrative Code \(TAC\)](#).

Contractors that directly perform tubal sterilization and/or vasectomy (both List A procedures), must also complete the [TMDP Disclosure and Consent Form](#). This consent is in addition to the Sterilization Consent Form noted on the previous page.

The required disclosures for tubal sterilization are:

- injury to the bowel and/or bladder;
- sterility;

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- failure to obtain fertility (if applicable);
 - failure to obtain sterility (if applicable); and
 - loss of ovarian functions or hormone production from ovary(ies).

The required disclosures for vasectomy are:

- loss of testicle; and
- failure to produce permanent sterility.

For all other procedures not on List A, the physician must disclose, through a procedure-specific consent, all risks that a reasonable patient would want to know about. This includes all risks that are inherent to the procedure (one which exists in and is inseparable from the procedure itself) and that are material (could influence a reasonable person in making a decision whether or not to consent to the procedure).

CONSENT FOR SERVICES TO MINORS

Minors age 17 and younger are required to obtain consent from a parent or guardian before receiving certain medical services. HHSC Family Planning Program contractors must have proof of a parent's or guardian's consent prior to providing Family Planning Program services to a minor client. Proof of consent must be included in the minor client's medical record.

Parental consent is **not** required for minors to receive pregnancy testing, HIV/STD testing, treatment for a STD, or prenatal care.

For information on health services and consent requirements for minors see: [Adolescent Health – A Guide for Providers](#) and [The Texas Family Code, Chapter 32](#), part of which is outlined below.

Texas Family Code Chapter 32 Sec. 32.003. CONSENT TO TREATMENT BY CHILD: There are instances in which a child may consent to medical, dental, psychological, and surgical treatment for the child by a licensed physician or dentist if the child:

- (1) is on active duty with the armed services of the United States of America;
- (2) is:
 - (A) 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and
 - (B) managing the child's own financial affairs, regardless of the source of the income;

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- (3) consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health, including all diseases within the scope of Section 81.041, Health and Safety Code;
 - (4) is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
 - (5) consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use;
 - (6) is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental, psychological, or surgical treatment for the child; or
 - (7) is serving a term of confinement in a facility operated by or under contract with the Texas Department of Criminal Justice, unless the treatment would constitute a prohibited practice under Section 164.052(a)(19), Occupations Code.

CONSENT FOR HIV TESTS

[Texas Health and Safety Code](#) §81.105 and §81.106 are as follows:

§ 81.105. INFORMED CONSENT

- (a) Except as otherwise provided by law, a person may not perform a test designed to identify HIV or its antigen or antibody without first obtaining the informed consent of the person to be tested.
- (b) Consent need not be written if there is documentation in the medical record that the test has been explained and the consent has been obtained.

§ 81.106. GENERAL CONSENT

- (a) A person who has signed a general consent form for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical tests or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect.

- (b) Except as otherwise provided by this chapter, the result of a test or procedure to determine HIV infection, antibodies to HIV, or infection with any probable causative agent of AIDS performed under the authorization of a general consent form in accordance with this section may be used only for diagnostic or other purposes directly related to medical treatment.

CLINICAL POLICY

This chapter describes the requirements and recommendations for Family Planning Program contractors pertaining to the delivery of direct clinical services to patients. In addition to the requirements and recommendations found within this section, contractors should develop protocols consistent with national evidence-based guidelines appropriate to the target population.

All providers must offer the following core family planning services:

- Contraceptive services (pregnancy prevention and birth spacing)
 - Intrauterine devices (IUDs), contraceptive implants, oral contraceptive pills, three-month (medroxyprogesterone) injections, sterilizations, etc.
- Pregnancy testing and counseling
- Health screenings
 - Cervical cancer screening (Pap smears, etc.)
 - Screening for hypertension, diabetes, and elevated cholesterol
- Preconception health (e.g., screening for obesity, smoking, and mental health)
- Sexually transmitted infection (STI) services
 - Chlamydia and gonorrhea screening and treatment
 - HIV screening

COVERED SERVICES

The Family Planning Program seeks to promote the general and reproductive health of Texas residents by providing safe and effective family planning services to men and women through 64 years of age who reside in Texas and meet program eligibility requirements.

The following services are covered under the Family Planning Program:

- Annual family planning and preventive healthcare visit
- Contraceptive services, all methods except elective abortion and emergency contraception, including necessary follow-up and surveillance
- Preconception care
- Basic infertility services
- Certain screening and diagnostic services, as indicated:
 - Pregnancy testing
 - Screening and treatment of Cervical Intraepithelial Neoplasia; diagnosis of cervical cancer
 - Screening and outpatient treatment for sexually transmitted diseases and infections (STD/STI)
 - HIV testing
 - Breast cancer screening and diagnosis
- Prenatal care services

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- Recommended immunizations
 - Diabetes screening
 - Hypertension screening
 - Screening for elevated cholesterol

Requirement for Documentation of Reproductive Health Services

All patients must receive services related to reproductive health at least annually for covered services to remain reimbursable under the Family Planning Program. Patients using long-acting reversible contraception (intrauterine device, implantable hormonal contraceptive agent) and patients who have undergone permanent sterilization may continue to receive services under the program if they meet eligibility requirements. Providers must document reproductive health-related services (e.g., contraceptive, family planning, preconception, infertility services) using appropriate CPT and ICD-10 codes to ensure continued reimbursement for covered services.

The guiding principle of the Family Planning Program is to improve the reproductive health of women to ensure that every pregnancy and every baby are healthy. At each patient encounter, including encounters for treatment of other conditions (e.g., diabetes, follow up of an abnormal Pap smear), the provider must educate the patient on how the service being provided relates to reproductive health or contraception, and this must be documented in the patient record.

CLIENT HEALTH RECORDS AND DOCUMENTATION OF PATIENT ENCOUNTERS

Providers must ensure that a patient health record (medical record) is created for every client who obtains clinical services (also see Section 1, Chapter 4 – Client Records Management).

All patient health records must be:

- A complete, legible, and accurate documentation of all clinical encounters, including those that take place by telephone;
- Written in ink without erasures or deletions; or documented in the Electronic Health Record (EHR) or Electronic Medical Record (EMR);
- Signed by the provider making the entry, including name of provider, provider title, and date for each entry.
 - Electronic signatures are allowable to document provider review of care.
 - Stamped signatures are not allowable.
- Readily accessible to ensure continuity of care and availability to patients; and
- Systematically organized to allow easy documentation and prompt retrieval of information.

The client health record must include:

- Client identification and personal data, including financial eligibility;
- The client’s preferred language and method of communication;
- Client contact information, including the best way and alternate ways to reach the client, to ensure continuity of care, confidentiality, and compliance with HIPAA regulations;
- A patient problem list, updated as needed at each encounter, indicating significant illnesses and medical conditions;
- A complete medication list, including prescription and nonprescription medications, as well as dietary supplements, updated at each encounter;
- A complete listing of all medication allergies and adverse reactions, and other allergic reactions, displayed in a prominent place, and confirmed or updated at each encounter; if the patient has no known allergies, this should be properly noted.
- Documentation of the client’s past medical history to include all serious illnesses, hospitalizations, surgical procedures, pertinent biopsies, accidents, exposures to blood products, and mental health history;
- Documentation of current and past use of tobacco products, alcohol, and other substances, updated as appropriate;
- A record or history of immunizations, including immunity to rubella based on a history of vaccine or documented serology testing;
- A patient health risk survey and assessment, including tobacco and substance use/abuse, domestic and/or intimate partner violence and/or abuse (for any positive result, the client should be offered referral to a family violence shelter in compliance with [Texas Family Code, Chapter 91](#)), occupational and environmental hazard exposure, environmental safety (e.g., seat belt use, car seat use, bicycle helmets, etc.), nutritional and physical activity assessment, and living arrangements, updated as appropriate at each encounter;
- At each encounter, an encounter-relevant history and physical examination pertinent to the patient’s reason for presentation, with appropriate laboratory and other studies as indicated;
- A plan of care, updated as appropriate, consistent with diagnoses and assessments, which in turn are consistent with clinical findings ;
- Documentation of recommended follow-up care, scheduled return visit dates, and follow-up for missed appointments;
- Documentation of informed consent or refusal of services, to include at a minimum:
 - A general consent for treatment;
 - Verbal or written consent for HIV testing, or patient refusal of testing;
 - Sterilization consent form, if applicable;
 - A completed Texas Medical Disclosure Panel Consent form for any surgical services provided, if applicable;
 - For required or recommended services refused or declined by the patient, documentation of the service offered, counseling provided, and the patient’s decision to decline.

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- Note the following special considerations for adolescent (17 years of age and younger) consent requirements, as required by the [Texas Family Code, Chapter 32](#):
 - Adolescents are required to have consent from a parent or guardian prior to receiving certain medical services; proof of parental consent must be included in the minor patient's medical record.
 - Adolescents are not required to have parental consent in order to receive pregnancy-related services (including pregnancy testing), sexually transmitted disease/infection (STD/STI) and HIV testing, or STD/STI treatment.
 - Documentation of client counseling and education, with attention to risks identified in the health risk assessment; and
 - At every client visit, the record should be updated as appropriate, and the reason for the visit and current health status documented.

Initial Clinical Visit

At the initial clinical visit, or an early subsequent visit, a comprehensive health history must be taken, to include in addition to the elements required for the Client Health Record above (adapt as appropriate to the gender of the client):

- Reason for the visit and current health status;
- Review of systems with documentation of pertinent positives and negatives; and
- A reproductive health history.
 - For women, this includes menstrual history, complete obstetrical history, sexual behavior history (including contraceptive practices, sexually transmitted infection/sexually transmitted disease [STI/STD] and HIV history and risk factors, whether currently sexually active), and reproductive life plan.
 - For men, this includes sexual behavior history (including contraceptive practices, sexually transmitted infection/sexually transmitted disease [STI/STD] and HIV history and risk factors, whether currently sexually active), and reproductive life plan.
- Intimate partner history, to include number and gender of partners, injectable drug use, STI/STDs and HIV history and risk factors, as applicable;
- Cervical and breast cancer screening history, noting any abnormal results and treatment, and dates of most recent testing;
- Other history of gynecological, genital, and/or urological conditions;
- Family health and genetic history.

At every subsequent visit, including the annual primary health care and problem visits, the record must be updated as appropriate, and the reason for the visit and current health status documented.

Annual Comprehensive Family Planning Visit Physical Examination and Testing

The annual family planning visit offers an excellent opportunity for providers to address issues of wellness and health risk reduction as well as addressing any current findings or patient concerns. The annual visit must include an update of the person's health record as described in the Client Health Record section above, as well as appropriate screening, assessment, counseling, and immunizations based on the individual's age, risk factors, preferences, and concerns.

All clients must undergo a physical examination annually as part of the family planning visit. This can be deferred to a later date if the patient's current history and health status do not suggest issues requiring more urgent examination. However, the annual physical examination should not be deferred longer than 6 months, unless the clinician identifies a compelling reason for extended deferral. Such reason must be documented in the client record. Any breast or pelvic examination should be performed only with the consent of the patient. Clients must be offered a suitable method of contraception, such as oral contraceptives, without delay even if the physical examination is put off temporarily or an otherwise asymptomatic individual declines any or all components of the examination.

It is recommended that the family planning visit include all the following components, at least annually, in addition to any other appropriate elements as suggested by history and presenting signs and symptoms (all findings, including tests, results, and patient notification, should be documented in the medical record, as well as patient refusal or other reason for not testing or performing a specified part of the examination):

- Measurement of height, weight, and blood pressure (BP) screening for hypertension; and
- Calculation of body mass index (BMI) with assessment for underweight, overweight, or obesity, with counseling (if indicated) on achieving and maintaining a healthy body weight. (A [BMI calculator](#) is available from the Centers for Disease Control and Prevention.)
- For female patients:
 - Clinical breast examination, breast cancer risk assessment, and breast cancer screening as appropriate based on patient's age, risk, and preferences;
 - Counseling on breast awareness and advice to report any symptom or sign that is concerning to the patient;
 - Screening for cervical cancer beginning at 21 years of age, regardless of sexual history, and continuing as indicated based on the individual's age, prior test results, and treatment history; and
 - Pelvic examination (for all consenting patients 21 years and older; only if indicated by the medical history in consenting patients less than 21 years of age)

to include the following elements:

- Visual examination of the external genitalia, vaginal introitus, urethral meatus, and perianal area;
 - Speculum examination of the cervix and vagina;
 - Bimanual examination of the cervix, uterus, and adnexa; and when indicated, rectovaginal examination.
- For male patients:
 - Visual and manual examination of the external genitalia (scrotum, penis, and testicles) and visual inspection of the perianal area;
 - Assessment for hernia;
 - Palpation of the prostate as indicated by history and patient age; and
 - Advice on testicular awareness and recommendation to report any symptom or sign that is concerning to the patient.
 - Other examination as indicated by history, signs and symptoms, and patient concerns (e.g., thyroid, heart, lungs, abdomen, etc.);
 - Diabetes screening as appropriate for age and risk factors;
 - Other appropriate screening or testing as indicated by age, risk factors, history, physical findings, and patient concerns:
 - Sexually transmitted infections;
 - Pregnancy testing, available on-site (If the pregnancy test is positive, the patient must be given information on good health practices during pregnancy and given or referred for appropriate physical evaluation and initiation of prenatal care, preferably within 15 days.);
 - Rubella immunity testing in women of reproductive age if the status cannot be determined by history or previous testing;
 - Cholesterol and/or serum lipid testing;
 - Thyroid stimulating hormone; and
 - Other testing if indicated.
 - Appropriate family planning counseling and treatment;
 - *[Immunizations](#) as indicated; and
 - Healthy lifestyle interventions and counseling as indicated based on age, risk factors, and client interest and receptiveness.

* Healthcare providers can voluntarily participate in the Texas Department of State Health Services (DSHS) [Adult Safety Net \(ASN\) vaccine program](#), which provides vaccines at no cost.

Counseling and Education

All clients must receive accurate patient-centered education and counseling in their preferred language, presented in a way they are able to understand and to demonstrate their understanding, and documented in the medical record. The intent of patient education is to enable the client to

understand the range of available services and how to access them, to make informed decisions about family planning, to reduce personal health risk, and to understand the importance of recommended tests, health promotion, and disease prevention strategies.

Specific clinical policies must be in place to address counseling and other services provided to adolescents 17 years of age and younger, to include the following, at a minimum:

- Counseling of adolescents must include the following topics:
 - All medically approved methods of contraception, including abstinence;
 - Prevention of STD/STIs and HIV;
 - Domestic, partner, dating, and family violence and the offer of assistance as needed; and
 - Recognition and avoidance of sexual coercion.
- Counseling and clinical services to adolescents must be expedited so that appointments are made available as soon as possible.
- Adolescents must be assured that their privacy and confidentiality will be protected within the parameters of applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), [Texas Family Code, Chapter 32](#), and the Health and Human Services (HHSC) Family Planning Policy Manual.

Details of appropriate educational interventions are included in each section of this clinical policy manual. In addition, links are provided to information of use to patients and educators at the end of most sections.

Requirements for Policies to Ensure Appropriate Follow-up and Continuity of Care

Providers must develop and maintain policies and procedures to ensure proper timely follow-up and continuity of care, to include, at a minimum:

- Tracking pending tests until results are reviewed by provider and patient is notified of results and recommended follow-up;
- Documentation of all tests and results in the client health record;
- A mechanism to inform clients promptly of test results that protects the patient's privacy and confidentiality while supporting and promoting timely, appropriate follow-up;
- A mechanism to track patient compliance with recommended follow-up care, schedule return visits, and follow up on missed appointments; and
- A process to ensure compliance with all applicable state and local laws for disease reporting.

Before a patient is considered lost to follow-up, the contractor must make at least three documented separate attempts to contact the patient.

Problem Visits

For all problem visits, the following elements must be documented in the medical record:

- Reason for the visit
- Appropriate interval medical history and focused history relevant to the problem reported
- Relevant physical examination and testing as indicated, as well as an assessment and treatment prescribed

Referrals

When a client is referred to another provider of services for consultation or continuation of care, the chart must reflect a record of the purpose for the referral, the name of the provider consulted or referred to, counseling of the patient regarding the purpose of the referral, and answering any questions the patient has about the referral. Pertinent patient information and appropriate portions of the medical record must be provided to the referral clinician, and this must also be documented in the medical record. The results of the consultation or referral must be followed up on and documented in the medical record.

When services required as part of the Family Planning contract are to be provided by referral, the contractor must establish a written agreement with a referral resource for the provision of services and reimbursement of costs, and ensure that the patient is charged no more than the appropriately assessed fee.

Contractors must maintain a written policy reflecting these requirements for referral activities.

PRESCRIPTIVE AUTHORITY AGREEMENTS, STANDING DELEGATION ORDERS, AND PROCEDURES

Contractors that provide clinical services must develop and maintain written clinical prescriptive authority agreements (PAAs) and standing delegation orders (SDOs) in compliance with statutes and rules governing medical and nursing practice and consistent with national evidence-based clinical guidelines. When DSHS revises a policy, contractors need to incorporate the revised policy into their written PAAs, SDOs, and procedures.

Prescriptive Authority Agreements

Contractors who delegate the act of prescribing or ordering a drug or device to Advanced Practice Registered Nurse(s) and/or Physician Assistant(s) must have in place a prescriptive authority agreement (PAA), as required by [Texas Administrative Code Title 22, Part 9, Chapter 193](#). The PAA must meet all the requirements delineated in the [Texas Medical Practice Act, Chapter 157](#), including, but not limited to, the following minimum criteria:

- Be in writing and signed and dated by the parties to the agreement;

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- Include the name, address, and all professional license numbers of all parties to the agreement;
 - State the nature of the practice, practice locations, or practice settings;
 - Identify the types or categories of drugs or devices that may be prescribed, or the types or categories of drugs or devices that may not be prescribed;
 - Provide a general plan for addressing consultation and referral;
 - Provide a plan for addressing patient emergencies;
 - Describe the general process for communication and sharing of information between the physician and the advanced practice registered nurse or physician assistant to whom the physician has delegated prescriptive authority related to the care and treatment of patients;
 - If alternate physician supervision is to be utilized, designate one or more alternate physicians who may:
 - Provide appropriate supervision on a temporary basis in accordance with the requirements established by the prescriptive authority agreement and the requirements of this subchapter; and
 - Participate in the prescriptive authority quality assurance and improvement plan meetings required under this section; and
 - Describe a prescriptive authority quality assurance and improvement plan and specify methods for documenting the implementation of the plan that includes the following:
 - Chart review, with the number of charts to be reviewed determined by the physician and advanced practice registered nurse or physician assistant; and
 - Periodic face-to-face meetings between the advanced practice registered nurse or physician assistant and the physician at a location determined by the physician and the advanced practice registered nurse or physician assistant.

The PAA need not describe the exact steps that an advanced practice registered nurse or physician assistant must take with respect to each specific condition, disease, or symptom. The PAA and any amendments must be reviewed at least annually, dated, and signed by the parties to the agreement. A copy of the current PAA must be maintained on-site.

Standing Delegation Orders

Contractors that employ unlicensed and licensed personnel, other than advanced practice nurses or physician assistants, whose duties include actions or procedures for a patient population with specific diseases, disorders, health problems or sets of symptoms, must have written SDOs in place. SDOs are distinct from specific orders written for a particular patient. SDOs are instructions, orders, rules, regulations or procedures that specify under what set of conditions and circumstances actions should be instituted. The SDOs delineate under what set of conditions and circumstances an RN, LVN, or non-licensed healthcare provider (NLHP) actions or tasks may be initiated in the clinical setting, and provide authority for use with patients when

a physician or advance practice provider is not on the premises, and or prior to being examined or evaluated by a physician or advanced practice provider. Example: SDO for assessment of Blood Pressure/Blood Sugar which includes an RN, LVN or NLHP that will perform the task, the steps to complete the task, the normal/abnormal range, and the process of reporting abnormal values.

Other applicable SDOs when a physician is not present on-site may include, but are not limited to:

- obtaining a personal and medical history;
- performing an appropriate physical exam and the recording of physical findings;
- initiating/performing laboratory procedures;
- administering or providing drugs ordered by voice communication with the authorizing physician;
- providing pre-signed prescriptions for:
 - oral contraceptives;
 - diaphragms;
 - contraceptive creams and jellies;
 - topical anti-infective for vaginal use;
 - oral anti-parasitic drugs for treatment of pinworms;
 - topical anti-parasitic drugs; or
 - antibiotic drugs for treatment of STI/STDs.
- handling medical emergencies – to include on-site management as well as possible transfer of client;
- giving immunizations; or
- performing pregnancy testing.

The SDOs must be reviewed, signed, and dated by the supervising physician who is responsible for the delivery of medical care covered by the orders and other appropriate staff, at least annually and maintained on- site.

