IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201301 JANUARY 8, 2013

The IHCP announces billing and reimbursement details for the new Family Planning Eligibility Program

In BT201243, dated November 20, 2012, the Indiana Health Coverage Programs (IHCP) announced implementation of the Family Planning Eligibility Program, effective January 1, 2013. The family planning program provides only family planning services to qualifying individuals, per *IC 12-15-46 Medicaid Waivers and State Plan Amendments*.

The family planning eligibility category includes individuals who:

- Do not qualify for any other category of Medicaid
- Are male or female of any age
- Are not pregnant
- Have not had a hysterectomy or sterilization
- Have income that is at or below 133% of the federal poverty level
- Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens

Members eligible under the Family Planning Aid Category will receive services through the Traditional Medicaid program within the fee-for-service delivery system. These individuals will be identified as being in the “MA E” aid category. Providers must check eligibility before rendering services.

The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy. **Services covered under the Family Planning Eligibility Program include**:

- Annual family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods
- Limited history and physical (H&P) examinations
- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods
- Pap smears
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Providing Food and Drug Administration (FDA)-approved oral contraceptives and contraceptive devices and supplies, including emergency contraceptives
- Initial diagnosis and treatment of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs), if medically indicated, including the provision of FDA-approved anti-infective agents.
- Screening, testing, counseling, and referral of members at risk for HIV
- Tubal ligations
- Hysteroscopic sterilization with an implant device
- Vasectomies

Services not covered under the Family Planning Eligibility Program include:

- Abortions
- Any drug or device intended to terminate fertilization
- Artificial insemination
- IVF (in vitro fertilization)
- Fertility counseling
- Fertility treatment
- Fertility drugs
- Inpatient hospital stays
- Reversal of tubal ligation and vasectomies
- Treatment for any chronic condition, including STDs and STIs that have advanced to a chronic condition
- Services unrelated to family planning

Description of services

Annual examinations and office visits (see Table 3.0 for related procedure codes)

IHCP reimbursement is available for annual examinations and office visits for the purpose of family planning. An annual examination for purposes of family planning consists of a limited history and physical,

including Pap smears, testing for STDs and STIs when indicated, and medical laboratory evaluations as necessary for determination of contraceptive use. Members enrolled in the Family Planning Eligibility Program are eligible for one annual examination in a 12-month period.

The IHCP considers counseling services to be part of evaluation and management (E/M) services. As such, separate reimbursement is not available for counseling-only services.

Contraception (see Tables 4.0 through 4.5 for related procedure codes)

IHCP reimbursement is available for most FDA-approved oral contraceptives, supplies, and devices. Covered drugs, supplies, and devices are as follows:

- Birth control pills
- Contraceptive vaginal ring
- Contraceptive patch
- Male condoms
- Female condoms
- Spermicides
- Injectable drugs
- Emergency contraception
- Intrauterine devices (IUDs)
- Contraceptive capsules
- Diaphragms

Members must be given information and education about all methods of contraception available, including reversible methods (for example, oral, emergency, injectable, implant, intrauterine device (IUD), diaphragm, cervical cap, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (for example, tubal ligation, and vasectomy). Education regarding all contraceptive methods must include relative effectiveness, common side effects, risks, appropriate use, and difficulty in usage. Basic information concerning STDs and STIs must also be discussed.

Prescriptions for a contraceptive method must reflect the member's choice, except where such choice is in conflict with sound medical practice. Generic medications must be dispensed when available; however, if generic drugs are not available, brand name drugs may be dispensed. Generic and preferred drugs must be used when available, unless the physician indicates a medical reason for using a different drug. In exception, brand name drugs may be dispensed, even if generic drugs are available, if Indiana Medicaid determines that the brand name drugs are less costly to the Indiana Medicaid program.

Contraceptive drugs and supplies may be administered, dispensed, prescribed, or ordered. Prescriptions for family planning drugs and supplies may be refilled as prescribed by the practitioner for up to one year. Emergency contraception may be dispensed or prescribed.

Members are encouraged to follow up with their family planning provider when a specific problem related to a contraceptive method occurs, or additional services and supplies are needed. All members, regardless of the contraceptive method chosen, must be encouraged to return for a physical examination, laboratory services, and health history at least once per year.

Sterilization (see Tables 5.0 through 5.4 for related procedure codes)

The IHCP reimburses for sterilizations when the consent form accompanies claims connected with the service for men and women, according to *405 IAC 5-28-8*.

Medicaid reimbursement is available for sterilization with the following restrictions:

- Sterilization procedures must comply with the mandates of federal rules.
- The patient must be 21 years of age or older at the time the informed consent form is signed.
- The patient must be competent and not institutionalized.
- The patient must have voluntarily given informed consent on forms prescribed for such purposes by the federal Department of Health and Human Services.
- All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement will be made.

The IHCP covers the Essure implant device as a sterilization option. Essure is an implant device providing a nonincision permanent sterilization option. The implant can be performed by a medical doctor (MD) or a doctor of osteopathy (DO) trained in the procedure, and can be performed in the office, at an outpatient hospital facility, or in an ambulatory surgical center (ASC).

STIs and STDs (see Table 2.1 for related diagnosis codes and Tables 6.0 and 6.1 for related procedure codes)

The IHCP considers the initial diagnosis and treatment of STIs, STDs, HIV testing, and counseling provided during a family planning encounter to be covered family planning services. When an STI or STD is diagnosed during a family planning visit, the member has 180 days, from the date of the initial diagnosis, to receive treatment for the STI/STD. The treatment for the STI or STD must be prescribed in conjunction with a family planning visit and be related to family planning.

