



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Family Planning Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 27, 2016	<p>Semiannual update:</p> <ul style="list-style-type: none"> • Revised language in the Introduction section regarding the definition and scope of family planning services • Updated the Long-Acting Reversible Contraception Devices section: <ul style="list-style-type: none"> – Updated billing codes for IUDs – Added information about LARC reimbursement during an inpatient stay for delivery • Updated the Sterilization section: <ul style="list-style-type: none"> – Removed information about hysterectomies (now in the <i>Obstetrical and Gynecological Services</i> module) – Updated expiration date information for the <i>Consent for Sterilization</i> form – Added a Vasectomy subsection – Added a Tubal Ligation subsection – Updated the Hysteroscopic Sterilization with an Implant Device (Essure) subsection 	FSSA and HPE

Table of Contents

Introduction.....	1
Billing for Family Planning Services.....	2
Contraceptives.....	2
Contraceptive Supplies.....	3
Oral and Injectable Contraceptives.....	3
Long-Acting Reversible Contraception Devices.....	4
Sterilization.....	4
Informed Consent for Sterilization.....	5
Vasectomy.....	9
Tubal Ligation.....	9
Hysteroscopic Sterilization with an Implant Device (Essure).....	9

Family Planning Services

Note: For policy information regarding coverage of family planning services, see the [Medical Policy Manual](#) at indianamedicaid.com.

Introduction

Family planning services are services provided to individuals who are not pregnant to temporarily or permanently prevent or delay pregnancy. Based on Centers for Medicare & Medicaid Services (CMS) policies, the Indiana Health Coverage Programs (IHCP) also considers initial diagnosis and treatment of sexually transmitted diseases (STDs), human immunodeficiency virus (HIV) testing, and counseling provided during a family planning encounter to be part of family planning services.

Note: Ongoing follow-up of STDs and visits for treatment of chronic STDs are not considered to be a part of family planning services.

Family planning services include the following:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated as part of the decision-making process for choice of contraceptive methods
- Pregnancy testing and counseling
- Provision of contraceptive pills, devices, and supplies, including emergency contraceptives
- Tubal ligation
- Hysteroscopic sterilization with an implant device (Essure)
- Vasectomy
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Initial diagnosis and treatment of STDs, if medically indicated
- Screening, testing, and counseling of members at risk for HIV, as well as referral and initial treatment
- Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, within the parameters described in the [Obstetrical and Gynecological Services](#) module

The IHCP does not place restrictions on access to family planning services for members who are not pregnant and who desire such services and supplies. Family planning services may be self-referred. For members enrolled in a managed care program, such as the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise, providers should contact the member's managed care entity (MCE) or plan administrator for guidelines regarding their specific policies and prior authorization (PA) procedures.

Note: The IHCP Family Planning Eligibility Program provides only family planning services to qualifying individuals. Family Planning Eligibility Program coverage is restricted to specific procedure codes and diagnosis codes, as described in the [Family Planning Eligibility Program](#) module and listed on the [Family Planning Eligibility Program Codes on the Code Sets](#) page indianamedicaid.com.

Billing for Family Planning Services

Providers must bill family planning services and supplies not classified as drugs or biologicals using the *CMS-1500* claim form or 837P electronic transaction, with the appropriate Current Procedural Terminology (CPT^{®1}) or Healthcare Common Procedure Coding System (HCPCS) codes and the appropriate International Classification of Diseases (ICD) diagnosis codes for the services rendered or condition treated. For example, use ICD-10 diagnosis codes Z30.011 through Z30.9 (ICD-9 codes V25.01 through V25.9, for dates of service prior to October 1, 2015) for contraceptive management, and use ICD-10 diagnosis codes A56.00 through A56.3 (ICD-9 code 099.53) for acute chlamydial diseases of the genitourinary system. See the [Claim Submission and Processing](#) module for step-by-step instructions for completing the *CMS-1500* claim form or the 837P transaction.

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

Contraceptives

IHCP reimbursement is available for most Food and Drug Administration (FDA)-approved oral contraceptives and contraceptive 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

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Members must be given information and education about all methods of contraception available, including reversible methods (for example, oral, emergency, injectable, implant, 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 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. 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.

Contraceptive Supplies

Condoms are considered medically necessary for men and women for the prevention of pregnancy and to reduce the risk of STDs. Therefore, reimbursement for condoms is available for both male and female 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.

HCPCS 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*.