References

American Academy of Family Physicians (2016). Summary of recommendations for clinical preventive services. AAFP Policy Action Order No. 1968. Available at http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/February%2016%202016%20SCPS.pdf

American College of Obstetricians and Gynecologists (2012). Committee opinion 534: Well-woman visit. *Obstet Gynecol* 120: 421-424. Available at http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Well-Woman_Visit

Centers for Disease Control and Prevention. Clinical care for women website. Available at <http://www.cdc.gov/preconception/careforwomen/index.html>

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Family Planning and Contraceptive Services

Reproductive Life Plan

Providers should encourage all clients to develop a reproductive life plan, which is an outline of each person's immediate and future plans for having children. Questions such as the following can be useful in helping clients to develop the plan:

- Do you have children now?
- Do you desire to have (more) children?
- How many children would you like to have and when?

Of course, providers and clients should understand that such plans can change with time. Providers should take the client's stated plan into account in counseling on contraceptive and family planning services.

- If the client is sexually active and does not desire pregnancy, offer contraceptive services.
- Provide pregnancy testing and counseling to any female client who may be pregnant or who requests such testing. Initiate or provide referral for prenatal services if positive.
- If pregnancy is currently desired and the female client is not pregnant, offer services to help her and her partner to achieve a safe and healthy pregnancy, including basic infertility services if appropriate.

Contraceptive Counseling and Education

At each encounter for services, clients must receive patient-centered counseling and education to enable them to make informed decisions about family planning, including information on preventing STD/STIs and HIV, the results of the physical examination and other testing, method-specific counseling as described below, and other counseling as indicated by the history and clinical evaluation.

Providers must offer clients a wide array of contraceptive options appropriate for the person's health status and reproductive plan. A 6-step approach that seeks to engage the client in the decision-making process while addressing individual personal and cultural preferences will improve client satisfaction and the likelihood that the selected method will be used correctly and consistently.

1. Establish and maintain rapport with the client. Some ways to do this include:
 - a. Ask open-ended questions.
 - b. Ensure confidentiality and privacy, and explain how confidential information may be used.
 - c. Listen to and observe the client.

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- d. Encourage questions, and provide culturally sensitive answers that demonstrate knowledge of the subject matter in language the client understands.
2. Obtain social and clinical information from the client to include the following:
 - a. Health history;
 - b. Current reproductive life plan;
 - c. Contraceptive experience and possible preferences; and
 - d. Assessment of sexual health:
 - i. Current and past practices (e.g., vaginal, oral, anal sex);
 - ii. Past and current contraceptive practices;
 - iii. Partner history (e.g., number, gender, whether concurrently monogamous);
 - iv. Current and past STD/STI prevention (e.g., limiting partners, use of condoms, barriers to condom use, consistency of use); and
 - v. Prior treatment for and possible exposure to STD/STIs.
 3. Work interactively with the client to choose the most appropriate contraceptive method for the individual.
 - a. Educate the client about all contraceptive methods that are safe and appropriate for that individual. An online [patient decision support tool](#) is available from the Association of Reproductive Health Professionals.
 - b. Providers should counsel patients on the [relative effectiveness of methods](#), correct use of methods, potential non-contraceptive benefits (e.g., reduced risk of iron-deficiency anemia with combination hormonal contraceptives), and method side effects, working with the individual or couple to select the method that best meets their needs and wishes.
 - c. Clients should be informed that contraceptive methods other than condoms provide no protection from STD/STIs, including HIV; and that condoms used correctly and consistently do help to reduce the risk of STD/STIs, including HIV.
 - d. Help the client to identify barriers to correct contraceptive method use and develop solutions to overcome barriers.
 4. Perform a physical evaluation appropriate to the method chosen, when warranted. In most cases, no physical examination or laboratory testing is necessary prior to initiating a contraceptive method.
 - a. Blood pressure should be recorded prior to starting combination hormonal contraception.
 - b. Current pregnancy status should be determined at the time of service for any woman receiving contraceptive services, but routine pregnancy testing is not necessary if it is possible to be reasonably certain that she is not pregnant. A provider may be reasonably certain that a woman is not currently pregnant if she
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has no signs or symptoms of pregnancy (either intrauterine or ectopic) and meets at least one of the following criteria:

- i. ≤ 7 days since the start of a normal menses;
 - ii. No sexual intercourse since the beginning of the last normal menses;
 - iii. Has been using a reliable method of contraception correctly and consistently;
 - iv. ≤ 7 days since a spontaneous or induced abortion;
 - v. ≤ 4 weeks postpartum; or
 - vi. < 6 months postpartum, amenorrheic since delivery, and exclusively or almost exclusively breast feeding (at least 85% of infant feedings are breast feedings).
- c. Weight assessment is not necessary before initiating a contraceptive method because obesity alone is not a contraindication to any method. However, a baseline weight measurement may aid in assessing the possible effect of a chosen method on weight change.
- d. Certain tests and components of the physical examination may provide logistical, economic or emotional barriers to contraceptive access or acceptance for some women. In most cases, many of these interventions can be safely delayed or avoided altogether if necessary, to enable a healthy individual to initiate an appropriate and preferred method (although there may be other healthcare-related indications for the interventions). The following tests and examinations are not necessary prior to initiating a contraceptive method:
- i. Pelvic examination, except when fitting a diaphragm or inserting an IUD;
 - ii. Cervical, breast, or other cancer screening;
 - iii. HIV screening;
 - iv. Laboratory testing for hemoglobin, glucose, lipid, or liver enzyme levels; or for thrombogenic mutations; or
 - v. Any physical examination prior to distributing condoms to male or female clients
5. Once a method of contraception is selected, the provider should provide counseling on correct and consistent use, assist the client to develop a plan for correct use and follow-up, and confirm the client's understanding. Certain considerations may increase the likelihood of correct and consistent use.
- a. Ideally, the method should be dispensed on-site (note on-site pharmacy requirements for contractors in the section below on Specific method access requirements for contractors) and started at the time of the visit (rather than waiting for the next menses), if the provider can be reasonably certain the woman is not pregnant (see item 4.b above for criteria to determine with reasonable certainty that a woman is not currently pregnant).

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- b. Multiple cycles (ideally a full year's supply) of oral contraceptive pills, the patch, or the ring should be prescribed or provided to reduce the number of return visits necessary.
 - c. Make condoms available easily and inexpensively.
Note: All Family Planning contractors must make barrier methods and spermicides available on-site.
 - d. If the client's chosen method is not available on-site or immediately, provide another method on the day of the visit to be used until the chosen method can be started.
6. Finally, help the client develop a plan for correct and consistent use of the chosen method and provide a plan for follow-up.
- a. Explore possible reasons for incorrect or inconsistent use and help develop strategies to deal with these. For example:
 - i. Suggest a daily text message or a sign on the bathroom mirror to routinize daily pill taking.
 - ii. Discuss ways to ensure timely return for injections.
 - iii. Discuss side effects, a common reason for method discontinuation, and ways to deal with these.
 - b. Create a follow-up plan with the client, taking into account the client's individual needs and perceived risk of method lapse or discontinuation.
 - c. Confirm the client's understanding of the information given and document this in the medical record.
 - i. The teach-back method, in which the client demonstrates understanding of the information by repeating back the messages received, is a good way to confirm understanding and to increase retention of the information received.
 - ii. Provide counseling with teach-back of the following topics, at a minimum:
 1. Real-world method effectiveness;
 2. Correct method use and common side effects;
 3. Back-up contraceptive methods, including issues related to discontinuation of the chosen method;
 4. Whether or not the method protects against STD/STIs;
 5. Signs of rare, but serious, complications, and what to do if any of these signs occurs;
 6. How to seek urgent or emergency care, including a 24-hour emergency telephone number; and
 7. When to return for follow-up.
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Relative Method Effectiveness

The following contraceptive methods and services necessary to provide them are approved for reimbursement under the Family Planning (FP) Program. Providers must make each method available either on-site or by referral (note on-site pharmacy requirements for Family Planning contractors in the section below on Specific method access requirements for contractors):

- Extremely effective
 - Total sexual abstinence;
 - Lactational amenorrhea (< 6 months postpartum, amenorrheic, and providing at least 85% of infant feedings as breast feedings);
 - *Contraceptive implant;
 - *Intrauterine device; and
 - Male or female sterilization.

- Very effective:
 - Hormonal contraceptive pills;
 - Hormonal contraceptive patch;
 - Progestin injection (i.e., Depo-Provera); and
 - Vaginal ring

- Effective
 - Diaphragm
 - Female condom
 - Male condom
 - Withdrawal (“pulling out”)

- Moderately effective
 - Cervical cap
 - Fertility awareness (“rhythm”)
 - Spermicide
 - Sponge

***Long-Acting Reversible Contraceptive (LARC) Methods**

Because of their safety, reversibility, ease of use, and very high real-world effectiveness, providers are encouraged to make long-acting reversible contraceptive (LARC) agents and devices (i.e., the intrauterine device and the subdermal contraceptive implant) available to all clients who are candidates for their use. See the web page [Long-Acting Reversible Contraception](#)

[Program](#) from the American Congress of Obstetricians and Gynecologists for information and resources on the use of LARCs.

Consent for Sterilization

For clients who choose male or female sterilization, 2 consent forms are required to be signed by the patient after counseling on method-specific risks and benefits is provided and all the patient's questions have been answered:

- The [Sterilization Consent Form](#) must be signed by the patient at least 30 days and not more than 180 days prior to the procedure. An exception is made if the patient undergoes emergency abdominal surgery or preterm birth, in which case, the form must be signed at least 72 hours before the sterilization procedure (and at least 30 days prior to the expected date of delivery if preterm birth is the reason for the exception).
- A Texas Medical Disclosure Panel Consent for the surgical procedure by which sterilization will be performed must be signed by the patient after full disclosure of the risks and possible benefits is provided and all the patient's questions are answered.

Specific Method Access Requirements for Contractors

- LARC methods (i.e., the intrauterine device and the subdermal contraceptive implant) must be available on-site or by referral.
- Male and female sterilization must be made available to clients, subject to program funding stipulations.
- All contractors must make injectable hormonal contraceptive agents, male and female condoms, spermicides, diaphragm, contraceptive sponge, cervical cap, and counseling and education on sexual abstinence available on-site.
- Contractors who are subject to the requirement to maintain a class D pharmacy must also make oral and transdermal hormonal contraceptive agents or vaginal hormonal contraceptive ring available on-site.

The table below outlines the requirements for on-site availability of contraceptive methods and anti-infective agents for Family Planning Program contractors:

Contraceptive Method or Anti-infective Agent	On-site Availability Required	
	Class D Pharmacy	Class D Pharmacy Exempt
Anti-infective agents for treatment of STD/STIs	•	
Barrier methods and spermicides	•	•
Injectable hormonal contraceptives	•	•
Oral contraceptives	•	
Transdermal hormonal contraceptive (patch) and/or vaginal hormonal contraceptive (ring)	•	
Sexual abstinence education and counseling	•	•

Requirements for Contraceptive Referral Services

If the clinicians associated with a Family Planning Program contractor do not provide covered contraceptive services that require a special level of training or expertise (e.g., sterilization, intrauterine device, hormonal implant), these services may be offered by referral to another provider, provided that the service is offered at no more than the discounted client fee that would be charged if the service were provided on-site. Family Planning Program contract clinics that offer such services by referral must have a written agreement with the referral provider to offer the method or service under this condition.

Note:

- Abortion is not considered a method of family planning and no state funds appropriated to the department shall be used to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures provided by contractors.
- Emergency contraceptive pills (EC or ECP) and related provider services are not reimbursable under the Family Planning Program.

References

Centers for Disease Control and Prevention (2014). Providing quality family planning services. *MMWR* 63(4). Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm> (web) <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf> (PDF)

Centers for Disease Control and Prevention. Selected practice recommendations for contraceptive use 2013. *MMWR* 62(No.RR-5). Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm?s_cid=rr6205a1_w (web) <http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf> (PDF)

Resources for Patients and Educators

Association of Reproductive Health Professionals. Method Match. Online decision support tool to help patients compare and select from different methods of contraception; includes information on relative effectiveness of methods. Available at <http://www.arhp.org/methodmatch/>

Resources for Providers

American Congress of Obstetricians and Gynecologists. Long-acting reversible contraception program web page. Provides information, clinical guidance, and educational materials on Long-acting reversible contraceptives [LARCs]. Available at https://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception

Further Reading

O’neil-Callahan M, et al. Twenty-four-month continuation of reversible contraception. *Obstet Gynecol.* (2013) 122(5):1083-91. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012225/> (web); <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012225/pdf/nihms570115.pdf> (PDF)

Peipert JF, et al. Continuation and satisfaction of reversible contraception. *Obstet Gynecol.* (2011) 117(5):1105-13. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3548669/> (web); <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3548669/pdf/nihms430088.pdf> (PDF)

Preconception Services

The goal of preconception care is optimizing the health of every woman to lay the foundation for the best possible outcome of every pregnancy. Because almost half of all pregnancies in the United States are unplanned, and most pregnancies occur in women who did not have a specific preconception care visit prior to becoming pregnant, providers should keep preconception care in mind at every encounter with a woman of childbearing potential.

Good preconception care incorporates all components of general health care as described elsewhere in this manual. Attention should be paid to the following components:

- Optimization of known chronic medical conditions, such as diabetes, hypertension, thyroid disease, epilepsy, asthma, etc.
 - A normal hemoglobin A1c prior to and early in pregnancy can substantially reduce the risk of birth defects in the offspring of mothers with Type 1 and Type 2 diabetes.
 - Women with hyperthyroidism or hypothyroidism should be treated as necessary to ensure that they are euthyroid prior to and during pregnancy to reduce the risk of miscarriage and preterm birth.
 - Women with a history of phenylketonuria should be counseled on the need to follow a low-phenylalanine diet before and during pregnancy to reduce the risk of birth defects and serious developmental delay in the offspring.
- Screening as indicated for any conditions that may be undiagnosed;
- Confirming that immunizations are current;
- Medications (prescription and nonprescription) and potential radiation exposure in early pregnancy:
 - In general, the lowest effective dose of necessary medications is preferred, but patients should be cautioned against discontinuing or changing medications without first consulting their doctor, because an untreated or incompletely treated medical condition may pose greater risk to the fetus and mother than the medication prescribed.
 - Some known teratogenic medications include warfarin, valproic acid, carbamazepine, isotretinoin, and angiotensin-converting enzyme inhibitors.
 - For more patient and provider information on risk associated with specific exposures to medications and other environmental factors, consult the web site of the [Organization of Teratology Information Specialists](#).
- Prevention of STD/STIs;
- Nutrition and food insecurity;
- Occupational and environmental exposures to health risks and teratogens;
- Tobacco and substance use, other high-risk behaviors;
- Family medical history and genetic risk;

- Domestic, intimate, and partner violence;
- Social issues, such as homelessness; and
- Mental health.

Infertility Services

Family Planning contractors must provide basic infertility services to include, at a minimum, an initial infertility interview, related counseling and education, an appropriate physical examination, and referral for further services as indicated. A written policy must be maintained for this. The reader is referred to the references section for more information. A complete discussion of the evaluation and treatment of infertility is beyond the scope of this manual, and many related services are not covered under this program.

Optimizing Natural Fertility

For information on counseling a patient or couple facing difficulty attempting to conceive, see [Optimizing natural fertility: a committee opinion](#) from the American Society for Reproductive Medicine.

References

American Academy of Pediatrics/American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care 7th Ed.* (2012). Ch. 5, pp. 95-106.

American College of Obstetricians and Gynecologists. Committee opinion 313: The importance of preconception care in the continuum of women’s health care. *Obstet Gynecol* (2005). 106: 665-666. Available at http://www.acog.org/Resources_And_Publications/~/_link.aspx?id=75AD1BF47A76489F8E719EA5E3F22797&z=z

Centers for Disease Control and Prevention. Recommendations to improve preconception health and health care – United States. *MMWR* (2006). 55(RR06): 1-23. Available at <http://www.cdc.gov/mmWR/PDF/rr/rr5506.pdf>

Organization of Teratology Information Specialists. MotherToBaby: Medications & more during pregnancy & breastfeeding. Available at <http://mothertobaby.org/fact-sheets-parent/> (provides information for patients and health care providers on teratogenic risk of drugs and other exposures in pregnancy)

Resources for Patients and Providers

Centers for Disease Control and Prevention. Clinical care for women website. Available at <http://www.cdc.gov/preconception/careforwomen/index.html>

Centers for Disease Control and Prevention. Clinical care for men website. Available at <http://www.cdc.gov/preconception/careformen/index.html>

Centers for Disease Control and Prevention. Preconception health and health care web site. Contains links to resources for patients, providers, and patient educators on planning for a healthy pregnancy. Available at <http://www.cdc.gov/preconception/index.html>

References

American Society for Reproductive Medicine (2015). Diagnostic evaluation of the infertile female: A committee opinion. *Fertil Steril* 103: e44-e50. Available at https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/Diagnostic_eval_infertile_female_inpress-noprint.pdf

American Society for Reproductive Medicine (2015). Diagnostic evaluation of the infertile male: A committee opinion. *Fertil Steril* 103: e18-e25. Available at [https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/optimal_evaluation_of_the_infertile_male\(1\).pdf](https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/optimal_evaluation_of_the_infertile_male(1).pdf)

American Society for Reproductive Medicine (2013). Optimizing natural fertility: A committee opinion. *Fertil Steril* 100: 631-637. Available at [https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/optimizing_natural_fertility\(1\).pdf](https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/optimizing_natural_fertility(1).pdf)

Centers for Disease Control and Prevention (2014). Providing quality family planning services. *MMWR* 63(4). Available at <http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>

Patient and Provider Information

American Society for Reproductive Medicine. ReproductiveFacts.org (information for patients on a variety of topics related to fertility and infertility)

Cervical Cancer Screening

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Family Planning Program, and do not include guideline recommendations for patients outside this range.

The majority of cases of cervical cancer occur in women who have never had screening or have had inadequate screening. It is estimated that half of women who receive a diagnosis of cervical cancer have never had cervical cytology testing, and an additional 10% have not had screening in the 5 years prior to the diagnosis of cancer. Providers are encouraged to implement and participate in programs aimed at increasing the percentage of women in their communities who receive indicated cervical cancer screening.

General Considerations

- Cervical cancer screening should begin at age 21 for all sexually active women who are not infected with HIV or receiving immunosuppressive drugs due to a solid organ transplant. (See References section below for information on managing HIV-infected patients. It is reasonable to extrapolate the guidelines for screening of HIV-infected patients to solid organ transplant recipients.)
- Women with a history of in utero exposure to diethylstilbestrol or personal history of cervical intraepithelial neoplasia (CIN) 2 or 3 are at higher risk and should have more frequent screening than described in this policy manual, which is intended for women of average risk.
- Either liquid-based or conventional (PAP smear) methods of cervical cytology are acceptable.

Screening Frequency and Response to Abnormal Findings

- Women 21-29 years of age should undergo screening every 3 years by cervical cytology testing alone, with reflex human papillomavirus (HPV) testing when cytology reveals atypical squamous cells of undetermined significance (ASCUS).
- Women 30-64 years of age should have cotesting with cervical cytology and HPV testing every 5 years (preferred), or cervical cytology testing alone (with reflex HPV testing for ASCUS) every 3 years.
- It is reasonable to perform annual cervical cytology testing in women with in utero exposure to diethylstilbestrol.
- For any patient with an abnormal result, further testing and follow-up should be dictated by findings, diagnosis, and current evidence-based guidelines.

Discontinuation of Screening

- Screening should be discontinued after a hysterectomy with removal of the cervix in patients with no prior history of CIN 2 or greater.

References

Practice Bulletin No. 157: Cervical Cancer Screening and Prevention. *Obstet Gynecol.* 2016 Jan; 127(1):e1-e20

Panel on opportunistic infections in HIV-infected adults and adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at https://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf

Breast Cancer Screening

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Family Planning Program, and do not include guideline recommendations for patients outside this range.

Risk Screening and Patient Counseling

All female patients should have an assessment of their risk for breast cancer, updated periodically, to include the patient's age and ethnicity, personal and family history of breast cancer, other relevant genetic predisposition to breast cancer, and any history of chest radiation (particularly before age 30). A [risk calculator](#) for the individual 5-year risk of developing breast cancer for women 35 years of age and older is available from the National Cancer Institute.

All patients should be counseled on breast awareness, and advised to be familiar with their breasts and to report any changes (such as a mass, lump, thickening, or nipple discharge) promptly.

Screening Frequency

The following considerations* apply to women 40 years of age and older who do not have a preexisting breast cancer or other high-risk breast lesion and who do not have a known underlying genetic mutation (such as a BRCA1 or 2 mutation, or other familial breast cancer syndrome) or a history of chest radiation at an early age.

- All patients 50-64 years of age should be offered screening mammography every other year.
- The decision for screening mammography in women 40-49 years of age should be individualized:
 - While screening mammography may reduce cancer-related deaths in this population, the number of deaths prevented is less than in older populations and the number of false-positive mammography results and negative biopsies is higher.
 - Women who place a higher value on the potential benefits of screening than on the potential harms may choose, and should be allowed, to undergo biennial screening beginning sometime between age 40 and 49.
 - Women with a first-degree relative (parent, sibling, or child) with breast cancer are at increased risk and may benefit more from screening in their 40s than average-risk women.

- There is insufficient evidence to assess the balance of benefits and harms for the following:
 - The use of digital breast tomosynthesis (DBT) as a primary breast cancer screening modality; and
 - The use of breast ultrasonography, DBT, magnetic resonance imaging, or other methods of adjunctive screening in women with dense breasts identified on an otherwise negative screening mammogram.