The Family Planning Eligibility Program does not cover ongoing treatment of STIs and STDs. This program covers antiviral medications for the initial treatment of an STI or STD, which is limited to general antiviral and topical antiviral medications. This coverage does not include pharmaceuticals for the treatment of hepatitis B, hepatitis C, or HIV. Referral to a physician, clinic, or other medical professional should be made for ongoing treatment and follow-up of chronic STDs to maintain continuity of patient care.

Pap smears (see Table 8.0 for related laboratory procedure codes)

Family planning services can include Pap smears if performed according to the United States Preventative Services Task Force (USPSTF) Guidelines. The guidelines specify cervical cancer screening every one to three years, however, Pap smear annual frequency may be reduced if three or more annual smears are normal.

Billing and reimbursement requirements

General information

IHCP reimbursement is available for Family Planning Eligibility Program services rendered by IHCP-enrolled providers, including but not limited to physicians, certified nurse midwives, family planning clinics, and hospitals. Family Planning Eligibility Program services may be self-referred.

The IHCP requires prior authorization (PA) for selected procedures, services, and items. Providers are expected to meet all PA and other IHCP requirements applicable to any covered services provided under the Family Planning Eligibility Program. Providers are responsible for obtaining PA.

Reimbursement requires compliance with all IHCP guidelines. Providers must bill using the appropriate procedure codes. Physicians bill professional services on the *CMS-1500* claim form. Providers must bill the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code to the highest level of specificity that supports medical necessity. Clinics and ambulatory surgical centers bill using the most appropriate procedure and revenue codes on the *UB-04* claim form.

The following edits are applicable to claims for family planning services.

Table 1.0 – Edits applicable to family planning services

New EOB	Explanation of benefits (EOB) description	Submission requirements
2057	Claim denial due to Family Planning procedure required and/or Family Planning diagnosis submitted on claim detail that is not a valid Family Planning diagnoses	Physician and physician crossover claims must include only family planning diagnosis codes on each claim detail. If multiple diagnosis codes are applicable per detail, every diagnosis code must be a family planning diagnosis. A family planning procedure code must be included on each detail to allow payment.

Table 1.0 (continued)− Edits applicable to family planning services

New EOB	Explanation of benefits (EOB) description	Submission requirements
2058	Family Planning procedure/NDC required and/or Family Planning diagnosis not submitted in Primary position	Outpatient and outpatient crossover claims must include a family planning diagnosis in the PRIMARY position. A family planning procedure code must be included on each detail, along with the revenue code to allow payment. Pharmacy and compound claims must include a National Drug Code (NDC) on each applicable family planning product and drug detail.
2059	Invalid claim type for Family Planning Services	Family planning services are not applicable for inpatient, inpatient crossover, and long-term care claims.
2060	Invalid claim type for Family Planning Services	Family planning services are not applicable for home health and dental claims.

Diagnosis codes

When billing family planning program services, providers must use the appropriate diagnosis code identified in Table 2.0 as the primary diagnosis, and enter "F" in field 24H on the *CMS-1500* or the appropriate field if billing electronically.

Table 2.0 − Family Planning Eligibility Program − Diagnosis codes

Diagnosis code	Description
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive measures
V25.03	Encounter for emergency contraceptive counseling and prescription
V25.04	Counseling and instruction in natural family planning to avoid pregnancy
V25.09	Other – Family Planning Advice
V25.11	Encounter for insertion of intrauterine contraceptive device
V25.12	Encounter for removal of intrauterine contraceptive device
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device
V25.2	Sterilization
V25.3	Menstrual extraction
V25.40	Contraceptive surveillance, unspecified

Table 2.0 (continued) − Family Planning Eligibility Program − Diagnosis codes

Diagnosis code	Description
V25.41	Contraceptive pill
V25.42	Intrauterine contraceptive device (IUD)
V25.43	Implantable subdermal contraceptive
V25.49	Other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management
V25.9	Contraceptive management, unspecified

Table 2.1 lists the STD and STI diagnosis codes that may be billed during a family planning visit under the family planning program.

Table 2.1 – Family Planning Eligibility Program − STD and STI diagnosis codes

Diagnosis code	Description
042	Human immunodeficiency virus (HIV) disease
079.53	Human immunodeficiency virus type 2 [hiv-2]
090.1	Early congenital syphilis latent
090.2	Early congenital syphilis unspecified
090.3	Syphilitic interstitial keratitis
090.4	Juvenile neurosyphilis
090.40	Juvenile neurosyphilis unspecified
090.41	Congenital syphilitic encephalitis
090.42	Congenital syphilitic meningitis
090.49	Other juvenile neurosyphilis
090.5	Other late congenital syphilis symptomatic
090.6	Late congenital syphilis latent
090.7	Late congenital syphilis unspecified
090.9	Congenital syphilis unspecified
091	Early syphilis symptomatic
091.0	Genital syphilis (primary)
091.1	Primary anal syphilis
091.2	Other primary syphilis
091.3	Secondary syphilis of skin or mucous membranes
091.4	Adenopathy due to secondary syphilis
091.5	Uveitis due to secondary syphilis
091.50	Syphilitic uveitis unspecified
091.51	Syphilitic chorioretinitis (secondary)

Table 2.1 (continued) – Family Planning Eligibility Program − STD and STI diagnosis codes