The IHCP covers HCPCS codes J7303 – *Contraceptive supply, hormone containing vaginal ring, each* and J7304 – *Contraceptive supply, hormone containing patch, each*. Providers must bill J7303 or J7304, instead of a miscellaneous supply code, as these codes are more specific to the service being supplied. As with most other physician-administered drugs, providers must include the NDC when submitting a claim for either of these procedure codes.

Oral and Injectable Contraceptives

For oral and injectable contraceptives, providers must bill the appropriate NDC for the drug dispensed or administered, along with the appropriate procedure code:

- J1050 – *Injection, medroxyprogesterone acetate, 1 mg*
- S4993 – *Contraceptive pills for birth control*

According to the U.S. 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 to women is 150 mg every three months.

Long-Acting Reversible Contraception Devices

Long-acting reversible contraception (LARC) devices are defined as implantable devices that remain effective for several years to prevent pregnancies. Devices include IUDs and birth control implants.

The IHCP reimburses for IUDs (J7297, J7298, J7300, and J7301) and the insertion of IUDs (58300), including IUD insertions on the same date of service as a dilation and curettage. The IHCP also reimburses for the removal of an IUD (58301). A provider will not be reimbursed for both an office visit and an IUD removal when billed on the same date of service. The appropriate NDC is required when billing the following HCPCS codes:

- J7297 – *Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration*
- J7298 – *Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration*
- J7300 – *Intrauterine copper contraceptive*
- J7301 – *Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg*

Note: For dates of service before January 1, 2016, use J7302 instead of J7297 or J7298.

The IHCP reimburses for contraceptive implants (J7306 and J7307), and their insertion and removal (11981, 11982, and 11983). 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.

Norplant contraceptive systems are no longer available in the United States; however, the IHCP does reimburse for removal of the Norplant systems. Providers removing Norplant systems must bill using CPT code 11976 – *Removal, implantable contraceptive capsules*. Providers should use ICD-10 diagnosis code Z30.49 – *Encounter for surveillance of other contraceptives* (ICD-9 code V25.43 for dates of service before October 1, 2015).

For dates of service on or after June 1, 2015, the IHCP allows separate reimbursement for LARC devices J7300, J7301, J7302, J7306, and J7307 implanted during an inpatient hospital or birthing center stay for a delivery. (For dates of service on or after January 1, 2016, providers should use J7297 or J7298 instead of J7302). Separate reimbursement applies to the LARC devices only. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital diagnosis-related group (DRG) or the birthing center all-inclusive reimbursement amount. To receive separate reimbursement for LARC devices implanted during inpatient hospital or birthing center stays for delivery, the appropriate HCPCS code should be billed on a *CMS-1500* claim form.

Sterilization

Note: The IHCP does not cover a hysterectomy performed solely to render a member permanently incapable of bearing children, whether performed as a primary or secondary procedure. For information about IHCP coverage for medically necessary hysterectomies performed to treat an illness or injury, see the [Obstetrical and Gynecological Services](#) module.

Sterilization renders a person unable to reproduce. The IHCP reimburses for sterilizations for men and women only when a valid consent form accompanies all claims connected with the service, according to *Indiana Administrative Code 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 over at the time the informed consent is given (*Code of Federal Regulations 42 CFR 441.253*)
- Is neither mentally incompetent nor institutionalized (*42 CFR 441.251*)
- Has voluntarily given informed consent (*42 CFR 441.257 through 441.258*)

A sterilization consent form is not necessary when a provider renders a patient sterile as a result of an illness or injury. The physician must attach a certification to the claim indicating that the sterilization occurred due to an illness or injury when prior acknowledgement was not possible. The provider must also include a description of the nature of the emergency.

See the *Family Planning Services Codes* on the [Code Sets](#) page at indianamedicaid.com for lists of CPT, HCPCS, and ICD sterilization procedure codes that, when submitted to the IHCP, cause a claim to suspend for an analyst to review the consent form or documentation of partial sterilization.

*Note: Providers **must note** partial sterilization on the face of the claim form, preferably on the line below the HCPCS procedure code.*

For sterilizations performed at the time of delivery, providers must bill with modifier XE, XP, XS, or XU, as the situation dictates.

Informed Consent for Sterilization

Providers must allow at least 30 days, but not more than 180 days, to pass between the date when the member gives the informed consent and the date when the provider performs the sterilization procedure.

For sterilizations planned concurrent with a delivery, the patient must give the informed consent at least 30 days before the expected date of delivery. The following exceptions apply to premature delivery (defined by the IHCP as labor before 37 weeks' gestation) or emergency abdominal surgery:

- The member must sign the *Consent for Sterilization* form 72 hours before the sterilization, when done at the time of a premature delivery.
- The physician must indicate the reason for the surgery being performed early and the individual's expected date of delivery. The reason for the surgery must be only premature delivery or emergency abdominal surgery.