More frequent or earlier screening mammography may be considered in women with increased or uncertain individual breast cancer risk and in other circumstances where the balance of potential benefits and harms of screening is felt to justify it.

*Note that the recommendations for frequency of mammography screening described above come from the US Preventive Services Task Force Recommendation Statement on Screening for Breast Cancer. The National Comprehensive Cancer Network recommends annual screening mammography be offered to all asymptomatic women 40 years of age and older. Links to both guidelines are provided in the References section immediately below.

Follow-up and Referral for Treatment

Any patient with an abnormality identified on screening or a specific breast complaint (including, but not limited to, a mass, lump, thickening, or nipple discharge) should be evaluated as indicated in a timely manner. Providers should have procedures in place to ensure appropriate patient education and counseling, referral for further evaluation (including additional testing and biopsy) when indicated, communication and coordination with the patient and other providers, and proper follow-up through the conclusion of the case.

Patients who have abnormal clinical breast exam (CBE) or cervical cytology findings may be scheduled to return for repeat exams if this is considered to be appropriate follow up by the clinician. For patients whose cervical cytology test or CBE results in an abnormal finding that requires referral for services beyond those available through family planning, contractors are encouraged, whenever possible, to refer to a DSHS Breast and Cervical Cancer Services (BCCS) contractor. In order to promote the most effective use of limited resources, family planning contractors' clinicians should be familiar with nationally recognized guidelines and algorithms describing recommended practice regarding abnormal cervical cytology and CBE results.

Eligible patients in need of treatment for biopsy-proven breast cancer may apply for coverage under the Medicaid for Breast and Cervical Cancer Program. Information is available at <http://www.dshs.state.tx.us/bcccs/treatment-info.shtm>.

References

Siu, AL. Screening for breast cancer: US Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2016;164(4):279-296. Available at <http://annals.org/article.aspx?articleid=2480757> (web)

National Comprehensive Cancer Network. (2015). NCCN clinical practice guidelines in oncology: Breast cancer screening and diagnosis. Version 1.2015. Available at http://www.nccn.org/professionals/physician_gls/f_guidelines_nojava.asp#detection

Additional Reading

National Comprehensive Cancer Network. (2015). NCCN clinical practice guidelines in oncology: Breast cancer risk reduction. Version 2.2015. Available at http://www.nccn.org/professionals/physician_gls/f_guidelines_nojava.asp#detection

National Comprehensive Cancer Network. (2016). NCCN clinical practice guidelines in oncology: Genetic/familial high-risk assessment: Breast and ovarian. Version 1.2016. Available at http://www.nccn.org/professionals/physician_gls/f_guidelines_nojava.asp#detection

Information for Patients

National Cancer Institute. Mammograms patient information page. Available at <http://www.cancer.gov/types/breast/mammograms-fact-sheet>

National Cancer Institute. Breast Cancer – Patient Version. Available at <http://www.cancer.gov/types/breast>

Online Provider Resources

National Cancer Institute. Breast Cancer Risk Assessment Tool. Available at <http://www.cancer.gov/bcrisktool/Default.aspx>

Sexually Transmitted Disease/Infection (STD/STI) Screening and Treatment

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Family Planning Program, and do not include guideline recommendations for patients outside this range.

Screening and treatment of STD/STIs must follow the current guidelines for [screening](#) and [treatment](#) from the Centers for Disease Control and Prevention (CDC). A risk assessment should be done for all clients to determine what testing is indicated, and documented in the medical record. Following is a brief overview of STD/STI screening recommendations (for more detailed information, go to the CDC screening link above):

- **HIV Screening:**
 - Contractors must provide on-site HIV testing.
 - If HIV testing is done, verbal or written consent should be documented in the medical record. If testing is indicated and the client declines, this should be documented.
 - All clients 13 to 64 years of age should be screened at least once for [HIV](#), using a policy that provides HIV education and allows patients to opt out of screening (i.e., prior to testing, patients are informed that HIV testing will be done as part of the general consent for care and they are free to decline testing if they choose to do so) as desired.
 - Clients who engage in risky sexual practices or share injection drug paraphernalia should be tested annually.
 - Clients who seek testing or treatment of STD/STIs should be tested for HIV at the same time.
 - HIV Counseling: Contractors may provide negative HIV test results to patients in person, by telephone, or by the same method or manner as the results of other diagnostic or screening tests. The provision of negative test results by telephone must follow procedures that address patient confidentiality, identification of the client, and prevention counseling. Contractors must always provide positive HIV test results to patients in a face-to-face encounter with an immediate opportunity for counseling and referral to community support services. Test results must be provided by staff knowledgeable about HIV prevention and HIV testing. Clients whose risk assessment reveals high-risk behaviors should be provided directly or referred for, more extensive risk reduction counseling by a DSHS HIV/STD Program trained risk reduction specialist. To find a DSHS HIV/STD Program contractor, visit the [DSHS HIV/STD](#) website.

- **Chlamydia and Gonorrhea Testing:**
 - Chlamydia and gonorrhea screening must be provided by contractors.

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- Annual chlamydia and gonorrhea screening should be provided for all sexually active women under 25 years of age. If a pelvic examination will not be performed, as in asymptomatic women under 21 years of age and other women who decline a pelvic examination, screening can be performed using a nucleic acid amplification technique on a urine sample or a patient self-obtained vaginal swab.
 - Testing should also be done in older asymptomatic women with increased risk and in all symptomatic women. Indications include, but are not limited to:
 - New or multiple sex partners;
 - A partner who has other partner;
 - Exposure to an STD/STI;
 - Symptoms or signs of cervicitis or an STD/STI;
 - History of pelvic inflammatory disease;
 - A positive test for an STD/STI in the prior 12 months; and
 - Sex work or drug use.
 - Treated patients should be retested approximately 3 to 4 months after treatment to assess evidence of reinfection.
 - All women who are pregnant or attempting pregnancy should be tested.
 - Routine screening of male patients for chlamydia and gonorrhea is not recommended, but should be considered in settings where the prevalence of infection is high such as correctional facilities and adolescent clinics.
 - **Herpes Simplex Virus (HSV) Screening:**
 - Routine screening of asymptomatic patients for genital herpes simplex virus (HSV) infection is not recommended in the general or pregnant population.
 - Testing, counseling, and treatment of symptomatic patients (ie, presence of genital lesions), as well as management of affected pregnant patients, should follow current [CDC guidelines](#).
 - The preferred tests for confirmation of the diagnosis in patients with active genital ulcers or mucocutaneous lesions are cell culture and polymerase chain reaction (PCR) assay.
 - Type-specific serologic testing may be appropriate in some circumstances:
 - When the diagnosis is suspected, but no lesions are present (a culture or PCR assay is not indicated if no lesions are present);
 - When the diagnosis is uncertain and virologic tests (ie, culture and PCR) are negative in a symptomatic patient; or
 - For counseling patients regarding the risk of infection by a partner with known infection.
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- Screening for other infections and more frequent screening should be considered as appropriate based on the patient’s condition, risk factors, and concerns.
 - Pregnant patients:
 - All pregnant women should undergo screening for syphilis, HIV (by an [opt-out](#) policy), and hepatitis B surface antigen as early as possible in the pregnancy.
 - Patients under 25 years of age, and women at increased risk should also have chlamydia and gonorrhea testing.
 - Repeat testing in the third trimester is recommended for patients at increased risk of new infection.

Patient-Delivered Partner Therapy

Patient-delivered partner therapy (PDPT) is the practice of providing therapy to the sexual partner(s) of a person being treated for chlamydia or gonorrhea without first developing a patient-clinician relationship with the partner(s). An amendment to the [Texas Administrative Code, Chapter 22, Section 190.8](#) [Texas Secretary of State], adopted in June, 2009 by the Texas Medical Board, expressly allows PDPT. The exception created by this amendment acknowledges the serious impact of sexually transmitted diseases and the contribution of untreated partners to the reinfection of treated patients and exposure of others to infection.

Providers are encouraged to implement PDPT by providing patients who are being treated for either chlamydia or gonorrhea with medications or prescriptions the partner(s) can use to be treated as well.

Providers may not receive reimbursement for providing partner treatment under this policy to persons who have not been seen as patients.

References

American College of Obstetricians and Gynecologists. Committee Opinion No. 598: The initial reproductive health visit. *Obstet Gynecol* (2014) 123: 1143-1147. Available at http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Adolescent_Health_Care/The_Initial_Reproductive_Health_Visit

Branson, BM., et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR* (2006) 55(RR14): 1-17. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

Centers for Disease Control and Prevention. Genital herpes. Available at <http://www.cdc.gov/std/Herpes/default.htm>

Centers for Disease Control and Prevention. Pregnant women, infants, and children: An opt-out approach to HIV screening. Available at <http://www.cdc.gov/hiv/group/1/pregnantwomen/opt-out.html>

Centers for Disease Control and Prevention. Sexually transmitted diseases: Treatment. Available at <http://www.cdc.gov/std/treatment/default.htm>

Centers for Disease Control and Prevention. STD & HIV Screening Recommendations. Available at <http://www.cdc.gov/std/prevention/screeningreccs.htm>

Expedited (Patient-Delivered) Partner Therapy (information for Patients and Providers):

Centers for Disease Control and Prevention. Expedited partner therapy website. Available at <http://www.cdc.gov/std/ept/>

Texas Dept. of State Health Services. Expedited partner therapy website. Available at <http://www.dshs.state.tx.us/hivstd/ept/default.shtm>

Healthy Lifestyle Intervention

All clients should receive a health risk survey at least annually, to determine areas where lifestyle modifications might reduce the risk of future disease and improve health outcomes and quality of life.

Counseling on Healthy Lifestyle Choices

- All clients should be advised not to smoke or to use tobacco products, and to avoid exposure to second-hand smoke as much as possible. Those who use tobacco products should be advised to quit and assessed for their readiness to do so at each encounter.
- Clients should be counseled on healthy eating patterns and offered access to relevant information.
- Clients should be advised to limit their salt intake.
- Clients should be advised to engage in at least 30 minutes of physical activity or resistance training, tailored to their individual health condition and risks, at least 3 days per week, with no more than 2 consecutive inactive days. More frequent and longer duration (e.g., 60 minutes/day) activity is better.
- See the following section details on why and how to achieve some of these goals.

Diet and Nutrition

There is strong evidence that nutrition plays an important role in our risk of disease. Dietary patterns that emphasize a lower percentage of total calories from fat, reduced amounts of saturated fats, and reduced sodium intake while achieving and maintaining a healthy body weight, have been shown to reduce the risk of cardiovascular disease, the most common cause of death in both men and women in the United States. No single diet has been shown to be the best, and providers should counsel clients on a variety of healthy eating patterns tailored to their particular health condition and cultural background, while preserving the pleasure of meals and eating.

Healthy Dietary Patterns

Two dietary patterns that have been shown to improve some measures of cardiovascular risk are the Dietary Approaches to Stop Hypertension (DASH) and Mediterranean (MED) diets. Both dietary patterns emphasize reduced saturated fat and red meat; and increased fiber, vegetables, fruits, fish, oils, and nuts, while allowing wide freedom of food choices to accommodate eating preferences and cultural differences among individuals.

The MED diet emphasizes:

- Increased servings of fruits (particularly fresh fruits), vegetables (particularly green and root vegetables), whole grains (such as whole-grain breads, rice, pasta, and cereals), and fatty fish (which are rich in omega-3 fatty acids);
- Reduced amounts of red meat (emphasizing lean meats when meat is eaten);
- Substituting lower fat or fat-free dairy products for higher fat options; and

- Using oils (such as olive or canola), nuts (such as walnuts, almonds, or hazelnuts), or margarines containing flaxseed or rapeseed oil, in place of butter and other saturated fats.

The DASH diet is:

- High in vegetables, fruits, low-fat or fat-free dairy products, whole grains, poultry, fish, legumes, and nuts; and
- Low in sweets, sugar-sweetened beverages, and red meats; and
- Lower in total fat and saturated fat than a typical American diet.

Dietary counseling on healthy eating patterns, such as those described above, provided as a routine part of a client encounter, has been shown to reduce blood pressure in those with type 2 diabetes or risk factors for cardiovascular disease, including those with mild untreated hypertension. For individuals with normal or modestly elevated cholesterol, regardless of gender or ethnicity, following a DASH dietary pattern can reduce low-density-lipoprotein cholesterol (LDL-cholesterol) and high-density-lipoprotein cholesterol (HDL-cholesterol). Following a DASH dietary pattern can reduce blood pressure in all individuals, regardless of age, sex, and ethnicity, including those with mild untreated hypertension.

Salt Intake

There is strong evidence that reducing sodium (salt) intake reduces blood pressure in individuals with normal blood pressure as well as those with mild to moderate hypertension, regardless of sex, ethnicity, and age. This holds true even if no other dietary changes are made. Therefore, some individuals who consider the dietary patterns described above too drastic a change can reduce their blood pressure just by lowering their salt intake. Those who adopt a DASH dietary pattern and reduce their salt intake can lower their blood pressure even more. All clients should receive advice to limit their salt intake and counseled on ways to do so.

Cholesterol

In spite of much public attention given to cholesterol in the diet as a cause of poor health, there has been very little research on the effect of reducing dietary cholesterol on the risk of future disease; therefore, no recommendation can be made to counsel clients on dietary cholesterol intake specifically.

Physical Activity

Regular aerobic physical activity (e.g., walking, jogging, dancing, swimming, water-walking, gardening, climbing stairs, even house cleaning) and resistance training (e.g., working with light weights or elastic bands) can reduce the risk of serious disease by lowering LDL-cholesterol and blood pressure. Clients should be encouraged to engage in at least 30 minutes of an activity they enjoy, suitable to their current health status and risk, at least 3 times a week, with no more than two consecutive inactive days. More intensive physical activity (e.g., up to 60 minutes at a setting, more sessions per week), for those whose health status permits, offer more benefit.

Reference

National Heart, Lung, and Blood Institute. Lifestyle interventions to reduce cardiovascular risk: Systematic Evidence Review from the Lifestyle Work Group (2013). Available at <http://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/cardiovascular-risk-reduction/lifestyle>

Information for Patients and Educators

American Heart Association. Healthy Eating. Provides information on food choices, recipes, how to eat healthy when dining out, and how to shop for groceries with a focus on healthy eating. Available at http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/HealthyEating_UCM_001188_SubHomePage.jsp

American Heart Association. Get moving! Easy tips to get active. Provides information on physical activity and fitness. Available at http://www.heart.org/HEARTORG/HealthyLiving/PhysicalActivity/Physical-Activity_UCM_001080_SubHomePage.jsp

American Heart Association. Sodium and Salt. Provides information on ways to reduce dietary salt intake. Available at http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/Nutrition/Sodium-and-Salt_UCM_303290_Article.jsp#.VtcjvPkrKM8

Mayo Clinic. Healthy diets. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/basics/healthy-diets/hlv-20049477>

Mayo Clinic. DASH diet: Healthy eating to lower your blood pressure. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/dash-diet/art-20048456>

Mayo Clinic. DASH diet recipes. Available at <http://www.mayoclinic.org/healthy-lifestyle/recipes/dash-diet-recipes/rcs-20077146>

Mayo Clinic. Mediterranean diet recipes. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/mediterranean-diet-recipes/art-20046682>

Diabetes Mellitus Screening

Who Should Be Screened for Diabetes

The criteria below apply to non-pregnant patients only.

1. Begin screening all adults at 45 years of age.
2. Screen adults < 45 years of age who are overweight or obese (BMI \geq 25 kg/m² [BMI \geq 23 kg/m² for Asian Americans]) with 1 or more risk factor. An [adult BMI calculator](#) is available from the Centers for Disease Control and Prevention (CDC).
3. Screen overweight or obese children or adolescents (19 years of age or younger) with 2 or more additional risk factors. To determine whether the client is overweight or obese, see the CDC web page [Defining Childhood Obesity](#) and the [child and teen BMI calculator](#) provided by the CDC.
4. If test results are normal, retest at least every 3 years. Consider more frequent testing in patients with risk factors.
5. *Patients with prediabetes (IFG or IGT) should be retested every year.
 - IFG and IGT refer to laboratory values that are above the normal range but do not meet the diagnostic criteria for diabetes. Persons with these results are said to have “prediabetes.”
6. All women with a diagnosis of gestational diabetes in a recent pregnancy should have diabetes screening with a 2-hour oral glucose tolerance test at 6-12 weeks postpartum, regardless of other risk factors.
7. All women with any history of gestational diabetes should have testing for diabetes and prediabetes at least every 3 years, regardless of other risk factors.

Risk Factors for Diabetes

- High-risk race or ethnicity (e.g., Latino, African American, Asian American, Native American, Pacific Islander);
- Diabetes in a first-degree relative;
- Physical inactivity;
- Women who ever had gestational diabetes or delivered a baby weighing > 9 pounds;
- *History of prediabetes: hemoglobin A1C > 5.7% (39 mmol/mol), impaired fasting glucose (IFG), or impaired glucose tolerance (IGT) in previous testing;
- HDL cholesterol < 35 mg/dL (0.90 mmol/L) and/or serum triglyceride level > 250 mg/dL (2.82 mmol/L);
- A history of polycystic ovary syndrome;
- A diagnosis of hypertension;
- A history of cardiovascular disease; or
- Any other condition in which insulin resistance is common, such as severe obesity or acanthosis nigricans.

Diagnostic Criteria

Any one or more of the following results, confirmed on repeat testing, meets the criteria for a diagnosis of diabetes (repeat testing for confirmation is not required in the presence of unequivocal clinical hyperglycemia):

1. Fasting plasma glucose (after no caloric intake for a minimum of 8 hours) \geq 126 mg/dL (7.0 mmol/L);
2. Oral glucose tolerance test (OGTT) with a 2-hour postprandial glucose level \geq 200 mg/dL (11.1. mmol/L) following a 75-g glucose load;
3. Hemoglobin A1C \geq 6.5% (48 mmol/mol) (For diagnosis of type I diabetes in individuals with acute hyperglycemic symptoms, blood glucose testing is preferred.); or
4. Random plasma glucose \geq 200 mg/dL (11.1. mmol/L) in the setting of a hyperglycemic crisis or classic symptoms of hyperglycemia. (Confirmation by repeat testing is not required in this setting.)

Test	Criteria to Diagnose Diabetes Mellitus	Comments
Fasting plasma glucose	> 126 mg/dL (7.0 mmol/L)	After no caloric intake for a minimum of 8 hours
Oral glucose tolerance test (with a 75-g glucose load)	2-hour glucose > 200 mg/dL (11.1. mmol/L)	
Hemoglobin A1C	> 6.5% (48 mmol/mol)	For diagnosis of type I diabetes in individuals with acute hyperglycemic symptoms, blood glucose testing is preferred
Random plasma glucose	> 200 mg/dL (11.1. mmol/L)	If this occurs in the setting of a hyperglycemic crisis or classic symptoms of hyperglycemia, confirmation by repeat testing is not required

Table: Diagnostic Criteria for Diabetes Mellitus. All initial results should be confirmed with repeat testing.

References

American College of Obstetricians and Gynecologists (2013). Practice Bulletin No. 137: Gestational diabetes mellitus. *Obstet Gynecol.* 122 406-416.

American Diabetes Association. Standards of medical care in diabetes – 2016. *Diabetes Care* (2016); 39(Suppl. 1). Available at <http://care.diabetesjournals.org/site/misc/2016-Standards-of-Care.pdf>

Resources for Patients and Educators

American Diabetes Association home page: <http://www.diabetes.org>

American Diabetes Association DiabetesPro website (information for providers of care) <http://professional.diabetes.org>

American Diabetes Association Diabetes Educators (information and resources for both patients and educators) <http://professional.diabetes.org/diabetes-education>

Centers for Disease Control and Prevention. Adult BMI calculator. Available at http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

Centers for Disease Control and Prevention. BMI calculator for child and teen. Available at <http://nccd.cdc.gov/dnpabmi/Calculator.aspx>

Centers for Disease Control and Prevention. Defining childhood obesity web page (provides definition of overweight and obesity in children and adolescents 2 to 19 years of age, and link to BMI calculator for children and teens) Available at <http://www.cdc.gov/obesity/childhood/defining.html>

National Diabetes Education Initiative (patient education handouts and links to professional resources): <http://www.ndei.org>

National Institute of Diabetes and Digestive Diseases. National Diabetes Education Program (resources for patients and educators). Available at <http://www.niddk.nih.gov/health-information/health-communication-programs/ndep/pages/index.aspx>

National Heart, Lung, and Blood Institute Aim for a Healthy Weight website: https://www.nhlbi.nih.gov/health/educational/lose_wt

Hypertension Screening

All clients, including those with hypertension, should be advised to adhere to a healthy lifestyle as described in the Healthy Lifestyle Intervention section of this clinical policy manual.