Diagnosis code	Description
091.52	Syphilitic iridocyclitis (secondary)
091.6	Secondary syphilis of viscera and bone
091.61	Secondary syphilitic periostitis
091.62	Secondary syphilitic hepatitis
091.69	Secondary syphilis of other viscera
091.7	Secondary syphilis relapse
091.8	Other forms of secondary syphilis
091.81	Acute syphilitic meningitis (secondary)
091.82	Syphilitic alopecia
091.89	Other forms of secondary syphilis
091.9	Unspecified secondary syphilis
092	Early syphilis latent
092.0	Early syphilis latent serological relapse after treatment
092.9	Early syphilis latent unspecified
093	Cardiovascular syphilis
093.0	Aneurysm of aorta specified as syphilitic
093.1	Syphilitic aortitis
093.2	Syphilitic endocarditis
093.20	Syphilitic endocarditis of valve unspecified
093.21	Syphilitic endocarditis of mitral valve
093.22	Syphilitic endocarditis of aortic valve
093.23	Syphilitic endocarditis of tricuspid valve
093.24	Syphilitic endocarditis of pulmonary valve
093.8	Other specified cardiovascular syphilis
093.81	Syphilitic pericarditis
093.82	Syphilitic myocarditis
093.89	Other specified cardiovascular syphilis
093.9	Cardiovascular syphilis unspecified
094	Neurosyphilis
094.0	Tabes dorsalis
094.1	General paresis
094.2	Syphilitic meningitis
094.3	Asymptomatic neurosyphilis
094.8	Other specified neurosyphilis
094.81	Syphilitic encephalitis
094.82	Syphilitic parkinsonism
094.83	Syphilitic disseminated retinochoroiditis

Table 2.1 (continued) – Family Planning Eligibility Program − STD and STI diagnosis codes

Diagnosis code	Description
094.84	Syphilitic optic atrophy
094.85	Syphilitic retrobulbar neuritis
094.86	Syphilitic acoustic neuritis
094.87	Syphilitic ruptured cerebral aneurysm
094.89	Other specified neurosyphilis
094.9	Neurosyphilis unspecified
095	Other forms of late syphilis with symptoms
095.0	Syphilitic episcleritis
095.1	Syphilis of lung
095.2	Syphilitic peritonitis
095.3	Syphilis of liver
095.4	Syphilis of kidney
095.5	Syphilis of bone
095.6	Syphilis of muscle
095.7	Syphilis of synovium tendon and bursa
095.8	Other specified forms of late symptomatic syphilis
095.9	Late symptomatic syphilis unspecified
096	Late syphilis latent
097	Other and unspecified syphilis
097.0	Late syphilis unspecified
097.1	Latent syphilis unspecified
097.9	Syphilis unspecified subacute to chronic infectious venereal disease caused by the spirochete treponema pallidum.
098	Gonococcal infections acute infectious disease characterized by primary invasion of the urogenital tract; the etiologic agent is Neisseria gonorrhoeae.
098.0	Gonococcal infection (acute) of lower genitourinary tract acute infectious disease characterized by primary invasion of the urogenital tract; the etiologic agent is Neisseria gonorrhoeae.
098.1	Gonococcal infection (acute) of upper genitourinary tract
098.10	Gonococcal infection (acute) of upper genitourinary tract site unspecified
098.11	Gonococcal cystitis (acute)
098.12	Gonococcal prostatitis (acute)
098.13	Gonococcal epididymo-orchitis (acute)
098.14	Gonococcal seminal vesiculitis (acute)
098.15	Gonococcal cervicitis (acute)
098.16	Gonococcal endometritis (acute)
098.17	Gonococcal salpingitis specified as acute
098.19	Other gonococcal infection (acute) of upper genitourinary tract

Table 2.1 (continued) – Family Planning Eligibility Program – STD and STI diagnosis codes

Diagnosis code	Description
098.2	Gonococcal infection chronic of lower genitourinary tract
098.3	Gonococcal infection chronic of upper genitourinary tract
098.30	Chronic gonococcal infection of upper genitourinary tract site unspecified
098.31	Gonococcal cystitis chronic
098.32	Gonococcal prostatitis chronic
098.33	Gonococcal epididymo-orchitis chronic
098.34	Gonococcal seminal vesiculitis chronic
098.35	Gonococcal cervicitis chronic
098.36	Gonococcal endometritis chronic
098.37	Gonococcal salpingitis (chronic)
098.39	Other chronic gonococcal infection of upper genitourinary tract
098.4	Gonococcal infection of eye
098.40	Gonococcal conjunctivitis (neonatorum)
098.41	Gonococcal iridocyclitis
098.42	Gonococcal endophthalmia
098.43	Gonococcal keratitis
098.49	Other gonococcal infection of eye
098.5	Gonococcal infection of joint
098.50	Gonococcal arthritis
098.51	Gonococcal synovitis and tenosynovitis
098.52	Gonococcal bursitis
098.53	Gonococcal spondylitis
098.59	Other gonococcal infection of joint
098.6	Gonococcal infection of pharynx
098.7	Gonococcal infection of anus and rectum
098.8	Gonococcal infection of other specified sites
098.81	Gonococcal keratosis (blennorrhagica)
098.82	Gonococcal meningitis
098.83	Gonococcal pericarditis
098.84	Gonococcal endocarditis
098.85	Other gonococcal heart disease
098.86	Gonococcal peritonitis
098.89	Gonococcal infection of other specified sites
099	Other venereal diseases
099.0	Chancroid

Table 2.1 (continued) – Family Planning Eligibility Program – STD and STI diagnosis codes