The person who obtains informed consent must verbally communicate all information about a sterilization procedure to the member to be sterilized, including a member who is blind, deaf, or otherwise handicapped. Providers must furnish an interpreter if a language barrier exists. For a full description of the informed-consent process, *42 CFR 441.257* provides additional information.

Providers cannot obtain informed consent while the member to be sterilized is in one of the following situations:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substances that affect the member's state of awareness

Retroactive Eligibility or Failure to Provide Proof of Eligibility

If the provider does not obtain informed consent on the required State *Consent for Sterilization* form before the procedure because of a retroactive eligibility situation or because the patient failed to inform the provider of IHCP eligibility, the IHCP does not cover the service. The IHCP cannot pay for sterilizations performed if the member did not sign the *Consent for Sterilization* form before the procedure. In these situations, the provider may collect the balance due for the procedure from the patient. To prevent this situation and to ensure IHCP coverage, providers may use the *Consent for Sterilization* form for *all* patients in their practice.

Note: If unrelated services are provided at the same time as a sterilization for an IHCP member, the provider can be reimbursed for medically necessary services unrelated to the sterilization even when the sterilization is not covered due to consent not being obtained. Medically necessary services are subject to the IHCP established policy on retroactive services, as outlined in the [Member Eligibility and Benefit Coverage](#) module.

Consent for Sterilization Form

A properly completed *Consent for Sterilization* form (HHS-687) must accompany all claims for voluntary sterilization and related services. This requirement extends to all providers: attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services. Providers must attach a photocopy of the consent form for sterilization and related services to each claim form, or send it separately as an attachment to the electronic claim transaction, as described in the *Paper Attachments with Electronic Claims* section of the [Claim Submission and Processing](#) module.

Providers may download the *Consent for Sterilization* form (HHS-687) from the [Forms](#) page at indianamedicaid.com. A Spanish version of the form (HHS-687-1) is also available. For printed copies of the *Consent for Sterilization* form, send requests to the following address:

HPE Forms Request
P.O. Box 7263
Indianapolis, IN 46207-7263

Form requests must clearly indicate the *Consent for Sterilization* form (HHS-687 or HHS-697-1), specify the number of copies requested, and list the IHCP provider number and the address for shipping. After receiving the initial order of *Consent for Sterilization* forms, the provider can photocopy the form for future use, rather than order from the Forms Request address.

The most recent version of the *Consent for Sterilization* form can be found on the [Forms](#) page at indianamedicaid.com. Completed consent forms that are not the most recent version available at the IHCP website will cause full claim denial. The current *Consent for Sterilization* forms (HHS-687, in English and HHS-687-1, in Spanish) have an expiration date of December 31, 2018.

Consent Form Instructions

When providers properly complete the *Consent for Sterilization* form, the IHCP receives all the necessary information regarding consent, interpreter's statement, statement of person obtaining consent, and physician's statement.

Federal regulations require that certain elements of the consent form be handwritten. If providers or members make an error on the form, they must complete a new form rather than submitting the form with a strikethrough.

The IHCP contractor must receive a properly completed *Consent for Sterilization* form before making payment. To ensure timely payment to related service providers, the primary service provider should forward **exact** copies of the properly completed consent form to the related service providers.

Table 1 provides instructions for each item on the *Consent for Sterilization* form. Fields marked with an asterisk must be completed with exactly the same wording and must match the procedure billed on the claim.

Table 1 – Instructions for the *Consent for Sterilization Form (HHS-687)*

Field	Description
Consent to Sterilization	
Doctor or Clinic	Enter the name of the doctor or clinic. Providers can prestamp this line. If the provider is a physician group, providers can list all names, such as Drs. Miller and Smith. Also, providers can list the professional group name, such as Westside Medical Group. Providers can use the phrases <i>and/or</i> and <i>his/her associates</i> .
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write out the full name of the operation at the bottom of the form.
Date	Enter the patient's birth date in month, day, and year format. The IHCP requires this information, and it must match the birth date on the claim.
[Name of Individual]	Providers must enter the patient's name in this blank field. The name must be identical to the patient name appearing on the claim form.
Doctor or Clinic	Providers can prestamp this field. If the provider is a group, providers can list all names or use the phrases <i>and/or</i> and <i>his/her associates</i> .
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation on the bottom of the form.
Signature	The patient must sign his or her full name here. If the patient is illiterate, the IHCP permits X as the signature with a witness to countersign. The signature must match the name on the claim and consent form.
Date	The patient must enter the date the form is signed in month, day, and year format. The date must be handwritten. The IHCP calculates the waiting period from this date.
Ethnicity and Race Designation	The information is voluntary and should be completed only by the patient.
Interpreter's Statement	
[Language]	If an interpreter was used, use this field to indicate the language in which the patient was counseled.
Interpreter's Signature	The interpreter must sign here.
Date	Enter the date the interpreter translated the consent form to the member. The interpreter must hand-write the date in month, day, and year format, and it must be the same date the individual signed the consent form.