Blood Pressure Thresholds for Diagnosis of Hypertension in Adults

- All clients should undergo blood pressure assessment at least annually.
- At all patient encounters, providers should reinforce the importance of adherence to healthy lifestyle habits.
- For patients who are 60 years of age or older, a systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 90 mm Hg makes a diagnosis of hypertension.
- For patients who are < 60 years of age, a systolic blood pressure ≥ 140 mm Hg or diastolic blood pressure ≥ 90 mm Hg makes a diagnosis of hypertension.
- For all patients 18 years of age or older with chronic kidney disease or diabetes, a systolic blood pressure ≥ 140 mm Hg or diastolic blood pressure ≥ 90 mm Hg makes a diagnosis of hypertension.

Patient Population	BP Threshold to Diagnose Hypertension
< 60 years of age	SBP ≥ 140 DBP ≥ 90
60 years of age or older	SBP ≥ 160 DBP ≥ 90
18 years or older with chronic kidney disease or diabetes	SBP ≥ 140 DBP ≥ 90

Table: Thresholds for the diagnosis of hypertension.

References

James, PA, et al. 2014 Evidence-based guideline for the management of high blood pressure in adults: Report from the panel members appointed to the eighth joint national committee (JNC 8). *JAMA* (2014); 311(5): 507-520. Available at <http://jama.jamanetwork.com/article.aspx?articleid=1791497> (web)
<http://jama.jamanetwork.com/article.aspx?articleid=1791497> (PDF)

AFP Editors. JNC 8 Guidelines for the management of hypertension in Adults. *Am Fam Physician* (2014); 90(7): 503-504. Available at <http://www.aafp.org/afp/2014/1001/p503.html>

Resources for Patients and Educators

American Heart Association. High blood pressure. Provides information on the meaning and importance of high blood pressure, risks for and prevention of high blood pressure, blood pressure monitoring, and treatment of high blood pressure. Available at http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure_UCM_002020_SubHomePage.jsp

National Heart, Lung, and Blood Institute. Description of high blood pressure. Provides a plain-language discussion of the prevention, diagnosis, and treatment high blood pressure. Available at <http://www.nhlbi.nih.gov/health/health-topics/topics/hbp>

Resources for Providers

American Society of Hypertension. Hypertension Guidelines website: <http://www.ash-us.org/About-Hypertension/Hypertension-Guidelines.aspx>

Screening for High Cholesterol

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the Family Planning Program, and do not include guideline recommendations for patients outside this eligibility range.

The diagnosis and treatment of elevated blood cholesterol is a complex subject and a complete discussion is beyond the scope of this clinical policy manual. For more information, providers are referred to the reference section below and relevant textbooks.

Rationale for Cholesterol Screening

Evidence shows that a healthy lifestyle (following a heart healthy diet, maintaining a healthy weight, regular exercise, and avoidance of tobacco products) reduces the risk of cardiovascular disease. In certain persons with specific risk factors, cholesterol-lowering medications (i.e., statins) can further reduce the risk of an adverse health event. Measurement of blood cholesterol is a component of the individual risk assessment in some patients.

Who Should Be Screened for High Cholesterol

- All men 35 years of age and older;
- Men 20-35 years of age with increased risk for coronary heart disease;
- Women 20 years of age and older with increased risk for coronary heart disease (CHD);
- No recommendation is made regarding routine screening in men 20-35 years of age, or in women 20 years of age or older without increased risk of CHD.

Risk Factors

Increased risk of CHD is defined by the presence of any 1 of the risk factors below. Greater risk results from the presence of multiple risk factors.

- Diabetes;
- Personal history of previous CHD or non-coronary atherosclerosis;
- Family history of cardiovascular disease in men before age 50 and in women before age 60;
- Tobacco Use;
- Hypertension; or
- Obesity (body mass index ≥ 30 kg/m²).

Screening Frequency

The optimal interval for screening is uncertain. Reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.

An age at which to stop screening has not been established.

Screening Method

The preferred screening test for elevated cholesterol is the serum lipid panel (total cholesterol, high-density lipoprotein [HDL] cholesterol, and low-density lipoprotein [LDL] cholesterol) in the fasting or non-fasting state. If non-fasting results are used, only the total cholesterol and HDL-cholesterol are reliable. Abnormal screening results should be confirmed by a repeat sample on a separate occasion, and the average of both results should be used for risk assessment.

Evaluation of Screening Results

Results of the lipid profile should be interpreted in the context of the individual's risk factors and 10-year estimated risk of atherosclerotic cardiovascular disease (ASCVD; defined as acute coronary syndrome, myocardial infarction, stable or unstable angina, stroke, transient ischemic attack, coronary or other arterial revascularization procedure, or atherosclerotic peripheral arterial disease). A [risk calculator](#) for 10-year ASCVD risk is available from the American College of Cardiology and American Heart Association.

Studies have shown a benefit of statin therapy in patients with the following risk profiles:

- All patients with clinical ASCVD, regardless of lipid profile results;
- Any patient with LDL-cholesterol ≥ 190 mg/dL;
- Patients 40 years of age or older with diabetes and LDL-cholesterol ≥ 70 -189 mg/dL and no clinical ASCVD;
- Patients 40 years of age or older with diabetes and LDL-cholesterol 70-189 mg/dL and no clinical ASCVD; or
- Patients of any age without diabetes or clinical ASCVD, with LDL-cholesterol 70-189 mg/dL and 10-year ASCVD risk $\geq 7.5\%$.

References

Stone NJ, et al. 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. *Circulation* (2014). 129(25 Suppl 2): S1-S45 Available at <https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full>

National Heart, Lung, and Blood Institute. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Cholesterol in Adults (Adult Treatment Panel III). NIH Publication No. 01-3670, May 2001. Available at <http://www.nhlbi.nih.gov/files/docs/guidelines/atp3xsum.pdf>

U.S. Preventive Services Task Force. The Guide to Clinical Preventive Services, “Lipid Disorders in Adults” (2014). Page 45. Available at <http://www.ahrq.gov/sites/default/files/publications/files/cpsguide.pdf>

Further Reading

Pursnani A, et al. Guideline-based statin eligibility, coronary artery calcification, and cardiovascular events. *JAMA* (2015) 314:134-141 Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4754085/>

Resources for Providers

ASCVD Risk Estimator from the American College of Cardiology. Provides an estimate of the 10-year risk of developing ASCVD. Available at <http://tools.acc.org/ASCVD-Risk-Estimator/>

Postpartum Depression Screening

Prevalence and Risk Factors for Postpartum Depression

As many as 80% of new mothers experience a brief episode of the “baby blues” which may last up to about 2 weeks. Approximately 5-25% of new mothers will experience postpartum depression that warrants intervention. It typically begins in the first 4 to 6 weeks after birth of the infant, but may develop any time in the first year.

Risk factors for postpartum depression include all of the following:

- Lack of social support;
- Symptoms of depression (especially in the third trimester) or anxiety during the pregnancy;
- Prior psychiatric illness or poor mental health, especially prior postpartum depression;
- Family history of depression, anxiety, or bipolar disorder;
- Low socio-economic status or low educational level;
- Poor income or unemployment;
- Poor relationship with the partner or father of the baby;
- A negative attitude toward the pregnancy;
- A recent stressful life event or perceived stress;
- Intention to return to work;
- A history of bothersome premenstrual syndrome;
- A history of physical, sexual, or psychological abuse; domestic violence;
- Stress related to child care issues;
- Medical illness or prematurity in the infant;
- A temperamentally difficult infant; or
- Immigrant from another country.

Common signs and symptoms of postpartum depression include the following (note that some or none of these symptoms may be apparent):

- Difficulty sleeping even when the baby is sleeping;
- Tearfulness, prone to crying;
- Excessive worrying about the baby;
- Excessive anxiety;
- Feelings of guilt, such as the feeling that she is not a good mother;
- Flat affect; or
- Poor appetite.

Screening for Postpartum Depression

Because postpartum depression can be a serious, and sometimes life-threatening condition, all new mothers should have screening for postpartum depression at the postpartum visit. For those who screen negative, repeat screening should be considered at a later visit or when the mother takes her baby in for a checkup.

A standardized self-administered screening tool with review and follow-up questions in a face-to-face interview with the provider will ensure consistency and efficiency in the screening process. The following postpartum depression screening tools are available on-line, and have been validated for use in postpartum patients:

- [Edinburgh Postnatal Depression Scale](#) (EPDS; Cox, Holden, & Sagovsky, 1987)
- [Patient Health Questionnaire-9](#) (PHQ-9; Spitzer, Kroenke, & Williams, 1999)
- [Postpartum Depression Screening Scale](#) (PDSS; Beck & Gable, 2001)

To ensure that all patients are screened without undue interruption of clinic workflow, a convenient approach to screening is the following:

- Give each postpartum patient a screening tool to complete while she waits for her visit with the provider.
- Score the tool and assess whether the screen is positive or negative:
 - EPDS: A score of 10 or more suggests depressive symptoms, a score of 13 or more indicates a high likelihood of major depression; a score of 1 or more on question #10 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
 - PHQ-9: A score of 10 or more indicates a high risk of having or developing depression; a score of 2 or more on question #9 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
 - PDSS Full form: A score of 60 or more suggests depressive symptoms, a score of 81 or more indicates a high likelihood of major depression; a score of 6 or more on the SUI (suicidal thoughts) subscale is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
 - PDSS Short form: A score of 14 or more indicates a high risk of major depression; a score of 2 or more on question #7 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
- The provider should review the screen and discuss it with the woman and ask follow-up questions to evaluate her risk of postpartum depression.

Screening for Suicide Risk

Any patient with a positive screen based on responses to questions related to suicide risk, and any patient who expresses suicidal thoughts or ideation must be evaluated immediately for suicide risk. If the patient is felt to be acutely at risk of suicide, she must be referred for emergent evaluation and/or hospitalization as indicated.

Referral for Treatment

Patients in need of treatment for postpartum depression should be referred to a provider of behavioral health services. Providers must have arrangements in place for appropriate referral of patients to behavioral health providers in their area. For information on local behavioral health care providers, refer to the website of the [Office of Mental Health Coordination](#) of the Texas Health and Human Services Commission, or call 211.

References

American College of Obstetricians and Gynecologists Committee Opinion no. 630. Screening for perinatal depression. *Obstet Gynecol* (2015). 125: 1268-1271. Available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>

Hirst KP and Moutier CY. Postpartum major depression. *American Family Physician* (2010). 82: 926-933. Available at <http://www.aafp.org/afp/2010/1015/p926.html>

Norhayati MN, et al. Magnitude and risk factors for postpartum symptoms: A literature review. *J Affect Disord* (2015). 175: 34-52.

O'Connor E, et al. Primary care screening for and treatment of depression in pregnant and postpartum women: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA* (2016). 315: 388-406.

Trece, CA. An overview of postpartum mood disorders (Conference presentation). Presented at Texas Department of State Health Services Grand Rounds: Postpartum Depression Screening and Management, March 30, 2016.

Resources for Patients and Providers

American Academy of Family Physicians. Postpartum Depression web page. Information for patients and providers on postpartum depression. Available at <http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression.html>

American Academy of Family Physicians. Postpartum Depression Action Plan. Available at <http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression/treatment/postpartum-depression-action-plan.html>

Office of Mental Health Coordination website, Texas Health and Human Services Commission. Provides links to information for providers and patients in Texas on a variety of behavioral health topics, and a link to the Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health treatment services locator. Available at <http://mentalhealthtx.org/>

PERINATAL CLINICAL POLICY

Prenatal services should be provided based on ACOG guidelines.

COMPONENTS OF INITIAL PRENATAL INTERVENTIONS/SCREENING

Prenatal Visit – The initial encounter with a pregnant client includes:

Complete history, physical examination, assessment, planning, treatment, counseling and education, referral as indicated, routine prenatal laboratory tests and additional laboratory tests as indicated by history, physical exam and/or assessment.

COMPONENTS OF RETURN VISIT INTERVENTIONS/SCREENING

Return Prenatal Visit - Follow up prenatal visit includes interval history, physical examination, risk assessment, medical services, nutritional counseling, psychosocial counseling, family planning counseling, and client education regarding maternal and child health topics. Hemoglobin and/or hematocrit, and urinalysis for protein and glucose are also included.

PERINATAL HISTORIES

Prenatal Visit

The comprehensive medical history documented at the initial prenatal visit must at least address the following:

- current health status, including acute and chronic medical conditions, if any;
- significant past illnesses, including hospitalizations;
- previous surgeries and biopsies;
- blood transfusions and other exposure to blood products;
- mental health history (e.g., depression, anxiety);
- current medications, including prescription, over the counter (OTC) as well as complementary and alternative medicines (CAM);
- allergies, sensitivities or reactions to medicines and other substances (e.g. latex, seafood);
- immunization status/assessment, including rubella status;
- reproductive health history, including:
 - o pertinent sexual behavior history, including family planning practices (i.e., past contraceptive use), number of partners, gender of sexual partners;
 - o sexually Transmitted Infections (STIs) (including hepatitis B and C), and HIV history, risks, and exposure;
 - pertinent partner history, including injectable drug use, number of partners;
 - o menstrual history, including last normal menstrual period;
 - o obstetrical history, detailed;
 - o gynecological and urological conditions;

- o cervical cancer screening history (date and results of last Pap test or other cervical cancer screening test, note any abnormal results and treatment); and
- social history/health risk assessment (HRA), including:
 - o home environment, to include living arrangements;
 - o family dynamics with assessment for family violence (including safety assessment, when indicated) (Mandated by Texas Family Code, Chapter 261 and Rider 19);
 - o tobacco/alcohol/recreational drug use/abuse and/or exposure; drug dependency (including type, duration, frequency, route);
 - o nutritional history;
 - o occupational hazards or environmental toxin exposure;
 - o ability to perform activities of daily living (ADLs);
 - o risk assessment including, but not limited to:
 - diabetes;
 - heart disease;
 - intimate partner violence;
 - other physical or sexual abuse;
 - human trafficking;
 - injury;
 - malignancy;
- family history, including genetic conditions;
- review of systems with pertinent positives and negatives documented in health record.

Return Prenatal Visits

Interval history includes:

- symptoms of infections;
- symptoms of preterm labor;
- headaches or visual changes;
- fetal movement (>18 weeks); and
- family violence screening (repeat >28 weeks).

PHYSICAL ASSESSMENTS

All initial and routine prenatal visits must include an appropriate physical exam according to the purpose of visit and week of gestation. For any portion of the examination that is deferred, the reason(s) for deferral must be documented in the client health record.

Initial Prenatal Visit

- height measurement;

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- weight measurement, with documentation of pre-pregnancy weight and assessment for underweight, overweight, and obesity;
 - body mass index (BMI);
 - blood pressure evaluation;
 - cardiovascular assessment;
 - clinical breast exam;
 - visual inspection of external genitalia and perianal area;
 - pelvic exam, including estimate of uterine size (by bimanual exam for gestational age less than or equal to 14 weeks or by fundal height for gestational age equal to or more than 14 weeks);
 - fetal heart rate for gestational age > 12 weeks; and
 - other systems as indicated by history and health risk assessment. (e.g., evaluation of thyroid, lungs, abdomen).

Return Prenatal Visits

- weight measurement;
- blood pressure evaluation;
- uterine size/fundal height;
- fetal heart rate (> 12 weeks);
- fetal lie/position (> 30 weeks); and
- other systems as indicated by history or other findings.

LABORATORY AND DIAGNOSTIC TESTS

All initial and return prenatal visits must include appropriate laboratory and diagnostic tests as indicated by weeks of gestation and clinical assessment. Contractors must have written plans to address laboratory and other diagnostic test orders, results and follow-up to include:

- tracking and documentation of tests ordered and performed for each patient;
- tracking of test results and documentation in patient records; and
- mechanism to address abnormal results, facilitate continuity of care and assure confidentiality, adhering to HIPAA regulations (i.e., making results and interventions accessible to the delivering hospital, facility or provider).

Initial Prenatal Visit Laboratory and Diagnostic Tests

- blood type, Rh and antibody screen;
- sexually transmitted infection testing as indicated by risk assessment, history, and physical exam, and the following:
 - o chlamydia and gonorrhea testing should be done on all patients age 25 or younger, and older patients at increased risk of infection, even if symptoms are not present;

- o Hepatitis B Antigen (HbsAg) (Mandated by Health and Safety Code 81.090);
- o HIV, unless declined by client, who must then be referred to anonymous testing (Mandated by Health and Safety Code 81.090);
 - Review CDC's revised [recommendations for HIV testing](#) for adults and pregnant women.
- o syphilis serology (Mandated by Health and Safety Code 81.090);
- hemoglobin and/or hematocrit;
- rubella serology, or positive immune status /immunization documented in chart;
- cervical cancer screening test (e.g., Pap test) for women 21 years and older, if indicated;
- hemoglobinopathy screening, as indicated;
- urine culture;
- TB skin test as indicated by risk assessment, history, or physical exam (see the Heartland National TB Center algorithm for pregnant clients http://www.heartlandntbc.org/assets/products/evaluation_of_pregnant_patient_at_risk_for_tb.pdf .);
- ultrasound, as clinically indicated; and
- other laboratory and diagnostic tests as indicated by risk assessment, history and physical exam.

ACOG/ACS/ASCCP/ASCP Cervical Cancer Screening Guidelines

- Cervical cancer screening begins at age 21 years;
- Cervical cytology (Pap smear) alone, with reflex human papillomavirus (HPV) testing when cytology reveals atypical squamous cells of undetermined significance (ASCUS), every three (3) years for women between the ages of 21 and 29 years;
- Women 30 years of age and older should have cotesting with cervical cytology and HPV testing every 5 years (preferred), or cervical cytology testing alone (with reflex HPV testing for ASCUS) every 3 years.
- Both liquid-based and conventional methods of cervical cytology are acceptable for screening.

Women with special circumstances, who are considered high-risk (e.g. HIV+, immunosuppressed or were exposed to Diethylstilbestrol (DES) in utero) may be screened more frequently as determined by the clinician.

Clients already following a plan of care/algorithm may continue with that plan of care/algorithm until completed and they return to routine screening. Once the client returns to routine screening follow the guidelines above.

Return Prenatal Visits Laboratory and Diagnostic Tests

- Fetal aneuploidy screening appropriate for the gestational age at the time of testing should be offered to all patients with appropriate counseling;
- diabetes screen (24 – 28 weeks);

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- Glucose Tolerance test (GTT) for abnormal diabetic screen;
 - antibody screen for Rh negative clients, not previously known to be sensitized, between 24 – 28 weeks (if negative, repeat Anti-D immune globulin at ~28 weeks; if positive, refer to specialist in high-risk obstetrics for evaluation of possible maternal Rh-D alloimmunization);
 - hemoglobin and/or hematocrit (recommended recheck between 32 – 36 weeks);
 - group B streptococcus screen, between 35 – 37 weeks if using screened-based approach [see the Centers for Disease Control and Prevention (CDC) revised 2002 recommendations to prevent perinatal transmission of Group B Streptococcus (GBS) infection to the neonate on the CDC web site at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm>];
 - ultrasound, as clinically indicated;
 - non-stress test (NST) to assess fetal well-being, as clinically indicated;
 - biophysical profile (BPP)/fetal biophysical profile (FBPP) to assess fetal wellbeing, as clinically indicated; and
 - other laboratory and diagnostic as indicated by risk assessment, history and physical exam.

DIAGNOSTIC TESTS AND INTERVENTIONS

Ultrasounds

Obstetrical ultrasounds will be reimbursed when clinically indicated, including the following:

- estimation of gestational age for women with uncertain clinical dates;
- verification of dates for women who had a previous cesarean delivery;
- vaginal bleeding of undetermined origin;
- suspected multiple gestation;
- significant uterine size/clinical dates discrepancy;
- pelvic mass;
- suspected ectopic pregnancy;
- suspected fetal death;
- suspected uterine abnormality;
- intrauterine contraceptive device localization;
- abnormal alpha-fetoprotein value;
- follow-up observation of identified fetal anomaly;
- follow-up evaluation of placental location for suspected placenta previa;
- history of previous congenital anomaly;
- serial evaluation of fetal growth in multifetal gestation;
- evaluation of fetal condition in late registrants for prenatal care; and
- Other conditions associated with possible adverse fetal outcome.

Complete ultrasound – A complete evaluation of the pregnant uterus, to include fetal number, viability, presentation, dating measurements, complete anatomical survey; placental localization characterizations, and amniotic fluid assessment.

Complete ultrasound for confirmed multiple gestation – A complete evaluation of the pregnant uterus that includes viability, presentation, dating measurements, complete anatomical survey, placental localization characterizations, and amniotic fluid assessment.

Follow-up or limited ultrasound – A brief, more limited evaluation of the pregnant uterus that may follow a previous complete exam, be it an initial exam prior to 12 weeks, or be it an initial exam 12 weeks which is limited in scope. It includes fetal number, viability, presentation, dating measurements, limited anatomic assessment; placental localization and characterization; and amniotic fluid assessment.

Repeat D-antibody test - For all unsensitized D-negative women at 24-28 weeks of gestation followed by the administration of a full dose of D immunoglobulin if they are antibody negative. If the father is known with certainty to be Rh D-negative, this may be deferred.

Special Procedures

Non-Stress Test (NST) fetal well-being assessment to be performed in the presence of identified risk factors, as indicated, once a viable gestational age has been reached. It may be billed as often as the provider deems the procedure to be medically necessary.