Diagnosis code	Description
099.1	Lymphogranuloma venereum subacute inflammation of the inguinal lymph glands caused by certain immunotypes of Chlamydia trachomatis; a sexually transmitted disease in the United States but is more widespread in developing countries; do not confuse with granuloma venereum, which is caused by Calymmatobacterium granulomatis, for this use enterobacteriaceae disease.
099.2	Granuloma inguinale
099.3	Reiter's disease triad of nongonococcal urethritis followed by conjunctivitis and arthritis.
099.4	Other nongonococcal urethritis
099.40	Other nongonococcal urethritis unspecified
099.41	Other nongonococcal urethritis chlamydia trachomatis
099.49	Other nongonococcal urethritis other specified organism
099.50	Other venereal diseases due to chlamydia trachomatis unspecified site
099.51	Other venereal diseases due to chlamydia trachomatis pharynx
099.52	Other venereal diseases due to chlamydia trachomatis anus and rectum
099.53	Other venereal diseases due to chlamydia trachomatis lower genitourinary sites
099.54	Other venereal diseases due to chlamydia trachomatis other genitourinary sites
099.55	Other venereal diseases due to chlamydia trachomatis unspecified genitourinary site
099.56	Other venereal diseases due to chlamydia trachomatis peritoneum
099.59	Other venereal diseases due to chlamydia trachomatis other specified site
099.8	Other specified venereal diseases
099.9	Venereal disease unspecified diseases due to or propagated by sexual contact. Any contagious disease acquired during sexual contact; e.g. syphilis, gonorrhea, chancroid.
78.88	Other specified diseases due to Chlamydiae
79.4	Human papillomavirus
79.98	Unspecified chlamydial infection
V73.88	Other specified chlamydial diseases
V73.98	Unspecified chlamydial disease
V76.2	Special screening for malignant neoplasms; Cervix

Evaluation and management (E/M) codes

For annual and follow-up examinations, Family Planning Eligibility Program providers must bill the most appropriate E/M procedure code for the complexity of the examination provided. To bill an examination, providers must use the appropriate procedure codes from Table 3.0 along with modifier "FP" and a family planning diagnosis code.

Table 3.0 – Family Planning Eligibility Program − E/M procedure codes

Procedure code	Modifier	Description
99201	FP	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making.
99202	FP	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making.
99203	FP	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity.
99204	FP	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity.
99205	FP	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity
99211	FP	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes
99212	FP	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straight-forward medical decision making.
99213	FP	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making o
99214	FP	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity.
99215	FP	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity.
99241	FP	Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making.
99242	FP	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making.
99243	FP	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity.

Table 3.0 (continued) – Family Planning Eligibility Program − E/M procedure codes

Procedure code	Modifier	Description
99244	FP	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.
99245	FP	Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.
99383	FP	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	FP	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	FP	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	FP	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99393	FP	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	FP	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	FP	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	FP	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years

Contraceptive supplies

Providers must bill contraceptive services and supplies not classified as drugs or biologicals using the *CMS-1500* or 837P with the appropriate Current Procedural Terminology (CPT®[1]) or Healthcare Common Procedure Coding System (HCPCS) codes and appropriate ICD-9-CM diagnosis codes for services rendered or condition treated. For example, use ICD-9-CM diagnosis codes V25.01 through V25.9 for contraceptive management, and use ICD-9-CM diagnosis code 099.53 for acute chlamydial vaginitis.

Providers must ensure that the member's chart contains the date of the office visit, the National Drug Code (NDC) of the product dispensed or administered, the name of the product, and the number of units dispensed or administered (for example four boxes of 30 items).

[1] *CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Oral and injectable contraceptives

Reimbursement is available for oral and injectable contraceptives under the family planning program. Providers must bill the appropriate NDC for the drug dispensed or administered, along with appropriate code in Table 4.0.

Limits and restrictions are imposed for HCPCS code J1055 – *Injection, medroxyprogesterone acetate for contraceptive use, 150 mg*. Coverage is provided for females only and the allowable units per date of service (DOS) is limited to one.

According to the FDA, Depo-Provera contraceptive injection (CI) is a long-term contraceptive for women and is indicated only for the prevention of pregnancy. The recommended dose for women is 150 mg every three months.

Table 4.0 – Family Planning Eligibility Program − Procedure codes for oral and injectable contraceptives (require NDCs)

Procedure code	Description
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
J1056	Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg
S4993	Contraceptive pills for birth control

Contraceptive devices

Contraceptive devices listed in Table 4.1 must be billed with a primary Family Planning Eligibility Program diagnosis code listed in Table 2.0. Condoms are considered medically necessary for men and women for the prevention of pregnancy, and to reduce the risk of STDs. Therefore, reimbursement is available for both male and female family planning members. For a pharmacy provider to be reimbursed for over-the-counter external contraceptive supplies, a licensed IHCP-enrolled practitioner with prescriptive authority must prescribe them. The member may receive up to a three-month supply at one time.

Procedure codes A4261 − *Cervical cap for contraceptive use* and A4266 − *Diaphragm for contraceptive use* may be reimbursed separately from procedure code 57170 − *Diaphragm or cervical cap fitting with instructions*.

Table 4.1 – Family Planning Eligibility Program −
Procedure codes for contraceptive devices and supplies (do not require NDCs)

Procedure code	Description
A4261	Cervical cap for contraceptive use
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male, each
A4268	Contraceptive supply, condom, female, each
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each

Intrauterine devices

The IHCP reimburses for intrauterine devices (IUDs) and the insertion of IUDs under the family planning program. Additionally, the IHCP reimburses for IUD insertions on the same DOS as a dilation and curettage.

The IHCP also reimburses for the removal of an IUD. A provider will not be reimbursed for both an office visit and an IUD removal when billed on the same DOS.

Refer to Table 4.2 for procedure codes that may be reimbursed for IUDs. Procedure codes J7300 − *Intrauterine copper contraceptive* and J7302 − *Levonorgestrel-releasing intrauterine contraceptive system, 52 mg* must be billed along with the NDC of the product administered.

Table 4.2 – Family Planning Eligibility Program − Procedure codes for IUDs

Procedure code	Description
J7300	Intrauterine copper contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)

Vaginal ring and hormone patch

The IHCP reimburses for vaginal ring and hormone patch contraceptive devices under the family planning program. Providers must bill the specific codes listed in Table 4.3 instead of a miscellaneous supply code to identify the service being supplied. The NDC of the product dispensed or administered must be included along with the procedure code.

Table 4.3 – Family Planning Eligibility Program − Procedure codes for vaginal ring and hormone patch (require NDCs)

Procedure code	Description
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Contraceptive supply, hormone containing patch, each

Contraceptive implants

The IHCP reimburses for contraceptive implants under the family planning program. Refer to Table 4.4 for procedure codes that may be reimbursed for implants. Procedure codes J7306 − *Levonorgestrel (contraceptive) implant system, including implants and supplies* and J7307 − *Etonogestrel (contraceptive) implant system, including implant and supplies* must be billed along with the NDC of the product administered.

Table 4.4 – Family Planning Eligibility Program − Procedure codes for contraceptive implants

Procedure code	Description
J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with insertion, non-biodegradable drug delivery implant

Norplant Systems

Norplant Systems are no longer available in the United States; however, under the family planning program, the IHCP reimburses the removal of the implanted contraceptive capsule when billed with diagnosis code V25.43 − *Implantable subdermal contraceptive*.

Table 4.5 – Family Planning Eligibility Program − Procedure codes for Norplant Systems

Procedure code	Description
11976	Removal, implantable contraceptive capsules

Sterilization and sterilization-related procedures

Sterilization renders a person unable to reproduce. The IHCP reimburses for sterilizations when the consent form accompanies all claims connected with the service for men and women, according to *405 IAC 5-28-8*.

The IHCP may reimburse for the sterilization of an individual only if that individual meets the following requirements:

- Is 21 years old or older at the time the informed consent is given, per *42 CFR 441.253*
- Is neither mentally incompetent nor institutionalized, per *42 CFR 441.25*1
- Has voluntarily given informed consent, per *42 CFR 441.257* through *441.25*8

Hysteroscopic sterilizations

Hysteroscopic sterilizations with an implant device provide for a permanent sterilization option that doesn't require an incision. The IHCP covers this procedure for eligible female members 21 years of age and older under the family planning program. This procedure can be performed in the office, in an outpatient hospital, or in an ASC.

Providers should bill the procedure using CPT code 58565 – *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants*. However, CPT code 58579 – *Unlisted hysteroscopy procedure, uterus* is not appropriate billing for the hysteroscopic sterilization procedure with an implant device, and claims will suspend for manual review.

The IHCP covers the Essure implant device as a sterilization option. Essure is an implant device providing a nonincision permanent sterilization option. The implant can be performed by a medical doctor (MD) or a doctor of osteopathy (DO) trained in the procedure, and can be performed in the office, at an outpatient hospital facility, or in an ASC. The implant device must be billed separately on the *CMS-1500* claim form using HCPCS code A9900 – *Miscellaneous DME supply, accessory, and/or service component of another HCPCS code*. This code is the only code billable for the implant device.

Table 5.0 – Family Planning Eligibility Program − Procedure codes for hysteroscopic sterilizations

Procedure code	Description
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code

An outpatient hospital or ASC must adhere to the following billing instructions to receive reimbursement for the implant device in addition to the outpatient ASC rate. No additional reimbursement is available for the implant device if performed in an inpatient setting.

Table 5.1 – Family Planning Eligibility Program – Billing instructions for the hysteroscopic sterilization procedure with implant device

<table>
<tr><th>Provider</th><th>Claim type</th><th>Bill for the procedure and the supply</th><th>Additional billing requirements</th></tr>
<tr><td rowspan="2">Outpatient hospital or ASC</td><td>UB-04</td><td>CPT code 58565 with appropriate revenue code</td><td rowspan="4">Print “Essure Sterilization” in the body of the claim form or on the accompanying invoice
Submit a manufacturer’s cost invoice with the claim to support the cost of the Essure device. The IHCP reimburses 130% of the amount listed on the cost invoice up to a maximum of $1,700.
Submit a valid, signed Sterilization Consent Form with the claim
Enter ICD-9-CM V252-Sterilization as the primary diagnosis on the claim</td></tr>
<tr><td>CMS-1500 – Bill for the device under the professional or durable medical equipment (DME) provider number</td><td>Bill the device using A9900 – Include a cost invoice with the claim to support the actual cost of the device</td></tr>
<tr><td rowspan="2">Physician</td><td rowspan="2">CMS-1500</td><td>CPT code 58565</td></tr>
<tr><td>Bill the device on a separate line using HCPCS code A9900 – Include a cost invoice</td></tr>
</table>

Tubal ligation

Tubal ligations may be reimbursed by the IHCP under the family planning program. See Table 5.2 for billable procedure codes. Tubal ligations are considered permanent, once-per-lifetime procedures. If a tubal ligation has previously been reimbursed for the member, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

Table 5.2 – Family Planning Eligibility Program – Procedure codes for tubal ligation

Procedure code	Description
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)

Vasectomy

The IHCP may reimburse for a vasectomy for sterilization that is performed on a male by an IHCP-enrolled provider. Vasectomies are considered permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the member, providers may appeal with documentation that supports

the medical necessity for the repeat sterilization. See Table 5.3 for a list of billable vasectomy procedure codes under the family planning program.

Table 5.3 – Family Planning Eligibility Program − Procedure codes for vasectomy

Procedure code	Description
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral

Anesthesia for sterilization

See Table 5.4 for anesthesia procedure codes that may be billed along with the sterilization procedure under the family planning program.