Biophysical Profile (BPP)/Fetal Biophysical Profile (FBPP) – fetal well-being assessment to be performed in the presence of identified risk factors, as indicated, once a viable gestational age has been reached. It may be billed as often as the provider deems the procedure to be medically necessary.

EDUCATION AND COUNSELING SERVICES

Contractors must have written plans for client education that ensure consistency and accuracy of information provided, and that identify mechanisms used to ensure client understanding of the information.

Client education and counseling must be:

- documented in the client health record;
- appropriate to client's age, level of knowledge and socio-cultural background;
- presented in an unbiased manner.

Patient education and counseling during the initial prenatal visit, based on health history, risk assessment and physical exam, must cover the following:

- nutrition and weight gain counseling;
- family and intimate partner violence/abuse;

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- human trafficking;
 - physical activity and exercise;
 - sexual activity;
 - environmental or work hazards;
 - travel;
 - tobacco cessation;
 - alcohol use;
 - substance abuse;
 - breastfeeding;
 - when and where to obtain emergency care;
 - risk factors identified during visit;
 - anticipated course of prenatal care;
 - HIV and other prenatal tests;
 - injury prevention, including seat belt use;
 - cocooning infants/children against pertussis (immunization of family members and potential caregivers of infant);
 - toxoplasmosis precautions;
 - referral to WIC;
 - use of medications (including prescription, over the counter (OTC), and complementary/alternative medicines (CAM));
 - information on parenting and postpartum counseling (Mandated by Chapter 161, Health and Safety Code, Subchapter T); and
 - other education and counseling as indicated by risk assessment, history and physical exam.

Client education and counseling during the return prenatal visits, should be appropriate to weeks' gestation and be based on health history, risk assessment and physical exam, including, but not limited to:

- signs and symptoms of preterm labor beginning in 2nd trimester;
- signs and symptoms of labor as the patient nears term gestation;
- warning signs and symptoms of pregnancy induced hypertension (PIH);
- selecting provider for infant;
- postpartum family planning.

Tobacco Assessment and Quit Line Referral - All women receiving prenatal services should be assessed for tobacco use. Women who use tobacco should be referred to tobacco quit lines. The Texas American Cancer Society Quit Line is 1-877-YES-QUIT or 1-866-228-4327 (Hearing Impaired). The assessment and referral should be performed by agency staff and documented in the clinical record.

Information for Parents of Newborns Requirement: Chapter 161, Health and Safety Code, Subchapter T requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care to pregnant women during gestation or at delivery to provide the

woman and the father of the infant or other adult caregiver for the infant with a resource pamphlet that includes information on postpartum depression, shaken baby syndrome, immunizations, newborn screening, pertussis and sudden infant death syndrome. In addition, it must be documented in the client's chart that she received this information and the documentation must be retained for a minimum of five years. It is recommended that the information be given twice, once at the first prenatal visit and again after delivery.

Information for Parents of Children: Chapter 161, Health and Safety Code, Subchapter T also requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care during gestation or at delivery to pregnant women on Medicaid to provide the woman and the father of the infant or other adult caregiver for the infant with a resource guide that includes information relating to the development, health, and safety of a child from birth until age five. The resource guide must provide information about medical home, dental care, effective parenting, child safety, importance of reading to a child, expected developmental milestones, health care and other resources available in the state, and selecting appropriate child care.

Provision of Information about Umbilical Cord Blood Donation Requirement: Chapter 162, Health and Safety Code, Subtitle H requires that a physician or other person permitted by law to attend a pregnant woman during gestation or at delivery of an infant shall provide the woman with an informational brochure, before the third trimester of the woman's pregnancy or as soon as reasonably feasible, that includes information about the uses, risks and benefits of cord blood stem cells for a potential recipient, options for future use or storage of cord blood, the medical process used to collect cord blood, any costs that may be incurred by a pregnant woman who chooses to donate or store cord blood after delivery, and average cost of public and private storage. The brochure is available on the DSHS website or can be ordered from the DSHS literature warehouse. [https://www.dshs.state.tx.us/pdf/umbilical_brochure_\(2\).pdf](https://www.dshs.state.tx.us/pdf/umbilical_brochure_(2).pdf)

Patient education and counseling during postpartum visits should include but not be limited to:

- Physiologic changes;
- Signs and symptoms of common complications;
- Care of the breast;
- Care of perineum and abdominal incision, if indicated;
- Physical activity and exercise;
- Breastfeeding/Infant feeding;
- Resumption of sexual activity;
- Family planning/contraception;
- Preconception counseling; or
- Depression/postpartum depression

REFERRAL AND FOLLOW-UP

Agencies must have written policies and procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to patients' concerns for confidentiality and privacy and must be in compliance with state or federal requirements for transfer of health information.

For services determined to be necessary, but which are beyond the scope of the agency, patients must be referred to other providers for care. (Whenever possible, patients should be given a choice of providers from which to select.) When a patient is referred to another provider or for emergency clinical care, the agency must:

- Make arrangements for the provision of pertinent patient information to the referral provider (obtaining required patient consent with appropriate safeguards to ensure confidentiality – i.e., adhering to HIPAA regulations)
- Advise patient about his/her responsibility in complying with the referral
- Counsel patient of the importance of the referral and follow-up method.

PROGRAM PROMOTION and OUTREACH

Contractors must promote their Family Planning Program and provide outreach within the community to:

- inform the public of the purpose of the program and available services;
- disseminate basic family planning information;
- enlist community support; and
- attract potential clients.

To help facilitate community awareness of and access to Family Planning Program services, contractors should establish and implement planned community activities to promote their programs.

Contractors should consider a variety of program promotion and client outreach strategies in accordance with organizational capacity, availability of existing resources and materials, and the needs and culture of the local community. In order to gauge the efficacy of program promotion and client outreach activities, contractors must:

- develop an annual Family Planning Program promotion and client outreach plan that includes a minimum of 6 outreach/promotion activities for the year;
- regularly monitor plan implementation;
- evaluate the plan on an annual basis; and
- modify program promotion and outreach activities, as needed.

Contractors must submit a one-page Family Planning Program Promotion Plan for the contract period within forty-five (45) days of the contract start date. The plan should describe the agency's outreach and marketing strategy, and include a description of planned activities to reach potential family planning clients. Contractors must submit a Family Planning Program Promotion/Outreach Annual Report (found in Appendix E) to: famplan@hhsc.state.tx.us.

Section III

Reimbursement, Data Collection and Reporting

Purpose: Section III provides policy requirements for submitting reimbursement, data collection, and required reports.

MEDICAID PROVIDER ENROLLMENT

HHSC Family Planning Program contractors are required to enroll as Medicaid (Title XIX) providers with TMHP. The contractor must complete the required Medicaid provider enrollment application forms and enter into a written provider agreement with the HHSC, the single state Medicaid agency. TMHP Provider Enrollment supplies these forms.

Family planning agencies are not required to enroll as a Physician Group, which includes an application for Performing Provider number. To enroll as a family planning agency, all that is required is a supervisory practitioner. The supervisory practitioner may be a physician or nurse practitioner, and it may be the same person for all clinic sites. Changes in supervisory practitioner must be reported in writing to TMHP. An application must be submitted for the new supervisory practitioner.

When enrolling as a Title XIX provider, Clinical Laboratory Improvement Amendments (CLIA) information must be provided. For public health agencies that provide limited numbers of tests, one CLIA certificate is all that is required for all clinics.

Provider Identifiers

When a contractor's Medicaid application is approved, TMHP assigns the contractor a nine-digit Texas Provider Identifier (TPI). **Contractors must have a unique TPI for each clinical service site.**

Contractors must submit claims to TMHP using the billing TPI where clinical services are rendered. Contractors must not provide Family Planning Program services at one clinic site and bill those services to TMHP using the TPI of a different clinic site. If an additional TPI clinic site is required, providers must contact TMHP and complete the enrollment process.

The TPI is used in conjunction with a National Provider Identifier (NPI) to identify the provider for claims processing. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Numeration System (NPPES). Contractors may apply for an NPI at the [NPPES](#) website.

When a provider obtains their NPI they are required to attest to NPI data for each of their current TPI. For more information on NPI and the attestation process please visit the [TMHP](#) website.

Texas Medicaid & Healthcare Partnership and Compass 21

HHSC Family Planning Program claims are submitted to TMHP. TMHP processes claims using Compass 21, an automated claims processing and reporting system. Claims are subject to the following procedures:

- Claims are verified through a series of program edits and audits.

- Contractors receive an explanation of each payment or denial. The explanation is called the Remittance and Status (R&S) report, which contractors may access electronically through the TMHP website. The report identifies paid, denied, or pending claims. If no claim activity or outstanding account receivable exists during the time period, the contractor will not receive an R&S for the week.

Texas Medicaid Provider & Procedures Manual

The *Texas Medicaid Provider & Procedure Manual* (TMPPM) includes information related to HHSC Family Planning Program claims submission such as:

- Funding sources;
- Claim billing instructions for family planning and third-party insurance;
- Sterilization consent form instructions;
- Use of the 2017 Claim Form;
- Filing deadlines;
- Claim appeals;
- Family Planning Program information;
- Diagnosis and procedure codes;
- Contraceptive devices and related procedures;
- Drugs and supplies;
- Medical counseling and education;
- Sterilization and sterilization-related procedures; and
- Additional filing resources.

In addition, Medicaid bulletins and R&S banner messages provide up-to-date claims filing and payment information. The R&S banner messages, and the TMPPM are all available on the [TMHP website](#).

REIMBURSEMENT FOR FAMILY PLANNING SERVICES

Family planning contractors may seek reimbursement for project costs using one or two methods.

- a) Contractors may submit monthly vouchers for expenses outlined in a categorical budget approved by HHSC, as required for the categorical cost reimbursement method, and/or
- b) Contractors may be reimbursed using the fee-for-service reimbursement method, by submitting monthly claims to TMHP for services rendered.

Contractors may designate up to 50% of their total award on a categorical cost reimbursement basis. The remaining portion of their award will be paid on a fee-for-service basis. Contractors may designate up to 100% of their total award on a fee-for-services basis.

Categorical Reimbursement

The categorical portion of the HHSC Family Planning Program funding is used to develop and maintain contractor infrastructure for the provision of family planning services. The funding can be used to support clinic facilities, staff salaries, utilities, medical and office supplies, equipment, and travel, as well as direct medical services. Costs may be assessed against any of the following categories the contractor identifies during their budget development process:

- Personnel;
- Fringe Benefits;
- Travel;
- Equipment and Supplies;
- Contractual;
- Other; and
- Indirect Costs.

Up to 50% of the HHSC Family Planning Program funds may be disbursed to contractors through a voucher system as expenses are incurred during the contract period. Program income must be expended before categorical funds are requested through the voucher process. Contractors must still submit vouchers monthly even if program income equals or exceeds program expenses, or if the contract reimbursement limit has been met. When program expenses exceed program income, the monthly voucher will result in a payment. Program income includes all fees paid by the clients and HHSC Family Planning Program fee-for-service reimbursements.

To request reimbursement for the categorical contract, the following forms must be submitted monthly within **30 days following the end of the month in which the costs were incurred**:

- State of Texas Purchase Voucher (HHSC Form B-13);
- Supporting Schedule for HHSC Family Planning Program Reimbursement Vouchers (Form B-13X)

The following forms must be submitted within **45 days following the end of the contract term**:

- Final State of Texas Purchase Voucher (HHSC Form B-13)
- Supporting Schedule for HHSC Family Planning Program Reimbursement Vouchers (Form B-13X).

Fee-for-Service Reimbursement

The fee-for-service portion of the HHSC Family Planning Program funding pays for direct medical services on a fee-for-services basis. Up to 100% of HHSC Family Planning Program funds may be reimbursed on a fee-for-service basis. Each contracting agency is responsible for determining an individual's eligibility for clinical services. The HHSC Family Planning Program reimburses contractors on a fee-for-service basis for

services and supplies that have been provided to eligible clients. HHSC Family Planning Program contractors must continue to provide services to established clients and to submit and appeal claims for client services even after the contract funding limit has been met.

All contractors are required to submit claims for all HHSC Family Planning Program services to TMHP use the 2017 Claim Form. A copy of the [2017 Claim Form](#) is available from the TMHP website. The TMPPM provides detailed instructions of how to complete the form, including required and optional fields.

HHSC Family Planning Program claims or appeals must be filed within certain timeframes:

- Initial claims submission: Submitted within 95 days of the date of service on the claim or date of any third party insurance explanation of benefit (EOB). If the 95th day falls on a weekend or holiday, the filing deadline is extended until the next business day.
- Appeals: Submitted within 120 days of the date on the R&S Report on which the claim reaches a finalized status. If the 120th day falls on a weekend or holiday, the filing deadline is extended until the next business day. If the claim is denied for late filing due to the initial submission deadline, documentation of timely filing must be submitted along with the claim appeal. Refer to the TMPPM for further information.
- All claims and appeals must be submitted and processed within 60 days after the end of the contract period.
- All claims must continue to be billed and denied claims appealed even after the contract funding limit has been met.

HHSC Family Planning Program contractors may contact the TMHP Contact Center from 7:00 a.m. to 7:00 p.m. (CST), Monday through Friday at 800-925-9126 for questions about claims and payment status.

Rate Reduction of 7%

Legislative budget reductions from 2010 resulted in a 7% reduction of reimbursement rates effective September 1, 2011. The 7% reduction is taken from the total amount to be reimbursed. This reduction does not change the contract amount.

HHSC Family Planning Program Reimbursable Codes

HHSC Family Planning Program reimbursement is limited to a prescribed set of procedure codes approved by HHSC. For a complete list of valid HHSC Family Planning Program procedures, see Appendix A.

HHSC Family Planning Program contractors may submit claims for clients' office visits that reflect different levels of service for new and established clients. A new client is defined as one who has not received clinical services at the contractor's clinic(s) during the previous three years. The level of services, which determines the procedure code to be billed for that client visit, is indicated by a combination of factors such as the complexity of the problem addressed and the time spent with the client by clinic providers. The [American Medical Association \(AMA\)](#) publishes materials related to Current Procedural Terminology (CPT) ® coding that include guidance on office visit codes (Evaluation and Management Services – E/M).

Medroxyprogesterone Acetate Injection Fee

Providers may not bill a lower complexity office visit code (99211/99212) when the primary purpose is for the client to receive an injection of Medroxyprogesterone acetate (Depo-Provera/DMPA/depo) injection. Rather, contractors should bill the injection fee (96372) with the Depo-Provera contraceptive method (J1050).

Electronic Claims Submission

All HHSC Family Planning Program contractors are strongly encouraged to submit claims electronically. TMHP offers specifications for electronic claims formats. These specifications are available from the TMHP Provider Portal and relate the paper claim instruction to the electronic format. Contractors may use their own claims filing system, vendor software, or TexMedConnect (a free Web-based claims submission tool available through the TMHP website) for submission of electronic claims. For more information concerning electronic claims submission, contractors may contact the TMHP Electronic Data Interchange (EDI) Help Desk at 512-514-4150 or 888-863-3638. Additional information may be found on the TMHP website.

HTW Claims Pending Eligibility Determination

To verify an applicant's HTW eligibility:

- Clients will be issued a Your Texas Benefits card with "HTW" printed in the upper right corner.
- Clients should show their Your Texas Benefits card at the point of service delivery.
- Even with this, though, providers will need to verify the client's eligibility. Providers can do this by going to www.YourTexasBenefitsCard.com. Or, providers can continue to call TMHP at 1-800-925-9126 or go to TexMedConnect on the TMHP website and check the member's Medicaid ID number (PCN).

Contractors must hold claims up to 45 calendar days for clients who have applied to HTW. If a client's HTW eligibility has not been determined after 45 calendar days, the contractor may bill the service to the HHSC Family Planning Program if the client has a current HHSC Family Planning Program eligibility form on file. The contractor can file a HHSC Family Planning Program claim before the 45-day waiting period if a copy of the HTW program denial letter is in the client record before filing the claim.

STERILIZATION BILLING/REPORTING

HHSC Family Planning Program contractors can receive reimbursement for vasectomy or tubal ligation/occlusion sterilization procedures as part of their family planning services. The client may not be billed for any cost above the reimbursement rates. Client co-pays for sterilizations must follow the contractor's established co-pay policy and may not exceed the allowable amount.

Contractors shall expend no more than 15% of their combined HHSC fee-for-service and HHSC categorical contract amounts on female sterilizations. Waivers may be granted to this policy on a case-by-case basis. Contact famplan@hhsc.state.tx.us for more information.

Allowable sterilization codes and descriptions are presented in Appendix A.

Conditions for Sterilization Procedures

Clients receiving a vasectomy or tubal ligation/occlusion sterilization procedure must:

- be twenty-one years of age or older;
- be mentally competent; clients are presumed to be mentally competent unless adjudicated incompetent for the purpose of sterilization;
- not be institutionalized in a correctional facility, mental hospital, or other rehabilitative facility;
- not give consent in labor or childbirth; and
- not give consent if under the influence of alcohol or drugs.

Waiting Period

- Family Planning Program contractors may provide sterilization services to their clients after a waiting period of 30 days.
- Sterilization may be performed within 30 days but more than 72 hours after the date of the individual's signature on this consent form in the following two instances:
 - Premature delivery. The client's expected delivery date must be completed on the sterilization consent form; or
 - Emergency abdominal surgery. The client's circumstances must be described on the sterilization consent form.

The consent for sterilization is valid for 180 days from the date of the client's signature.

Sterilization Consent Form

The TMPPM provides both an English and Spanish version of the Sterilization Consent Form to be used by HHSC Family Planning Program contractors. The form may be copied for use and contractors are encouraged to frequently re-copy the original form to

ensure legible copies and to expedite consent validation. The TMPPM also includes detailed instructions for the completion of the Sterilization Consent Form. It is important that contractors use the most recent Sterilization Consent Form available. Additionally, it is the contractor's responsibility to ensure that the form is complete and accurate prior to submission to TMHP. For more information regarding the Sterilization Consent Form and Instructions please see Section II, Chapter 2 in this manual.

Sterilization Complications

Contractors may request reimbursement for costs associated with patient complications related to sterilization procedures. Contractors may be reimbursed for approved charges up to \$1,000 per occurrence. To request reimbursement, contractors should provide the HHSC Family Planning Program with the following information:

- A copy of the R&S report showing that a sterilization procedure was performed on the client in question;
- A narrative summary detailing the procedure performed and any related complications;
- All surgical and progress notes for the client related to the complications of the sterilization procedure;
- The initial operative report for the sterilization surgery; and
- A completed paper 2017 Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the HHSC Family Planning Program).

IUD AND CONTRACEPTIVE IMPLANT COMPLICATIONS

Contractors may request reimbursement for costs associated with patient complications related to IUD or contraceptive implant insertions or removals. Contractors may be reimbursed for approved charges up to \$1,000 per occurrence. To request reimbursement contractors should provide the HHSC Family Planning Program with the following information:

- A copy of the R&S report showing that an IUD or contraceptive implant insertion or removal procedure was performed on the client in question;
- A narrative summary detailing the procedure performed and any related complications;
- All surgical and progress notes for the client related to the complication of the IUD or contraceptive implant insertion or removal procedure; and

- A completed paper 2017 Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the HHSC Family Planning Program).

RETROACTIVE ELIGIBILITY

Title XIX Retroactive Eligibility

Retroactive eligibility occurs when an individual has applied for Medicaid coverage but has not yet been assigned a Medicaid client number at the time of service. Individuals who are eligible for Title XIX (Medicaid) medical assistance receive three months prior eligibility to cover any medical expenses incurred during that period.

HHSC Family Planning Program Retroactive Eligibility

Any co-pay collected from a client found to be eligible retroactively for Medicaid must be refunded to the client. If a claim has been paid and later the client receives retroactive Title XIX (Medicaid) eligibility, TMHP recoups/adjusts the funds paid from the HHSC Family Planning Program and processes the claim as Title XIX. A HHSC Family Planning Program accounts receivable (A/R) is then established for the adjusted claim.

Note: Contractors are responsible for paying HHSC back the amount of any HHSC Family Planning Program A/R balance that may remain at the end of a state fiscal year.

The contractors' HHSC Family Planning Program R&S Report(s) will reflect the retroactive Title XIX adjustment with EOB message "Recoupment is due to Title XIX retro eligibility."

Assistance on reconciling R&S reports may be provided through the TMHP Contact Center from 7:00 a.m. to 7:00 p.m. CST, Monday through Friday at 800-925-9126. A TMHP Provider Relations representative is also available for these specific questions, as a representative can be located by region on the TMHP website.

Performing Provider Number and Retroactive Eligibility

HHSC Family Planning claims do not require a performing provider number for reimbursement. However, if a Title XIX retroactive eligibility claim does not have a performing provider number in a TPI format, TMHP will deny the services. A common EOB message for this specific denial is *EOB 00118: Service(s) require performing provider name/number for payment*. A request for reconsideration of claim reimbursement may be sent to TMHP through the appeal methods.

Note: The performing provider number requirement applies to all Title XIX submissions.

Claims Submitted with Laboratory Services

If a Title XIX retroactive eligibility claim includes laboratory services and the HHSC Family Planning Program contractor is not CLIA certified for the date of service on the claim, TMHP will deny the laboratory services. The Title XIX R&S report will reflect

EOB 00488 message: “Our records indicate that there is not a CLIA number on file for this provider number or the CLIA is not valid for the dates of services on the claim”.