Table 5.4 – Family Planning Eligibility Program − Procedure codes for anesthesia services

Procedure code	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection
00920	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
00950	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); culdoscopy
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography

Sexually transmitted diseases and infections (STDs and STIs)

Under the family planning program, reimbursement is available for the initial diagnosis and treatment of STDs and STIs when diagnosed during a family planning visit. The member has 180 days from the date of initial diagnosis to seek treatment. The treatment for the STD or STI must be prescribed in conjunction with a family planning visit and be related to family planning. Ongoing treatment after 180 days will not be

reimbursed. See Table 2.1 for the diagnosis codes related to STDs and STIs. See Tables 6.0 and 6.1 for procedure codes that are billable for the treatment of STDs and STIs. The codes in Table 6.1 must be billed along with the appropriate NDC.

Table 6.0 − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
86255	Fluorescent noninfectious agent antibody; screen, each antibody
86256	Fluorescent noninfectious agent antibody; titer, each antibody
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86318	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
86593	Syphilis test, non-treponemal antibody; quantitative
86628	Antibody; Candida
86631	Antibody; Chlamydia
86632	Antibody; Chlamydia, IgM
86687	Antibody; HTLV-I
86688	Antibody; HTLV-II
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)
86692	Antibody; hepatitis, delta agent
86694	Antibody; herpes simplex, non-specific type test
86695	Antibody; herpes simplex, type 1
86696	Antibody; herpes simplex, type 2
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single result
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86780	Antibody; Treponema pallidum
86787	Antibody; varicella-zoster
86803	Hepatitis C antibody;
86804	Hepatitis C antibody; confirmatory test (eg, immunoblot)
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates

Table 6.0 (continued) − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
87073	Culture, bacterial; quantitative, anaerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
87075	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates
87076	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87077	Culture, bacterial; aerobic isolate, additional methods required for definitive identification, each isolate
87081	Culture, presumptive, pathogenic organisms, screening only;
87084	Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart
87086	Culture, bacterial; quantitative colony count, urine
87088	Culture, bacterial; with isolation and presumptive identification of each isolate, urine
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail
87102	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)
87109	Culture, mycoplasma, any source
87110	Culture, chlamydia, any source
87140	Culture, typing; immunofluorescent method, each antiserum
87147	Culture, typing; immunologic method, other than immunofluoresence (eg, agglutination grouping), per antiserum
87149	Culture, typing; identification by nucleic acid (DNA or RNA) probe, direct probe technique, per culture or isolate, each organism probed
87164	Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection
87166	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection
87181	Susceptibility studies, antimicrobial agent; agar dilution method, per agent (eg, antibiotic gradient strip)
87184	Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents)
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87206	Smear, primary source with interpretation; fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types
87207	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
87210	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)

Table 6.0 (continued) − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect
87254	Virus isolation; centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus
87255	Virus isolation; including identification by non-immunologic method, other than by cytopathic effect (eg, virus specific enzymatic activity)
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87273	Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 2
87274	Infectious agent antigen detection by immunofluorescent technique; Herpes simplex virus type 1
87285	Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis
87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87341	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization
87350	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis Be antigen (HBeAg)
87390	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1
87391	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2
87449	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism
87480	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique
87481	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique
87482	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, quantification
87485	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, direct probe technique
87486	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, amplified probe technique
87487	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique

Table 6.0 (continued) − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87510	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique
87511	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, amplified probe technique
87512	Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, quantification
87516	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, amplified probe technique
87517	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis B virus, quantification
87521	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, amplified probe technique
87522	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, quantification
87528	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, direct probe technique
87529	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, amplified probe technique
87530	Infectious agent detection by nucleic acid (DNA or RNA); Herpes simplex virus, quantification
87531	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, direct probe technique
87532	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, amplified probe technique
87533	Infectious agent detection by nucleic acid (DNA or RNA); Herpes virus-6, quantification
87534	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique
87535	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique
87536	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87537	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique
87538	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique
87539	Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification
87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87592	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification

Table 6.0 (continued) − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
87620	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique
87621	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique
87622	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification
87660	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique
87797	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
87799	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
87808	Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis
87810	Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis
87850	Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
87901	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease regions
87902	Infectious agent genotype analysis by nucleic acid (DNA or RNA); Hepatitis C virus
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision

Table 6.0 (continued) − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)
88160	Cytopathology, smears, any other source; screening and interpretation
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
88300	Level I - Surgical pathology, gross examination only
88302	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental, Fallopian tube, sterilization, Fingers/toes, amputation, traumatic, Foreskin, newborn, Hernia sac, any location, Hydrocele sac, Nerve, Skin, plastic repair, Sympathetic ganglion, Testis, castration, Vaginal mucosa, incidental, Vas deferens, sterilization
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced, Abscess, Aneurysm - arterial/ventricular, Anus, tag, Appendix, other than incidental, Artery, atheromatous plaque, Bartholin's gland cyst, Bone fragment(s), other than pathologic fracture, Bursa/synovial cyst, Carpal tunnel tissue, Cartilage, shavings, Cholesteatoma, Colon, colostomy stoma, Conjunctiva - biopsy/pterygium, Cornea, Diverticulum - esophagus/small intestine, Dupuytren's contracture tissue, Femoral head, other than fracture, Fissure/fistula, Foreskin, other than newborn, Gallbladder, Ganglion cyst, Hematoma, Hemorrhoids, Hydatid of Morgagni, Intervertebral disc, Joint, loose body, Meniscus, Mucocele, salivary, Neuroma - Morton's/traumatic, Pilonidal cyst/sinus, Polyps, inflammatory - nasal/sinusoidal, Skin - cyst/tag/debridement, Soft tissue, debridement, Soft tissue, lipoma, Spermatocele, Tendon/tendon sheath, Testicular appendage, Thrombus or embolus, Tonsil and/or adenoids, Varicocele, Vas deferens, other than sterilization, Vein, varicosity

Table 6.0 (continued) − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
88305	Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed, Artery, biopsy, Bone marrow, biopsy, Bone exostosis, Brain/meninges, other than for tumor resection, Breast, biopsy, not requiring microscopic evaluation of surgical margins, Breast, reduction mammoplasty, Bronchus, biopsy, Cell block, any source, Cervix, biopsy, Colon, biopsy, Duodenum, biopsy, Endocervix, curettings/biopsy, Endometrium, curettings/biopsy, Esophagus, biopsy, Extremity, amputation, traumatic, Fallopian tube, biopsy, Fallopian tube, ectopic pregnancy, Femoral head, fracture, Fingers/toes, amputation, non-traumatic, Gingiva/oral mucosa, biopsy, Heart valve, Joint, resection, Kidney, biopsy, Larynx, biopsy, Leiomyoma(s), uterine myomectomy - without uterus, Lip, biopsy/wedge resection, Lung, transbronchial biopsy, Lymph node, biopsy, Muscle, biopsy, Nasal mucosa, biopsy, Nasopharynx/oropharynx, biopsy, Nerve, biopsy, Odontogenic/dental cyst, Omentum, biopsy, Ovary with or without tube, non-neoplastic, Ovary, biopsy/wedge resection, Parathyroid gland, Peritoneum, biopsy, Pituitary tumor, Placenta, other than third trimester, Pleura/pericardium - biopsy/tissue, Polyp, cervical/endometrial, Polyp, colorectal, Polyp, stomach/small intestine, Prostate, needle biopsy, Prostate, TUR, Salivary gland, biopsy, Sinus, paranasal biopsy, Skin, other than cyst/tag/debridement/plastic repair, Small intestine, biopsy, Soft tissue, other than tumor/mass/lipoma/debridement, Spleen, Stomach, biopsy, Synovium, Testis, other than tumor/biopsy/castration, Thyroglossal duct/brachial cleft cyst, Tongue, biopsy, Tonsil, biopsy, Trachea, biopsy, Ureter, biopsy, Urethra, biopsy, Urinary bladder, biopsy, Uterus, with or without tubes and ovaries, for prolapse, Vagina, biopsy, Vulva/labia, biopsy
88307	Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse
88309	Level VI - Surgical pathology, gross and microscopic examination Bone resection, Breast, mastectomy - with regional lymph nodes, Colon, segmental resection for tumor, Colon, total resection, Esophagus, partial/total resection, Extremity, disarticulation, Fetus, with dissection, Larynx, partial/total resection - with regional lymph nodes, Lung - total/lobe/segment resection, Pancreas, total/subtotal resection, Prostate, radical resection, Small intestine, resection for tumor, Soft tissue tumor, extensive resection, Stomach - subtotal/total resection for tumor, Testis, tumor, Tongue/tonsil -resection for tumor, Urinary bladder, partial/total resection, Uterus, with or without tubes and ovaries, neoplastic, Vulva, total/subtotal resection
88312	Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)
88313	Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

Table 6.0 (continued) − Family Planning Eligibility Program − Procedure codes for STDs and STIs

Procedure code	Description
88314	Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)
88319	Special stain including interpretation and report; Group III, for enzyme constituents
88323	Consultation and report on referred material requiring preparation of slides
89321	Semen analysis; sperm presence and motility of sperm, if performed
90371	Hepatitis B immune globulin (HBIg), human, for intramuscular use
90636	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory (distance may be indicated)

Table 6.1 − Family Planning Eligibility Program − Procedure codes to treat STDs and STIs (require NDCs)

Procedure Code	Description
J0133	Injection, acyclovir, 5 mg
J0290	Injection, ampicillin sodium, 500 mg
J0456	Injection, azithromycin, 500 mg
J0561	Injection, penicillin G benzathine, 100,000 units
J0696	Injection, ceftriaxone sodium, per 250 mg
J0697	Injection, sterile cefuroxime sodium, per 750 mg
J0698	Injection, cefotaxime sodium, per g
J0744	Injection, ciprofloxacin for intravenous infusion, 200 mg
J1885	Injection, ketorolac tromethamine, per 15 mg
J1956	Injection, levofloxacin, 250 mg

Radiology services

Under the family planning program, radiology services may be reimbursed separately when performed in conjunction with the initial or annual examinations. See Table 7.0 for a list of billable radiology procedure codes under the family planning program.

Table 7.0 – Family Planning Eligibility Program − Radiology procedure codes

Procedure Code	Description
71010	Radiologic examination, chest; single view, frontal
71020	Radiologic examination, chest, 2 views, frontal and lateral;
72190	Radiologic examination, pelvis; complete, minimum of 3 views
74000	Radiologic examination, abdomen; single anteroposterior view
74740	Hysterosalpingography, radiological supervision and interpretation
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)
76870	Ultrasound, scrotum and contents
76872	Ultrasound, transrectal;
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
76998	Ultrasonic guidance, intraoperative

Laboratory procedures

Laboratory services may be reimbursed separately when performed in conjunction with the initial or annual examinations under the family planning program. See Table 8.0 for a list of billable laboratory procedure codes under the family planning program.