When this occurs, the laboratory that performed the procedure(s) is responsible for re-filing laboratory charges with TMHP to receive Title XIX reimbursement. For claims past the 95-day filing deadline, the laboratory will be required to follow their Medicaid appeals process. Contractors must make arrangements with their contracted laboratory to recoup any funds paid to the laboratory for lab services for HHSC Family Planning Program clients prior to Title XIX retro eligibility determination.

Patient Co-Pays

Title XIX does not allow providers to collect co-pays. HHSC Family Planning Program contractors must refund any co-pay collected if the client services were billed to Title XIX.

Also see Section II, Chapter 1 for HHSC Family Planning Program for co-pay guidelines.

NOTE: Contractors who have expended their awarded funds must continue to serve their existing eligible clients and submit fee-for-service claims for services provided. It is allowable to obtain other funding to pay for these services as well as continue to charge co-pay per policy. This funding should be recorded as program income for the Family Planning Program contract.

DONATIONS

Voluntary donations from clients are permissible. However, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies. Donations are considered program income per specification of contract general provisions. All donations must be documented by source, amount, and date they were received by the contractor. Contractors must have a written policy on the collection of donations. Client donations collected by the contractor must be utilized to support the delivery of family planning services.

REQUIRED REPORTS

Financial Reporting

VOUCHER AND REPORT SUBMISSION – Categorical

PROGRAM INFORMATION:

Program Name: HHSC Family Planning Program

Contract Type: Categorical

Contract Term: July 1, 2016 thru August 31, 2017

VOUCHER: Voucher 1

Voucher Name: State of Texas Purchase Voucher-Form B-13

Submission Date: By the last business day of the following month. Final voucher due within 45 days after end of the contract term.

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women’s Health & Education Services		X	Email	1

Instructions: Attach B-13X to voucher form B-13.

NOTE: Vouchers must be submitted each month even if there are zero expenditures. Vouchers must still be submitted each month for actual expenditures of the program even if the contract limit has been reached.

VOUCHER: Report 1--Supporting

Report Name: Supporting Schedule for Family Planning Reimbursement Vouchers Form B-13X in Excel format

Submission Date: By the last business day of the following month. Final B-13X due within 45 days after end of the contract term.

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women’s Health & Education Services		X	Email	1

Instructions: Attach B-13X to B-13.

REPORT: Report 1

Report Name: Financial Status Report Form 269A

Submission Date: For FY17, reports are due as follows: Quarter 1: July – August 2016; Quarter 2: September – November 2016; Quarter 3: December 2016 – February 2017; Quarter 4: March – May 2017; Quarter 5: June – August 2017. Submit 30 days after the end of each quarter. The final quarterly FSR is due 45 days after the end of the contract term. The final quarter report includes all final charges and expenses associated with the program contract. Mark it as "Final".

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women’s Health & Education Services	X		Email	1

Instructions: Form 269A must have an original signature (scanned email or fax accepted).

PROGRAM INFORMATION:

Program Name: HHSC Family Planning Program

Contract Type: Fee-for-Service (File Furnished Voucher thru TMHP TexMed Connect/Compass 21)

Contract Term: July 1, 2016 thru August 31, 2017

CLAIMS SUBMISSION INFORMATION:

Claims Submission Form: 2017 Claim Form--File Furnished Voucher thru TMHP TexMed Connect/Compass 21

Claims Filing Deadline: Within 95 days from date of service or date of 3rd party insurance EOB form. Within 45 days after the end of the contract term.

Claims Submission Entity: Texas Medicaid Healthcare Partnership/Compass 21

NOTE: Claims must continue to be submitted to TMHP TexMed Connect/Compass 21 even if the contract limit has been reached.

NOTE: Appeals must be submitted within 120 days of rejection during the contract term.

All appeals must be submitted and finalized within 45 days after the end of the contract term.

REPORT: Report 1

Report Name: Financial Reconciliation Report (FRR)

Submission Date: No later than 60 days after the end of the contract term

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women’s Health & Education Services	Yes	No		
	X		Email, scan, or fax	1

Instructions: FRR form does require a signature (scanned or fax accepted).

Financial Status Reports (FSRs) for Categorical Family Planning Contracts

The HHSC Family Planning Program operates using the FFS award, categorical award, and anticipated co-payments to be collected as the total budget. All revenue directly generated by or earned as a result of the project (co-payments), along with FFS reimbursement are considered program income on the quarterly FSRs. Categorical Family Planning contractors are required to identify and report receipt and expenditure of co-payments and FFS payments quarterly and annually on the FSR form 269a. See quarters for categorical FSR submission below. Program income (co-payments and FFS payments), must be expended prior to receiving reimbursement for program costs.

The quarterly reports are due 30 days following the end of each quarter of the contract term. The final FSR, 269A, is due within 45 days after the end of the contract term, unless stipulated differently in the contract attachment following the end of the contract term. HHSC reserves the right to base funding levels, in part, upon the contractor's proficiency in identifying, billing, collecting, and reporting income, and in utilizing it for the delivery of family planning services.

Quarters for Categorical FSR submission:

Quarter 1: July – August 2016

Quarter 2: September – November 2016

Quarter 3: December 2016 – February 2017

Quarter 4: March – May 2017

Quarter 5: June – August 2017

Family Planning Program Categorical Budget Revisions – Contractors may shift up to 25% of their total Family Planning Program categorical direct budget between categories, except equipment, without prior approval. However, if the amount being shifted is greater than 25% of the contractor's total budget, the contractor must receive prior approval from HHSC. In such a case, contractors are required to submit a revised budget for review.

Programmatic Reporting

Contractors must complete requested reports in accordance with the contract.

Section IV

Appendices

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

EVALUATION AND MANAGEMENT	
99201	Office Visit. New Client. Problem focused history/exam. Straightforward decision-making.
99202	Office Visit. New Client. Expanded problem focused history/exam. Straightforward medical decision-making.
99203	Office Visit. New Client. Detailed history/exam. Low complexity decision-making.
99204	Office Visit. New Client. Comprehensive history/exam. Moderate complexity decision-making.
99205	Office Visit. New Client. Comprehensive history/exam. High complexity decision-making.
99211	Office Visit. Established Client. Minor problem focus. Straightforward decision-making.
99212	Office Visit. Established Client. Problem focused history/exam. Straightforward decision-making.
99213	Office Visit. Established Client. Expanded problem focused history/exam. Low complexity decision-making.
99214	Office Visit. Established Client. Detailed history/exam. Moderate complexity decision-making.
99215	Office Visit. Established Client. Comprehensive history/exam. High complexity decision-making.
99241	Office Consultation. New or Established Client. Problem focused history/exam. Straightforward decision-making.
99242	Office Consultation. New or Established Client. Expanded problem focused history/exam. Straightforward decision-making.
99243	Office Consultation. New or Established Client. Detailed history/exam. Low complexity decision-making.
99244	Office Consultation. New or Established Client. Comprehensive history/exam. Moderate complexity decision-making.
99384	Preventive Visit. New Client. Age 12 – 17.
99385	Preventive Visit. New Client. Age 18 – 39.
99386	Preventive Visit. New Client. Age 40 – 64.
99394	Preventive Visit. Established Client. Age 12 – 17.
99395	Preventive Visit. Established Client. Age 18 – 39.
99396	Preventive Visit. Established Client. Age 40 – 64.

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

RADIOLOGY	
71010	Chest x-ray 1 view frontal
71020	Chest x-ray 2 view frontal and lateral
73060	Radiologic examination x-ray, humerus, minimum of two views
74000	X-ray, abdomen, single a/p view
74010	X-ray, abdomen, a/p and additional views
74740	Hysterosalpingogram
76098	Radiological exam, surgical specimen
76641	Ultrasound, complete examination of breast including axilla, unilateral
76642	Ultrasound, limited examination of the breast including axilla, unilateral
76700	US exam, abdominal , complete
76705	US exam, abdominal, limited
76770	US exam abdominal back wall, comp
76801	OB US < 14 weeks, single fetus
76802	OB US <14 weeks, additional fetus
76805	Ultrasound pregnant uterus, \geq / \leq 14 weeks gestation, single or 1 st gestation
76810	US exam, pregnant uterus, multiple gestation
76811	OB US, detailed, single fetus
76813	OB US, nuchal measure, 1 gestation
76815	Ultrasound of pregnant uterus, limited
76816	Ultrasound of pregnant uterus as follow-up of abnormal previous scan
76817	Transvaginal US, obstetric
76818	Fetal biophysical profile with W/NST

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

76819	Fetal biophysical profile with/out NST
76820	Umbilical artery echo
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic, non-obstetric
76857	Ultrasound, pelvic, non-obstetric, limited or follow-up
76881	Ultrasound, extremity, nonvascular, real-time with image documentation, complete
76882	Ultrasound, extremity, nonvascular, real-time with image documentation, limited, anatomic specific
76942	Echo guide for biopsy
76998	Ultrasound guidance, intraoperative
77051	Computer dx mammogram add-on
77052	Comp screen mammogram add-on
77053	Mammary ductogram or galactogram, single duct, global fee
77055	Mammogram, one breast
77056	Mammogram, both breasts
77057	Mammogram, screening
77058	Magnetic resonance imaging, breast, with and/or without contrast, unilateral, global fee
77059	Magnetic resonance imaging, breast, with and/or without contrast, bilateral, global fee
MEDICATIONS, IMMUNIZATIONS, AND VACCINES	
90460	IM admin 1 st /only component
90471	Immunization admin
90472	Immunization admin, any route, each additional vaccine (single or combination)
90632	Hep A vaccine, adult, IM
90633	Hep A vaccine, ped/adol, 2 dose, IM

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

90636	Hep A/Hep B vaccine, adult, IM
90649	HPV vaccine 4 valent, IM
90650	HPV vaccine 2 valent, IM
90651	HPV vaccine 9-valent, IM
90654	Flu vaccine, split virus, preservative-free, for intradermal use
90656	Flu vaccine no preservative 3 years & >and older
90658	Flu vaccine 3 years and older, IM
90660	Flu vaccine, live, tri-valent, no preservative, IM
90686	Flu vaccine, no preservative, quadrivalent, 3 years and older
90688	Flu vaccine, quadrivalent, split virus
90707	MMR vaccine, live, SC
90710	MMRV vaccine, live, SC
90714	Td vaccine, no preservative, age 7 and older/>, IM
90715	Tdap vaccine, age 7 and older/>, IM
90716	Chicken pox vaccine, IM
90723	Diphtheria, pertussis, tetanus, Hepatitis B, IMPV
90732	Pneumococcal vaccine, SC or IM
90733	Meningococcal vaccine, SC
90734	Meningococcal vaccine, IM
90736	Zoster vaccine, SC
90743	Hep B vaccine, adolescent, 2 dose, IM
90744	Hep B vaccine, birth – 19 years, 3 dose, IM
90746	Hep B vaccine, 20+ years, 3 dose, IM

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

96372	Non-neoplastic hormonal therapy injection
A9150	Non-Rx drugs – Use FP modifier w/ code
J0558	Penicillin G benzathine/procaine injection
J0561	Penicillin G benzathine injection
J0690	Cefazolin sodium injection
J0696	Ceftriaxone sodium injection
J0702	Betamethasone sodium phosphate & acetate
J1100	Dexamethasone sodium phosphate
J1725	Hydroxyprogesterone caproate injection
J2010	Lincomycin injection
J2790	Rho D immune globulin injection
J3490	Injection Medication for STD or G/U infection
S5000	Oral prescription medication, generic
CONTRACEPTIVE METHOD	
H1010	Instruction, NFP
A4261	Cervical cap
A4266	Diaphragm
57170	Diaphragm or cervical cap fitting w/ instructions
A4267	Condom, male, each
A4268	Condom, female, each
A4269	Spermicide (e.g., foam, gel) each, 6 suppositories or film are quantity of 1
S4993	Oral contraceptive pills, one cycle
J7297	Liletta IUD (52mg levonorgestrel-releasing intrauterine contraceptive)

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

J7298	Mirena IUD (52mg levonorgestrel-releasing intrauterine contraceptive)
J7300	Copper intrauterine contraceptive
J7301	Skyla IUD (13.5 mg levonorgestrol intrauterine contraceptive)
58300	Insertion of intrauterine device
58301	Removal of intrauterine device
J1050	Medroxyprogesterone acetate for contraceptive use, injection
96372	Injection fee, Medroxyprogesterone acetate
J7303	Vaginal ring, each
J7304	Contraceptive patch, each
J7307	Implantable contraceptive capsule
11976	Removal, implantable contraceptive
11981	Non-biodegradable drug delivery implant insertion
COUNSELING & EDUCATION	
90791	Psychiatric diagnostic interview without medical services
90792	Psychiatric diagnostic interview for provider of medical services
97802	Medical nutrition therapy, initial assessment, individual, face to face, each 15 minutes
97803	Medical nutrition therapy, reassessment, individual, face to face, each 15 minutes
97804	Medical nutrition therapy, group (2 or more), each 30 minutes
99078	Group health education
99406	Behavior change, smoking 3-10 minutes
99407	Behavior change, smoking >10 minutes

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

PATHOLOGY & LABORATORY	
80061	Lipid profile w/ cholesterol
80300	Drug screen, qualitative/multiple
80301	Drug screen, single
81000	Urinalysis, by dipstick or tablet, non-automated, with microscopy
81001	Urinalysis, by dipstick or tablet, automated, with microscopy
81002	Urinalysis, dipstick or tablet, non-automated, without microscopy
81003	Urinalysis, by dipstick or tablet, automated, without microscopy
81005	Urinalysis, qualitative or semiquantitative
81015	Urinalysis, microscopic only
81025	Urine pregnancy test, visual comparison methods
82947	Glucose, blood, except reagent strip
82948	Glucose, blood, reagent strip
84443	Thyroid Stimulating Hormone
84702	Chorionic gonadotropin, quantitative (pregnancy test)
84703	Chorionic gonadotropin, qualitative (pregnancy test)
85013	Microhematocrit, spun
85014	Hematocrit
85018	Hemoglobin
85025	CBC with differential, automated
85027	CBC, automated
86318	Immunoassay, infection agent
86580	Tb skin test, intradermal

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

86592	Syphilis
86689	HTLV/HIV confirmatory test
86695	Herpes simplex, type 1
86696	Herpes simplex, type 2
86701	HIV-1 antibody
86702	HIV-2 antibody
86703	HIV-1 and HIV-2, single assay
86762	Rubella antibody
86803	Hepatitis C antibody
86900	Blood typing, ABO
86901	Blood typing, Rh
87070	Culture, bacterial; any source other than blood or stool; with presumptive identification of isolates
87086	Urine culture, bacterial, quantitative
87088	Urine culture, bacterial, with presumptive identification of isolates
87102	Culture, fungi, with presumptive identification of isolates, source other than blood, skin, hair, or nail
87110	Chlamydia culture
87205	Smear with interpretation, routine stain for bacteria, fungi or cell types
87210	Wet mount for infectious agents (e.g. saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi, ectoparasite ova, mites
87252	Virus isolation, tissue culture inoculation and presumptive identification (herpes)
87389	HIV-1 AG w/ HIV-1 & HIV 2 AB
87480	Candida species, direct probe technique
87490	Chlamydia, direct probe technique

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

87491	Chlamydia, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87535	HIV-1 probe & reverse transcription
87590	Gonorrhea, direct probe technique
87591	Gonorrhea, amplified probe technique
87624	HPV, high-risk types
87625	HPV, types 16 and 18 only
87660	Trichomonas vaginalis, direct probe technique
87797	Infectious agent, NOS, direct probe
87800	Infectious agent, multiple organisms, direct probe technique
87801	Infectious agent, multiple organisms, amplified probe technique
87810	Chlamydia, immunoassay w/ direct optical observation.
87850	Gonorrhea, immunoassay with direct optical observation
88142	Cytopathology, cervical/vaginal, liquid based, automated
88150	Cytopathology, cervical/vaginal, slides, manual
88164	Cytopathology, cervical/vaginal, slides, manual, the Bethesda System
88175	Cytopathology, cervical/vaginal, any reporting system, fluid based, automated screening with manual rescreening or review.
80048	Basic metabolic panel
80053	Comprehensive metabolic panel
85730	Thromboplastin time, partial
88305	Tissue exam by pathologist
88307	Tissue exam by pathologist
93000	Electrocardiogram, complete

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

88141	Cytopath, cervical or vaginal (C/V), interpret
88143	Cytopath, C/V thin layer, redo
88173	Cytopath evaluation, FNA, report
88174	Cytopath, C/V auto, in fluid
80050	General health panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80069	Renal function panel
80074	Acute hepatitis panel
80076	Hepatic function panel
82270	Occult blood, feces
82465	Total cholesterol
82950	Glucose test
83020	Hemoglobin electrophoresis
83021	Hemoglobin chromatography
83036	Glycosylated hemoglobin test
84450	Transferase (AST) SGOT)
84460	Alanine amino (ALT) (SGPT)
84478	Assay of Triglycerides
84479	Assay of thyroid (T3 or T4)
85007	Differential WBC count
85610	Prothrombin time (PT)
85660	RBC sickle cell test

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

85730	Thromboplastin time, partial (PTT)
86631	Chlamydia trachomatis, immunofluorescent technique
86677	Helicobacter pylori antibody
86704	Hepatitis B core antibody, total
86706	Hepatitis B surface antibody
86780	Treponema pallidum
86885	Coombs test, indirect, qualitative
87270	Chlamydia trachomatis, immunofluorescent technique
87512	Gardnerella vaginalis, quantification
87529	HSV, DNA, amplified probe
87530	HSV, DNA, quantitative
87661	Trichomonas vaginalis, amplified
88155	Cytopath, C/V, index add-on
88160	Cytopath smear, other source
88161	Cytopath smear, other source
88165	Cyopath, bethesda system, w/manual screen/rescreen
88167	Cytopathology, Bethesda system, cervical/vaginal, select
88172	Cytopathology, evaluation of fine needle aspirate
80055	Obstetric panel
80300	Drug screen, single
82105	Alpha-fetoprotein, serum
82677	Estriol (UE3)
82951	Glucose tolerance test (GTT)

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

84436	T4
84479	Assay of thyroid (T3 or T4)
85384	Fibrinogen
85610	Prothrombin time
86336	Inhibin A
86777	Toxoplasmosis, IgG IFA
86778	Toxoplasmosis, IgM
86850	Blood, antibody screen
86900	Blood group type
86901	Rh type
87081	GBS culture
87184	Susceptibility test
87340	Hepatitis B surface antigen, by enzyme immunoassay
94760	Non-invasive pulse oximetry for oxygen saturation
99000	Specimen handling or conveyance
ANESTHESIA	
00851	Anesthesia for sterilization, lower abdomen
00400	Anesthesia for procedures on the integumentary system, anterior trunk
00940	Anesthesia for vaginal procedures (including biopsy of cervix), NOS
SURGICAL PROCEDURES	
55250	Male sterilization, vasectomy
58340	Catheter for hystero-graphy
58565	Female sterilization, hysteroscopy with bilateral fallopian tube cannulation and placement of permanent implants to occlude the fallopian tubes

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

58600	Female sterilization, fallopian tube transection, blocking, or other procedure
58611	Female sterilization, fallopian tube transection performed at time of cesarean delivery
58615	Female sterilization, occlusion of fallopian tubes by device, vaginal approach
58670	Female sterilization, laparoscopy with fulguration of oviducts
58671	Female sterilization, laparoscopy with occlusion of oviducts by device
10022	FNA with image
19000	Drainage of breast lesion
19081	Breast biopsy first lesion, includes stereotactic guidance
19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous, stereotactic guidance, each additional lesion
19083	Breast biopsy, first lesion, US imaging
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous, US guidance, each additional lesion
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesion
19101	Incisional breast biopsy, one or more lesions
19120	Removal of breast lesion
19125	Excision of abnormal breast tissue, duct, nipple or areolar lesion, single lesion; identified by preoperative placement of radiological marker (physician in facility)
19126	Excision of abnormal breast tissue, duct, nipple or areolar lesion, each additional lesion (physician in facility)
19281	Preoperative placement of breast localization device, percutaneous: mammographic guidance, first Lesion (physician in office)
19282	Preoperative placement of breast localization device, percutaneous: mammographic guidance, each additional lesion (physician in office)
19283	Preoperative placement of breast localization device, percutaneous: stereotactic guidance, first lesion (physician in office)
19284	Preoperative placement of breast localization device, percutaneous: stereotactic guidance, each additional lesion (physician in office)
19285	Preoperative placement of breast localization device, percutaneous: ultrasound guidance, first lesion (physician in office)
19286	Preoperative placement of breast localization device, percutaneous: ultrasound guidance, each additional lesion (physician in office)

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

56405	I & D of vulva/perineum
56420	Drainage of gland abscess
56501	Destroy, vulva lesions, simple
56515	Destroy vulva lesions, complex
56605	Biopsy of vulva/perineum
56606	Biopsy of vulva/perineum
56820	Exam of vulva w/scope
57023	I & D vaginal hematoma, non-ob
57061	Destroy vaginal lesions, simple
57100	Biopsy of vagina
57421	Exam/biopsy of vagina w/scope
57511	Cryocautery of cervix
58100	Biopsy of uterine lining
59025	Fetal non-stress test
59430	Postpartum visit
Cervical Cancer Screening Services	
57452	Examination of vagina – colposcopy
57454	Vagina examination & biopsy
57455	Biopsy of cervix w/scope
57456	Endocervical curettage w/scope
57460	Cervix excision
57461	Conization of cervix w/scope, leep
57500	Biopsy of cervix

APPENDIX A**HHSC FAMILY PLANNING PROGRAM REIMBURSABLE CODES
FY2017**

57505	Endocervical curettage
57520	Conization of cervix, cold knife or laser
57522	Conization of cervix, leep
58110	Biopsy done w/colposcopy add-on
SUPPLIES	
A4253	Blood glucose/reagent strips
A4258	Springload device for lancet
A4259	Lancets per box (100 count)
A4264	Intratubal occlusion device

Legislative budget reductions from 2010 resulted in a **7%** reduction of reimbursement rates effective **September 1, 2011**. The CPT code reimbursement rates will remain the same and the 7% reduction will be taken from the total amount to be reimbursed.



PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address		
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP	
SSN (optional)	Date of Birth	Age	Race	Ethnicity	Sex

- a) Please contact me by: (check all that apply) Mail Phone Email
- b) Do you have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? Yes No
**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.*
- c) Which benefits or health care coverage do you receive? (check all that apply)
- CHIP Perinatal SNAP WIC
 Medicaid for Pregnant Women TWHP None

PART II - HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s).

How many people are in your household?

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. Yes No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to me.

Signature – Applicant _____ Date _____

Signature – Person who helped complete this application _____ Relationship to Applicant _____ Date _____

PART V - PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

Eligibility effective date / /

1. Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Is the client eligible for the following program(s)?				Co-payment amount (if applicable)		
2. Total monthly household income \$ <input style="width: 100px;" type="text"/>		Yes	No	n/a			
3. Household FPL % <input style="width: 100px;" type="text"/>		BCCS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
4. Proof of income <input type="checkbox"/> Yes <input type="checkbox"/> Waived		DSHS FP	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
5. Verification of adjunctive eligibility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a		EPHC	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6a. Presumptively eligible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a		PHC	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6b. Full eligibility met <input type="checkbox"/> Yes	Title V/MCH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____		
6c. Full eligibility met date / / <input style="width: 50px;" type="text"/>	Notes:						

Name of Agency _____ Signature – Agency / Staff Member _____ Date _____

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

- a) Check all the boxes that apply.
- b) Check *yes* or *no*.
- c) Check all the boxes that apply:
- CHIP (Children's Health Insurance Program) Perinatal
 - Medicaid for Pregnant Women
 - SNAP (Supplemental Nutrition Assistance Program)
 - TWHP (Texas Women's Health Program)
 - WIC (Special Supplemental Nutrition Program for Women Infants and Children)
 - None

If you selected one of these benefits or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services.)

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Fill in the table with the following information:

- 1st column: The name of the person receiving the money.
- 2nd column: The name of the agency, person, or employer who provides the money.
- 3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT**Rights and Responsibilities:**

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). (*MBCC clients are not required to report changes in income, household, and residency*)

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months (*not applicable to MBCC*).

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Read the **Rights and Responsibilities** above. Check *yes* or *no*.

Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

(1) Check the appropriate box (*yes* or *no*) for Texas resident. (2) Total the *amount received per month* to fill in the *Total monthly household income* box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the *Household FPL* box. Check the appropriate box (*yes, no, waived, or n/a*) for (4) *Proof of income* and (5) *Verification of adjunctive eligibility*.

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (*yes, no, or n/a*) for *Presumptively eligible*. Once the client completes the requirements for full eligibility, (6b) check *Yes* for *Full eligibility met* and fill in the (6c) *Full eligibility met date* box.

(7) Check the appropriate box (*yes, no, or n/a*) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.

Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

APPENDIX B División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)
Formulario para la participación INDIVIDUAL



PARTE I - INFORMACIÓN DEL SOLICITANTE

Nombre (apellido, primer nombre, segundo nombre)		Número telefónico		Correo electrónico	
Domicilio en Texas (nombre de la calle o número de apartado postal)		Ciudad	Condado	Estado	Código postal
Número de Seguro Social (SSN) (opcional)		Fecha de nacimiento	Edad	Raza	Origen étnico
					Sexo

- a) Por favor contáctenme por: (marque todo lo que corresponda) Correo postal Teléfono Correo electrónico
- b) ¿Tiene usted cobertura médica integral (Medicaid, Medicare, CHIP, seguro médico, VA, TRICARE, etc.)? Sí No
**Si contestó que sí, el representante autorizado del DSHS presentará una reclamación de reembolso ante su compañía de seguro médico por las prestaciones, los servicios o la asistencia que usted haya recibido.*
- c) ¿Qué tipo de prestaciones o de cobertura médica tiene? (marque todo lo que corresponda)
- CHIP Perinatal SNAP WIC
- Medicaid para mujeres embarazadas TWHP Ninguno

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene las casillas con el número de personas que hay en su familia. Este número le incluye a usted y a cada persona que viva con usted y de la que usted sea legalmente responsable. Los menores de edad deben incluir al padre, a la madre o al tutor legal.

¿Cuántas personas viven en su casa?

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere abajo todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Nombre de la persona que recibe el dinero	Nombre de la agencia, la persona o el empleador que provee el dinero	Cantidad recibida al mes

PARTE IV - ACUERDO DEL SOLICITANTE

He leído las declaraciones de Derechos y Responsabilidades en la sección de *Instrucciones* de este formulario. Sí No

La información que aquí proporciono, incluidas mis respuestas a todas las preguntas, es verídica y correcta, según mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación cualquier información que sea necesaria para comprobar mis declaraciones respecto a mi derecho a la participación. Entiendo que dar información falsa podría dar por resultado la descalificación y el reembolso de los apoyos recibidos.

Autorizo al Departamento Estatal de Servicios de Salud de Texas (DSHS) y al Proveedor a que dispongan libremente de toda la información que proporciono, incluida la información sobre los ingresos y la médica, con el fin de que determinen mi derecho a la participación y a que paguen o presten servicios a mi familia o a mí.

Firma del solicitante	Fecha
Firma de la persona que ayudó a completar esta solicitud	Relación con el solicitante
	Fecha

PART V – PROVIDER ELIGIBILITY CERTIFICATION (debe ser completada por el proveedor)

Eligibility effective date / /

1. Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Is the client eligible for the following program(s)?				Co-payment amount (if applicable)		
2. Total monthly household income \$ <input type="text"/>		Yes	No	n/a			
3. Household FPL <input type="text"/> %		BCCS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
4. Proof of income <input type="checkbox"/> Yes <input type="checkbox"/> Waived		DSHS FP	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
5. Verification of adjunctive eligibility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a		EPHC	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6a. Presumptively eligible <input type="checkbox"/> Yes <input type="checkbox"/> No		PHC	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6b. Full eligibility met <input type="checkbox"/> Yes		Title V/MCH	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	\$ _____
6c. Full eligibility met date <input type="text"/> / /	Notes:						

Name of Agency	Signature – Agency / Staff Member	Date
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Instrucciones para llenar el formulario para la participación INDIVIDUAL

PARTE I - INFORMACIÓN DEL SOLICITANTE

Llene las casillas con su información personal.

a) Marque todas las casillas que correspondan.

b) Marque "sí" o "no".

c) Marque todas las casillas que correspondan:

- CHIP (Programa de Seguro Médico Infantil) Perinatal
- Medicaid para mujeres embarazadas
- SNAP (Programa de Asistencia de Nutrición Suplemental)
- TWHP (Programa de Salud para la Mujer de Texas)
- WIC (Programa de Nutrición Suplemental Especial para Mujeres, Niños y Bebés)
- Ninguno

Si usted seleccionó uno de estos programas de prestaciones o de cobertura médica y puede proporcionar un comprobante de inscripción actualizado, usted podría de manera adjunta (automáticamente) tener derecho a la participación de un programa de la División de Servicios de Salud Familiar y Comunitaria del DSHS y saltar a las Partes II y III de esta solicitud, si su agencia no cobra un copago. (Excepción: elegibilidad adjunto no se aplica a los solicitantes de los servicios del Título V.)

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene las casillas con el número de personas que hay en su familia. Este número le incluye a usted y a cada persona que viva con usted y de la que usted sea legalmente responsable.

Cómo determinar qué personas componen su familia:

- Si usted es casado (incluso en matrimonio de hecho), inclúyase a usted mismo e incluya a su cónyuge y a todos los hijos, tanto los habidos en común como los no habidos en común (incluidos los no nacidos).
- Si usted no es casado, inclúyase a usted mismo e incluya a sus hijos, de tenerlos (incluidos los no nacidos).
- Si usted no es casado y vive con su pareja con la cual tiene hijos en común, inclúyase a usted mismo e incluya a su pareja, a sus hijos y a los hijos que hayan tenido en común (incluidos los no nacidos).

Los solicitantes de 18 años de edad o más se consideran adultos. No incluya a ningún hijo de 18 años de edad o más ni a ningún otro adulto que viva en su casa como parte de la familia. Los menores de edad deben incluir al padre, a la madre o al tutor legal que vivan en la casa.

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere en la tabla todos y cada uno de los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Llene la tabla con la siguiente información personal:

- 1.ª columna: El nombre de la persona que recibe el dinero.
- 2.ª columna: El nombre de la agencia, la persona o el empleador que provee el dinero.
- 3.ª columna: La cantidad de dinero recibida al mes.

PARTE IV - ACUERDO DEL SOLICITANTE

Derechos y Responsabilidades:

Si el solicitante omite información, no la proporciona o se niega a proporcionarla, o da información falsa o engañosa sobre estas cuestiones, podría pedírsele que reembolse al Estado el importe de los servicios recibidos si se encontró que el solicitante no cumple con los requisitos para recibir los servicios. El solicitante deberá informar de cualquier cambio en la situación de su hogar o familia que afecte el derecho a la participación durante el periodo de certificación (cambios en los ingresos, en los miembros del hogar o la familia y el lugar de residencia). (Las clientes de MBCC no tienen que informar de cambios en los ingresos ni en el hogar o el lugar de residencia)

El solicitante entiende que, para mantener el derecho a participar del programa, se le pedirá que vuelva a solicitar la ayuda al menos cada doce meses (no aplicable para clientes de MBCC).

El solicitante entiende que tiene el derecho a presentar una queja con respecto al manejo de su solicitud o a cualquier acción llevada a cabo por el programa, ante la Oficina de Derechos Civiles de la HHSC, al teléfono 1-888-388-6332.

El solicitante entiende que los criterios para la participación en el programa son iguales para todos sin importar el sexo, la edad, la discapacidad, la raza o el lugar de nacimiento.

Con unas cuantas excepciones, el solicitante tiene derecho a pedir y a ser notificado sobre la información que el estado de Texas reúne sobre él. El solicitante tiene derecho a recibir y revisar la información al así pedirlo. El solicitante también tiene derecho a pedirle a la agencia estatal que corrija cualquier información que se determine que es incorrecta. Consulte <http://www.dshs.state.tx.us> para obtener más información sobre la Notificación de privacidad. (Fuente: Código Gubernamental, secciones 552.021, 522.023 y 559.004).

Lea los Derechos y Responsabilidades siguientes. Marque "sí" o "no".

Firme y escriba la fecha en las líneas correspondientes. Si alguna persona le ayudó a usted a llenar la solicitud, también debe firmar, declarar cuál es su relación con usted y escribir la fecha en las líneas correspondientes.

PARTE V – PROVIDER ELIGIBILITY CERTIFICATION (debe ser completada por el proveedor)

(1) Check the appropriate box (yes or no) for Texas resident. (2) Total the amount received per month to fill in the Total monthly household income box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the Household FPL box. Check the appropriate box (yes, no, waived, or n/a) for (4) Proof of income and (5) Verification of adjunctive eligibility.

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (yes, no, or n/a) for Presumptively eligible. Once the client completes the requirements for full eligibility, (6b) check Yes for Full eligibility met and fill in the (6c) Full eligibility met date box.

(7) Check the appropriate box (yes, no, or n/a) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in Notes to document other appropriate information concerning eligibility and screening. Fill in the Eligibility effective date box in the top right corner of Part V. Fill in the Name of Agency, sign, and date.

**DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form**



Use with HOUSEHOLD Worksheet (Form EF05-13227)

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address	
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP

a) Please contact me by: (check all that apply) Mail Phone Email

b) Do you – or anyone in your household – have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? Yes No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that anyone in your household has received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

- CHIP Perinatal SNAP WIC
 Medicaid for Pregnant Women TWHP None

PART II - HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race	Ethnicity	Relationship
1.						
2.						
3.						
4.						
5.						
6.						

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. Yes No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household or me.

Signature – Applicant Date

Signature – Person who helped complete this application Relationship to Applicant Date

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

- a) Check all the boxes that apply.
- b) Check *yes* or *no*.
- c) Check all the boxes that apply:
- *CHIP (Children's Health Insurance Program) Perinatal*
 - *Medicaid for Pregnant Women*
 - *SNAP (Supplemental Nutrition Assistance Program)*
 - *TWHP (Texas Women's Health Program)*
 - *WIC (Special Supplemental Nutrition Program for Women Infants and Children)*
 - *None*

If you selected one of these benefit or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services)

PART II – HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Fill in the table with the following information:

- 1st column: The name of the person receiving the money.
- 2nd column: The name of the agency, person, or employer who provides the money.
- 3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT

Read the **Rights and Responsibilities** above. Check *yes* or *no*.

Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

Rights and Responsibilities:

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). (*MBCC clients are not required to report changes in income, household, and residency*)

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months (*not applicable to MBCC*).

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Formulario para la participación FAMILIAR

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Nombre (apellido, primer nombre, segundo nombre)	Número telefónico		Correo electrónico	
Domicilio en Texas (nombre de la calle o número de apartado postal)	Ciudad	Condado	Estado	Código postal

a) Por favor contácteme por: (marque todo lo que corresponda) Correo postal Teléfono Correo electrónico

b) ¿Tiene usted o alguien de su familia cobertura médica integral (Medicaid, Medicare, CHIP, seguro médico, VA, TRICARE, etc.)? Sí No

*Si contestó que sí, el representante autorizado del DSHS presentará una reclamación de reembolso ante su compañía de seguro médico por las prestaciones, los servicios o la asistencia que cualquier persona en su hogar haya recibido.

c) ¿Qué tipo de prestaciones o de cobertura médica tiene? (marque todo lo que corresponda)

- CHIP Perinatal SNAP WIC
 Medicaid para mujeres embarazadas TWHP Ninguno

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Nombre (apellido, primer nombre, segundo nombre)	Número de Seguro Social (SSN) (opcional)	Fecha de nacimiento	Sexo	Raza	Origen étnico	Relación
1.						
2.						
3.						
4.						
5.						
6.						

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere abajo todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Nombre de la persona que recibe el dinero	Nombre de la agencia, la persona o el empleador que provee el dinero	Cantidad recibida al mes

PARTE IV - ACUERDO DEL SOLICITANTE

He leído las declaraciones de **Derechos y Responsabilidades** en la sección de *Instrucciones* de este formulario. Sí No

La información que aquí proporciono, incluidas mis respuestas a todas las preguntas, es verídica y correcta, según mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación cualquier información que sea necesaria para comprobar mis declaraciones respecto a mi derecho a la participación. Entiendo que dar información falsa podría dar por resultado la descalificación y el reembolso.

Autorizo al Departamento Estatal de Servicios de Salud de Texas (DSHS) y al Proveedor a que dispongan libremente de toda la información que proporciono, incluida la información sobre los ingresos y la médica, con el fin de que determinen mi derecho a la participación y a que paguen o presten servicios a mi familia o a mí.

Firma del solicitante _____ Fecha _____

Firma de la persona que ayudó a completar esta solicitud _____ Relación con el solicitante _____ Fecha _____

Instrucciones para llenar el formulario para la participación FAMILIAR

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Llene las casillas con su información personal.

a) Marque todas las casillas que correspondan.

b) Marque “sí” o “no”.

c) Marque todas las casillas que correspondan:

- CHIP (Programa de Seguro Médico Infantil) Perinatal
- Medicaid para mujeres embarazadas
- SNAP (Programa de Asistencia de Nutrición Suplemental)
- TWHIP (Programa de Salud para la Mujer de Texas)
- WIC (Programa de Nutrición Suplemental Especial para Mujeres, Niños y Bebés)
- Ninguno

Si usted seleccionó uno de estos programas de prestaciones o de cobertura médica y puede proporcionar un comprobante de inscripción actualizado, usted podría de manera adjunta (automáticamente) tener derecho a la participación de un programa de la División de Servicios de Salud Familiar y Comunitaria del DSHS y saltar a las Partes II y III de esta solicitud, si su agencia no cobra un copago. (Excepción: elegibilidad adjunto no se aplica a los solicitantes de los servicios del Título V.)

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Cómo determinar qué personas componen su familia:

- Si usted es casado (incluso en matrimonio de hecho), inclúyase a usted mismo e incluya a su cónyuge y a todos los hijos, tanto los habidos en común como los no habidos en común (incluidos los no nacidos).
- Si usted no es casado, inclúyase a usted mismo e incluya a sus hijos, de tenerlos (incluidos los no nacidos).
- Si usted no es casado y vive con su pareja con la cual tiene hijos en común, inclúyase a usted mismo e incluya a su pareja, a sus hijos y a los hijos que hayan tenido en común (incluidos los no nacidos).

Los solicitantes de 18 años de edad o más se consideran adultos. No incluya a ningún hijo de 18 años de edad o más ni a ningún otro adulto que viva en su casa como parte de la familia. Los menores de edad deben incluir al padre, a la madre o al tutor legal que vivan en la casa.

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere en la tabla todos y cada uno de los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Llene la tabla con la siguiente información personal:

- 1.^a columna: El nombre de la persona que recibe el dinero.
- 2.^a columna: El nombre de la agencia, la persona o el empleador que provee el dinero.
- 3.^a columna: La cantidad de dinero recibida al mes.

PARTE IV - ACUERDO DEL SOLICITANTE

Lea los **Derechos y Responsabilidades** siguientes. Marque “sí” o “no”.

Firme y escriba la fecha en las líneas correspondientes. Si alguna persona le ayudó a usted a llenar la solicitud, también debe firmar, declarar cuál es su relación con usted y escribir la fecha en las líneas correspondientes.

Derechos y Responsabilidades:

Si el solicitante omite información, no la proporciona o se niega a proporcionarla, o da información falsa o engañosa sobre estas cuestiones, podría pedirle que reembolse al Estado el importe de los servicios recibidos si se encontró que el solicitante no cumple con los requisitos para recibir los servicios. El solicitante deberá informar de cualquier cambio en la situación de su hogar o familia que afecte el derecho a la participación durante el periodo de certificación (cambios en los ingresos, en los miembros del hogar o la familia y el lugar de residencia). *(Las clientes de MBCC no tienen que informar de cambios en los ingresos ni en el hogar o el lugar de residencia)*

El solicitante entiende que, para mantener el derecho a participar del programa, se le pedirá que vuelva a solicitar la ayuda al menos cada doce meses *(no aplicable para clientes de MBCC)*.

El solicitante entiende que tiene el derecho a presentar una queja con respecto al manejo de su solicitud o a cualquier acción llevada a cabo por el programa, ante la Oficina de Derechos Civiles de la HHSC, al teléfono 1-888-388-6332.

El solicitante entiende que los criterios para la participación en el programa son iguales para todos sin importar el sexo, la edad, la discapacidad, la raza o el lugar de nacimiento.

Con unas cuantas excepciones, el solicitante tiene derecho a pedir y a ser notificado sobre la información que el estado de Texas reúne sobre él. El solicitante tiene derecho a recibir y revisar la información al así pedirlo. El solicitante también tiene derecho a pedirle a la agencia estatal que corrija cualquier información que se determine que es incorrecta. Consulte <http://www.dshs.state.tx.us> para obtener más información sobre la Notificación de privacidad. (Fuente: Código Gubernamental, secciones 552.021, 522.023 y 559.004)

**APPENDIX B DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet**



PART I – APPLICANT INFORMATION

Name (Last, First, Middle)	Today's Date (MM-DD-YYYY)	Eligibility Effective Date (MM-DD-YYYY)
Case Record Action <input type="checkbox"/> Adjunctive <input type="checkbox"/> Presumptive <input type="checkbox"/> Supplemental <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Client/Case #	Type of Determination <input type="checkbox"/> New <input type="checkbox"/> Re-certification
Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other benefits or health care coverage (Medicaid, Medicare, CHIP, private health insurance, VA, TRICARE, etc.)		
Special circumstances		

PART II – HOUSEHOLD INFORMATION

1.	Notes
2.	
3.	
4.	
5.	
6.	

PART III – INCOME INFORMATION

Income Type	Name(s) of household member(s) with income		Documentation of income (if applicable)
Gross earned income			
Cash gifts/contributions			
Child support income			
Dividends/interest/royalties			
Loans (non-educational)			
Lawsuit/lump-sum payments			
Mineral rights			
Pensions/annuities			
Reimbursements			
Social security payments			
Unemployment payments			
VA payments			
Worker's compensation			
Total countable income			
Deductions	-	-	
Net countable income			
	Household FPL		%

PART IV – PROGRAM ELIGIBILITY

1. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	2. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	3. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
4. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	5. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	6. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
Co-Pay/Fees		

Name of Agency	Signature – Agency / Staff Member	Date
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**APPENDIX B DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet Instructions**



PART I - APPLICANT INFORMATION

Fill in the boxes with the applicant's information.
Check the appropriate boxes.