Table 8.0 – Family Planning Eligibility Program − Laboratory procedure codes

Procedure Code	Description
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310), Carbon dioxide (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Potassium (84132), Sodium (84295), Urea nitrogen (BUN) (84520)

Table 8.0 (continued) – Family Planning Eligibility Program − Laboratory procedure codes

Procedure Code	Description
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053), Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004), OR, Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009), Thyroid stimulating hormone (TSH) (84443)
80051	Electrolyte panel This panel must include the following: Carbon dioxide (82374), Chloride (82435), Potassium (84132), Sodium (84295)
80053	Comprehensive metabolic panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Calcium, total (82310), Carbon dioxide (bicarbonate) (82374), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphatase, alkaline (84075), Potassium (84132), Protein, total (84155), Sodium (84295), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450), Urea nitrogen (BUN) (84520)
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465), Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718), Triglycerides (84478)
80074	Acute hepatitis panel This panel must include the following: Hepatitis A antibody (HAAb), IgM antibody (86709), Hepatitis B core antibody (HBcAb), IgM antibody (86705), Hepatitis B surface antigen (HBsAg) (87340), Hepatitis C antibody (86803)
80076	Hepatic function panel This panel must include the following: Albumin (82040), Bilirubin, total (82247), Bilirubin, direct (82248), Phosphatase, alkaline (84075), Protein, total (84155), Transferase, alanine amino (ALT) (SGPT) (84460), Transferase, aspartate amino (AST) (SGOT) (84450)
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dipstick
81015	Urinalysis; microscopic only
81025	Urine pregnancy test, by visual color comparison methods
82120	Amines, vaginal fluid, qualitative
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
82465	Cholesterol, serum or whole blood, total

Table 8.0 (continued) – Family Planning Eligibility Program − Laboratory procedure codes

Procedure Code	Description
82565	Creatinine; blood
82670	Estradiol
82728	Ferritin
82746	Folic acid; serum
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; blood, reagent strip
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)
83026	Hemoglobin; by copper sulfate method, non-automated
83036	Hemoglobin; glycosylated (A1C)
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, single step method (eg, reagent strip)
83901	Molecular diagnostics; amplification, target, multiplex, each additional nucleic acid sequence beyond 2 (List separately in addition to code for primary procedure)
83986	pH; body fluid, not otherwise specified
84144	Progesterone
84146	Prolactin
84181	Protein; Western Blot, with interpretation and report, blood or other body fluid
84443	Thyroid stimulating hormone (TSH)
84450	Transferase; aspartate amino (AST) (SGOT)
84478	Triglycerides
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
85002	Bleeding time
85004	Blood count; automated differential WBC count
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	Blood count; blood smear, microscopic examination without manual differential WBC count
85009	Blood count; manual differential WBC count, buffy coat
85013	Blood count; spun microhematocrit
85014	Blood count; hematocrit (Hct)
85018	Blood count; hemoglobin (Hgb)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count

Table 8.0 (continued) – Family Planning Eligibility Program − Laboratory procedure codes

Procedure Code	Description
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85032	Blood count; manual cell count (erythrocyte, leukocyte, or platelet) each
85041	Blood count; red blood cell (RBC), automated
85048	Blood count; leukocyte (WBC), automated
85049	Blood count; platelet, automated
85610	Prothrombin time;
85651	Sedimentation rate, erythrocyte; non-automated
85652	Sedimentation rate, erythrocyte; automated
85660	Sickling of RBC, reduction
85730	Thromboplastin time, partial (PTT); plasma or whole blood
86580	Skin test; tuberculosis, intradermal

Surgical procedures

See Table 9.0 for a list of the billable surgical procedure codes under the family planning program.

Table 9.0 – Family Planning Eligibility Program − Surgical procedure codes

Procedure Code	Description
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10140	Incision and drainage of hematoma, seroma or fluid collection
11004	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

Table 9.0 (continued) – Family Planning Eligibility Program − Surgical procedure codes

Procedure Code	Description
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
49321	Laparoscopy, surgical; with biopsy (single or multiple)
53040	Drainage of deep periurethral abscess
53230	Excision of urethral diverticulum (separate procedure); female
53260	Excision or fulguration; urethral polyp(s), distal urethra
54050	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical
54056	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
54065	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)
55600	Vesiculotomy;
55605	Vesiculotomy; complicated
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
56515	Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
56605	Biopsy of vulva or perineum (separate procedure); 1 lesion
56606	Biopsy of vulva or perineum (separate procedure); each separate additional lesion (List separately in addition to code for primary procedure)
56740	Excision of Bartholin's gland or cyst
56820	Colposcopy of the vulva;
56821	Colposcopy of the vulva; with biopsy(s)
57061	Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)

Table 9.0 (continued) – Family Planning Eligibility Program − Surgical procedure codes

Procedure Code	Description
57065	Destruction of vaginal lesion(s); extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
57100	Biopsy of vaginal mucosa; simple (separate procedure)
57105	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
57130	Excision of vaginal septum
57135	Excision of vaginal cyst or tumor
57150	Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease
57160	Fitting and insertion of pessary or other intravaginal support device
57170	Diaphragm or cervical cap fitting with instructions
57410	Pelvic examination under anesthesia (other than local)
57420	Colposcopy of the entire vagina, with cervix if present;
57421	Colposcopy of the entire vagina, with cervix if present;
57452	Colposcopy of the cervix including upper/adjacent vagina;
57454	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage
54755	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix
57456	Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505	Endocervical curettage (not done as part of a dilation and curettage)
57510	Cautery of cervix; electro or thermal
57511	Cautery of cervix; cryocautery, initial or repeat
57513	Cautery of cervix; laser ablation
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision
57558	Dilation and curettage of cervical stump
57800	Dilation of cervical canal, instrumental (separate procedure)
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)

Table 9.0 (continued) – Family Planning Eligibility Program – Surgical procedure codes

Procedure Code	Description
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach
58661	Add on code for 58660 - removal of Adnexal structures
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)
58740	Lysis of adhesions (salpingolysis, ovariolysis)
58825	Transposition, ovary(s)
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
62319	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
64435	Injection, anesthetic agent; paracervical (uterine) nerve

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