Other benefits or health care coverage: Document other benefits received/denied. (An applicant or family member eligible for Medicare Part A/B must be referred to the Medicare Prescription Drug Plan (Part D) for prescription drug benefits.)

Special circumstances: Document any special circumstances.

PART II – HOUSEHOLD INFORMATION

Fill in the boxes with members of the household.

This number will include a person living alone or two or more persons living together where legal responsibility for support exists.

Legal responsibility for support exists between: persons who are legally married (including common-law marriage), a legal parent and a minor child (including unborn children), or a legal guardian and a minor child.

(Title V contractors may add whether household members are US citizens, eligible immigrants, or non-US citizens.)

**Program Eligibility by 2015 Federal Poverty Level (FPL)
Effective March 1, 2015**

Family Size	Title V - MCH	PHC EPHC BCCS	FP
	185% FPL	200% FPL	250% FPL
1	\$1,815	\$1,962	\$2,452
2	2,456	2,655	3,319
3	3,097	3,348	4,185
4	3,739	4,042	5,052
5	4,380	4,735	5,919
6	5,021	5,428	6,785
7	5,663	6,122	7,652
8	6,304	6,815	8,519
9	6,945	7,508	9,385
10	7,587	8,202	10,252
11	8,228	8,895	11,119
12	8,869	9,588	11,985
13	9,511	10,282	12,852
14	10,152	10,975	13,719
15	10,793	11,668	14,585

PART III - INCOME INFORMATION

Income may be either earned or unearned. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- weekly income is multiplied by 4.33;
- income received every two weeks is multiplied by 2.17;
- income received twice a month is multiplied by 2.

Fill in the *Income Type* table with name(s) of household member(s) and income amounts.

Calculate the *Total countable income*.

Calculate the *Deductions*:

- child support payments;
- dependent childcare;
 - up to \$200 per child per month for children under age 2;
 - up to \$175 per child per month for children age 2 and older;
- adults with disabilities;
 - up to \$175 per adult per month.

Total the *Net countable income*.

Calculate the household FPL using the applicable DSHS program policy and fill in the *Household FPL* box.

Use the *Documentation of income* box for notes (if applicable).

PART IV – PROGRAM ELIGIBILITY

Determine program eligibility for each household member using the corresponding numbers from the household information section.

Document applicable copayments and fees by program in the *Co-Pay/Fees* box.

Fill in the *Name of Agency*, sign, and date.

**APPENDIX B DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet**



PART I – APPLICANT INFORMATION

Name (Last, First, Middle)	Today's Date (MM-DD-YYYY)	Eligibility Effective Date (MM-DD-YYYY)
Case Record Action <input type="checkbox"/> Adjunctive <input type="checkbox"/> Presumptive <input type="checkbox"/> Supplemental <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Client/Case #	Type of Determination <input type="checkbox"/> New <input type="checkbox"/> Re-certification
Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other benefits or health care coverage (Medicaid, Medicare, CHIP, private health insurance, VA, TRICARE, etc.)		
Special circumstances		

PART II – HOUSEHOLD INFORMATION

1.	Notes
2.	
3.	
4.	
5.	
6.	

PART III – INCOME INFORMATION

Income Type	Name(s) of household member(s) with income		Documentation of income (if applicable)
Gross earned income			
Cash gifts/contributions			
Child support income			
Dividends/interest/royalties			
Loans (non-educational)			
Lawsuit/lump-sum payments			
Mineral rights			
Pensions/annuities			
Reimbursements			
Social security payments			
Unemployment payments			
VA payments			
Worker's compensation			
Total countable income			
Deductions	-	-	
Net countable income			
	Household FPL		%

PART IV – PROGRAM ELIGIBILITY

1. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	2. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	3. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
4. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	5. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	6. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
Co-Pay/Fees		

Name of Agency	Signature – Agency / Staff Member	Date
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**APPENDIX B DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet Instructions**



PART I - APPLICANT INFORMATION

Fill in the boxes with the applicant's information.
Check the appropriate boxes.

Other benefits or health care coverage: Document other benefits received/denied. (An applicant or family member eligible for Medicare Part A/B must be referred to the Medicare Prescription Drug Plan (Part D) for prescription drug benefits.)

Special circumstances: Document any special circumstances.

PART II – HOUSEHOLD INFORMATION

Fill in the boxes with members of the household.

This number will include a person living alone or two or more persons living together where legal responsibility for support exists.

Legal responsibility for support exists between: persons who are legally married (including common-law marriage), a legal parent and a minor child (including unborn children), or a legal guardian and a minor child.

(Title V contractors may add whether household members are US citizens, eligible immigrants, or non-US citizens.)

**Program Eligibility by 2016 Federal Poverty Level (FPL)
Effective March 1, 2016**

Family Size	Title V - MCH	PHC EPHC BCCS	FP
	185% FPL	200% FPL	250% FPL
1	\$1,832	\$1,980	\$2,475
2	2,470	2,670	3,338
3	3,108	3,360	4,200
4	3,747	4,050	5,063
5	4,385	4,740	5,925
6	5,023	5,430	6,788
7	5,663	6,122	7,653
8	6,304	6,815	8,519
9	6,946	7,509	9,386
10	7,587	8,202	10,253
11	8,228	8,895	11,119
12	8,870	9,589	11,986
13	9,511	10,282	12,853
14	10,152	10,975	13,719
15	10,794	11,669	14,586

PART III - INCOME INFORMATION

Income may be either earned or unearned. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- weekly income is multiplied by 4.33;
- income received every two weeks is multiplied by 2.17;
- income received twice a month is multiplied by 2.

Fill in the *Income Type* table with name(s) of household member(s) and income amounts.

Calculate the *Total countable income*.

Calculate the *Deductions*:

- child support payments;
- dependent childcare;
 - up to \$200 per child per month for children under age 2;
 - up to \$175 per child per month for children age 2 and older;
- adults with disabilities;
 - up to \$175 per adult per month.

Total the *Net countable income*.

Calculate the household FPL using the applicable DSHS program policy and fill in the *Household FPL* box.

Use the *Documentation of income* box for notes (if applicable).

PART IV – PROGRAM ELIGIBILITY

Determine program eligibility for each household member using the corresponding numbers from the household information section.

Document applicable copayments and fees by program in the *Co-Pay/Fees* box.

Fill in the *Name of Agency*, sign, and date.

**HHSC Family Planning Program
Definition of Income**

Types of Income	Countable	Exempt
Adoption Payments		✓
Cash Gifts and Contributions	✓	
Child Support Payments	✓	
Child's Earned Income		✓
Crime Victim's Compensation		✓
Disability Insurance Benefits	✓	
Dividends, Interest, and Royalties	✓	
Educational Assistance		✓
Energy Assistance		✓
Foster Care Payment		✓
In-kind Income		✓
Job Training		✓
Loans (Non-educational)	✓	
Lump-Sum Payments	✓	✓
Military Pay	✓	
Mineral Rights	✓	
Pensions and Annuities	✓	
Reimbursements	✓	
RSDI /Social Security Payments	✓	
Self-Employment Income	✓	
SSDI	✓	
SSI Payments		✓
TANF		✓
Unemployment Compensation	✓	
Veteran's Administration	✓	✓
Wages and Salaries, Commissions	✓	
Worker's Compensation	✓	

A description of all types of countable income is provided below.

Cash Gifts and Contributions – Count unless they are made by a private, non-profit organization on the basis of need; and total \$300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January - March, April - June, July - September, and October - December. If these contributions exceed \$300 in a quarter, count the excess amount as income in the month received.

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a non-certified household member who:

APPENDIX C

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- Does not have a landlord/tenant relationship.

Child Support Payments – Count income after deducting \$75 from the total monthly child support payments the household receives.

Disability Insurance Payments/SSDI – Social Security Disability Insurance is a payroll tax-funded, federal insurance program of the Social Security Administration.

Dividends, Interest and Royalties – This income is countable with an exception: Exempt dividends from insurance policies as income. Count royalties, minus any amount deducted for production expenses and severance taxes.

Loans (Non-educational) – Count as income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments – Count as income in the month received if the person receives it or expects to receive it more often than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay – Count military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights – A payment received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, and gravel.

Pensions and Annuities – A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursements – Countable, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

RSDI/Social Security Payments – Count the Retirement, Survivors, and Disability Insurance (RSDI) benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

Self-Employment Income – Count total gross earned, minus the allowable costs of producing the self-employment income.

Terminated Employment – Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than the income received in a full month. Income is terminated if it will not be received in the next usual payment cycle.

APPENDIX C

Unemployment Compensation Payments – Count the gross benefit less any amount being recouped for a Unemployment Insurance Benefit overpayment.

VA Payments – Count the gross Veterans Administration (VA) payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Wages, Salaries, Tips and Commissions – Count the actual (not taxable) gross amount.

Worker's Compensation – Count the gross payment, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. Note: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.

EXAMPLE
HHSC Family Planning Program Co-pay Schedule
Based On Monthly Federal Poverty Guidelines

FAMILY SIZE	100% FPL	100-133% FPL	133-150% FPL	150-185% FPL	185-225% FPL	225-250% FPL	Above 250% FPL
	\$0 Co-Pay	\$5 Co-Pay	\$15 Co-Pay	\$20 Co-Pay	\$25 Co-Pay	\$30 Co-Pay	100% PAY
1	981.00	981.01 - 1,305.00	1,305.01 - 1,471.00	1,471.01 - 1,815.00	1,815.01 - 2,207.00	2,207.01 - 2,452.00	2,452.01 +
2	1,328.00	1,328.01 - 1,766.00	1,766.01 - 1,991.00	1,991.01 - 2,456.00	2,456.01 - 2,987.00	2,987.01 - 3,319.00	3,319.01 +
3	1,674.00	1,674.01 - 2,227.00	2,227.01 - 2,511.00	2,511.01 - 3,097.00	3,097.01 - 3,767.00	3,767.01 - 4,185.00	4,185.01 +
4	2,021.00	2,021.01 - 2,688.00	2,688.01 - 3,031.00	3,031.01 - 3,739.00	3,739.01 - 4,547.00	4,547.01 - 5,052.00	5,052.01 +
5	2,368.00	2,368.01 - 3,149.00	3,149.01 - 3,551.00	3,551.01 - 4,380.00	4,380.01 - 5,327.00	5,327.01 - 5,919.00	5,919.01 +
6	2,714.00	2,714.01 - 3,610.00	3,610.01 - 4,071.00	4,071.01 - 5,021.00	5,021.01 - 6,107.00	6,107.01 - 6,785.00	6,785.01 +
7	3,061.00	3,061.01 - 4,071.00	4,071.01 - 4,591.00	4,591.01 - 5,663.00	5,663.01 - 6,887.00	6,887.01 - 7,652.00	7,652.01 +
8	3,408.00	3,408.01 - 4,532.00	4,532.01 - 5,111.00	5,111.01 - 6,304.00	6,304.01 - 7,667.00	7,667.01 - 8,519.00	8,517.01 +
9	3,754.00	3,754.01 - 4,993.00	4,993.01 - 5,631.00	5,631.01 - 6,945.00	6,945.01 - 8,447.00	8,447.01 - 9,385.00	9,385.01 +
10	4,101.00	4,101.01 - 5,454.00	5,454.01 - 6,151.00	6,151.01 - 7,587.00	7,587.01 - 9,227.00	9,227.01 - 10,252.00	10,252.01 +

Based on the HHS Federal Poverty Guidelines, Department of Health & Human Services, January 2016

Note: Clients must never be denied services because of an inability to pay current or past fees.

Effective March 1, 2016

FAMILY PLANNING PROGRAM PROMOTION / OUTREACH ANNUAL

Agency Name				Person(s) completing report	Phone number	Email		
Activity	Date of activity	Number of agency staff monitoring	Estimated number of potential clients reached	Community partners / Collaborating organizations	MARKETING OUTLET(S)			
					Small media (i.e. brochures, posters)	Mass media (i.e. TV/radio, newspaper/magazine)	Social media* (i.e. active Facebook account, active twitter account)	Community Event (yes or no)
<i>Example activity 1 – Health Fair</i>	<i>1/1/2017</i>	<i>2</i>	<i>34</i>	<i>none</i>	<i>posters</i>	<i>none</i>	<i>none</i>	<i>yes</i>
<i>Example activity 2 – Started Facebook page with weekly posts</i>	<i>3/31/2017</i>	<i>1</i>	<i>167</i>	<i>none</i>	<i>none</i>	<i>none</i>	<i>Facebook</i>	<i>no</i>

Successes

Challenges/Barriers

Instructions
 Agencies must perform a minimum of 6 outreach activities per contract term.
 Complete and submit to famplan@hhsc.state.tx.us within 45 days of contract start date.
 An electronic version of this form may be found at http://www.dshs.state.tx.us/chscontracts/all_forms.shtm.

*Each social media outlet (i.e. Facebook, Twitter) may only count once a quarter.

From: Morbidity and Mortality Weekly Report (MMWR) Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs

Recommendations and Reports

April 25, 2014 / 63(RR04);1-29

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_e

pp.22-23: Summary of Recommendations for Providing Family Planning and Related Preventive Health Services

The screening components for each family planning and related preventive health service are provided in summary checklists for women ([Table 2](#)) and men ([Table 3](#)). When considering how to provide the services listed in these recommendations (e.g., the screening components for each service, risk groups that should be screened, the periodicity of screening, what follow-up steps should be taken if screening reveals the presence of a health condition), providers should follow CDC and USPSTF recommendations cited above, or, in the absence of CDC and USPSTF recommendations, the recommendations of professional medical associations. Following these recommendations is important both to ensure clients receive needed care and to avoid unnecessary screening of clients who do not need the services.

The summary tables describe multiple screening steps, which refer to the following: 1) the process of asking questions about a client's history, including a determination of whether risk factors for a disease or health condition exist; 2) performing a physical exam; and 3) performing laboratory tests in at-risk asymptomatic persons to help detect the presence of a specific disease, infection, or condition. Many screening recommendations apply only to certain subpopulations (e.g., specific age groups, persons who engage in specific risk behaviors or who have specific health conditions), or some screening recommendations apply to a particular frequency (e.g., a cervical cancer screening is generally recommended every 3 years rather than annually). Providers should be aware that the USPSTF also has recommended that certain screening services not be provided because the harm outweighs the benefit (see [Appendix F](#)).

When screening results indicate the potential or actual presence of a health condition, the provider should either provide or refer the client for the appropriate further diagnostic testing or treatment in a manner that is consistent with the relevant federal or professional medical associations' clinical recommendations.

APPENDIX F

TABLE 2. Check list of family planning and related preventive health services for women

Screening components	Family planning services (provide services in accordance with the appropriate clinical recommendation)					Related preventive health services
	Contraceptive services*	Pregnancy testing and counseling	Basic infertility services	Preconception health services	STD services†	
History						
Reproductive life plan§	Screen	Screen	Screen	Screen	Screen	
Medical history§.**	Screen	Screen	Screen	Screen	Screen	Screen
Current pregnancy status§	Screen					
Sexual health assessment§.**	Screen		Screen	Screen	Screen	
Intimate partner violence §.§.**				Screen		
Alcohol and other drug use§.§.**				Screen		
Tobacco use§.¶	Screen (combined hormonal methods for clients aged ≥35 years)			Screen		
Immunizations§				Screen	Screen for HPV & HBV§§	
Depression§.¶				Screen		
Folic acid§.¶				Screen		
Physical examination						
Height, weight and BMI§.¶	Screen (hormonal methods)††		Screen	Screen		
Blood pressure§.¶	Screen (combined hormonal methods)			Screen§§		
Clinical breast exam**			Screen			Screen§§
Pelvic exam§.**	Screen (initiating diaphragm or IUD)	Screen (if clinically indicated)	Screen			
Signs of androgen excess**			Screen			
Thyroid exam**			Screen			
Laboratory testing						
Pregnancy test **	Screen (if clinically indicated)	Screen				
Chlamydia§.¶	Screen¶¶				Screen§§	
Gonorrhea§.¶	Screen¶¶				Screen§§	
Syphilis§.¶					Screen§§	
HIV/AIDS§.¶					Screen§§	
Hepatitis C§.¶					Screen§§	
Diabetes§.¶				Screen§§		
Cervical cytology¶						Screen§§
Mammography¶						Screen§§

Abbreviations: BMI = body mass index; HBV = hepatitis B virus; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus; IUD = intrauterine device; STD = sexually transmitted disease.

* This table presents highlights from CDC’s recommendations on contraceptive use. However, providers should consult appropriate guidelines when treating individual patients to obtain more detailed information about specific medical conditions and characteristics (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. [MMWR 2010;59\(No. RR-4\)](#)).

† STD services also promote preconception health but are listed separately here to highlight their importance in the context of all types of family planning visits. The services listed in this column are for women without symptoms suggestive of an STD.

§ CDC recommendation.

¶ U.S. Preventive Services Task Force recommendation.

** Professional medical association recommendation.

†† Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used (U.S. Medical Eligibility Criteria 1) or generally can be used (U.S. Medical Eligibility Criteria 2) among obese women (Source: CDC. U.S. medical eligibility criteria for contraceptive use 2010. [MMWR 2010;59\(No. RR-4\)](#)). However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

§§ Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of an infection or condition.

¶¶ Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC’s STD treatment guidelines (Sources: CDC. STD treatment guidelines. Atlanta, GA: US Department of Health and Human Services, CDC; 2013. Available at <http://www.cdc.gov/std/treatment>. CDC. Sexually transmitted diseases treatment guidelines, 2010. [MMWR 2010;59\(No. RR-12\)](#)). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis or current chlamydial infection or gonorrhea should not undergo IUD insertion (U.S. Medical Eligibility Criteria 4) women who have a very high individual likelihood of STD exposure (e.g. those with a currently infected partner) generally should not undergo IUD insertion (U.S. Medical Eligibility Criteria 3) (Source: CDC. US medical eligibility criteria for contraceptive use 2010. [MMWR 2010;59\(No. RR-4\)](#)). For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

APPENDIX F

TABLE 3. Checklist of family planning and related preventive health services for men

Screening components and source of recommendation	Family planning services (provide services in accordance with the appropriate clinical recommendation)				Related preventive health services
	Contraceptive services*	Basic infertility services	Preconception health services [†]	STD services [§]	
History					
Reproductive life plan¶	Screen	Screen	Screen	Screen	
Medical history¶,††	Screen	Screen	Screen	Screen	
Sexual health assessment¶,††	Screen	Screen	Screen	Screen	
Alcohol & other drug use ¶,**,††			Screen		
Tobacco use¶,**			Screen		
Immunizations¶			Screen	Screen for HPV & HBV ^{§§}	
Depression¶,**			Screen		
Physical examination					
Height, weight, and BMI¶,**			Screen		
Blood pressure**,††			Screen ^{§§}		
Genital exam††		Screen (if clinically indicated)		Screen (if clinically indicated)	Screen ^{§§}
Laboratory testing					
Chlamydia¶				Screen ^{§§}	
Gonorrhea¶				Screen ^{§§}	
Syphilis¶,**				Screen ^{§§}	
HIV/AIDS¶,**				Screen ^{§§}	
Hepatitis C¶,**				Screen ^{§§}	
Diabetes¶,**			Screen ^{§§}		

Abbreviations: HBV = hepatitis B virus; HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; HPV = human papillomavirus virus; STD = sexually transmitted disease.

* No special evaluation needs to be done prior to making condoms available to males. However, when a male client requests advice on pregnancy prevention, he should be provided contraceptive services as described in the section "Provide Contraceptive Services."

[†] The services listed here represent a sub-set of recommended preconception health services for men that were recommended and for which there was a direct link to fertility or infant health outcomes (Source: Frey K, Navarro S, Kotelchuck M, Lu M. The clinical content of preconception care: preconception care for men. *Am J Obstet Gynecol* 2008;199[6 Suppl 2]:S389–95).

[§] STD services also promote preconception health, but are listed separately here to highlight their importance in the context of all types of family planning visit. The services listed in this column are for men without symptoms suggestive of an STD.

¶ CDC recommendation. ** U.S. Preventive Services Task Force recommendation.

†† Professional medical association recommendation.

^{§§} Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of infection or other condition.

TYPICAL EFFECTIVENESS OF FDA-APPROVED CONTRACEPTIVE METHODS

The figure shows the typical effectiveness of FDA-approved contraceptive methods, ranging from least effective (fertility-awareness based methods and spermicide) to the most effective (implants, intrauterine devices, and sterilization).

MMWR Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, Recommendations and Reports. April 25, 2014 / 63(RR04);1-29. (See http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s_cid=rr6304a1_w)