Field	Description
Statement of Person Obtaining Consent	
Name of Individual	Enter the patient's name here. The name must be identical to the name listed on the consent form and on the claim. The member, the member's legal representative, or a staff member in the physician's office or clinic can complete this field.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation at the bottom of the form.
Signature of Person Obtaining Consent	The person providing sterilization counseling can be a physician or the physician's designee, such as an office nurse.
Date	The signature date of the person obtaining the consent must be the same as the date the member signed the consent form. The person obtaining consent must hand-write this date in month, day, and year format.
Facility	Enter the name of the physician's office or clinic where the patient signed the sterilization consent form, which may not necessarily be the facility where the operation is performed. Providers can prestamp the name of the facility.
Address	Enter the address of the facility where the patient signed the sterilization consent form. The provider can prestamp the address. After the patient completes the <i>Statement of Person Obtaining Consent</i> section, the provider gives the patient a copy of the form.
Physician's Statement	
Name of Individual	Enter the patient's full name. The name must be identical to the names listed on the consent form and the claim.
Date of Sterilization	Enter, in month, day, and year format, the specific date of the sterilization procedure. This date must be at least 30 days, and not more than 180 days, following the member's signing the consent form (with previously noted exceptions for premature delivery or emergency abdominal surgery). The date on the claim must match the date entered here.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation at the bottom of the form.
Instructions for use of alternative final paragraphs	The form provides two options. Cross out the paragraph not used.
Premature delivery	Check this item if alternative paragraph 2 was selected due to premature delivery. If providers check this item, they must also enter a date of expected delivery (see the next item).
Individual's expected date of delivery	The member's physician estimates the date based on the patient's history and physical.
Emergency abdominal surgery	Check this item if alternative paragraph 2 was selected due to emergency abdominal surgery. If providers check this box, they must indicate the operation performed (see the next item).

Field	Description
Describe circumstances	Indicate the emergency operation performed and any relevant information about the circumstances requiring the emergency operation.
Physician's Signature	The physician who has verified consent and who actually performed the operation must complete this field after the sterilization operation. Signature stamps are not acceptable.
Date	The physician's signature must be dated and must be on or within 30 days after the sterilization date. The physician must hand-write the date in month, day, year format.
* All "Type of Operation" fields must be worded exactly the same , and must match the procedure billed on the claim.	

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.

Tubal Ligation

The IHCP may reimburse for a tubal ligation for sterilization that is performed on a female by an IHCP-enrolled provider. 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.

Hysteroscopic Sterilization with an Implant Device (Essure)

The IHCP covers the Essure implant device as a sterilization option. Essure is an implant device providing a nonincision permanent sterilization option. The implant procedure 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.

Providers should bill the procedure using CPT code 58565 – *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants*. (Note that CPT code 58579 – *Unlisted hysteroscopy procedure, uterus* is **not** appropriate billing for the hysteroscopic sterilization procedure with an implant device, and claims with that code will suspend for manual review.) The implant device must be billed separately on the *CMS-1500* claim form using HCPCS code A4264 – *Permanent implantable contraceptive intratubal occlusion device(s) and delivery system*. This is the only code billable for the implant device. Table 2 provides billing instructions for these services.

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 the procedure is performed in an inpatient setting.

Providers must adhere to the following procedures:

- Print “**Essure Sterilization**” on 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 cost invoice up to a maximum of \$1,700.
- Submit a valid, signed *Consent for Sterilization* form with the claim.
- Ensure that the primary diagnosis on the claim is ICD-10 diagnosis code Z30.2 – *Encounter for sterilization*. (For dates of service before October 1, 2015, use ICD-9 diagnosis code V25.2 – *Sterilization*.)

Table 2 – Billing Instructions for the Hysteroscopic Sterilization Procedure with Implant Device

Provider	Claim Type	Code for Procedure and Device	Additional Billing Requirements
Outpatient hospital or ASC	UB-04	Bill the procedure using 58565, with appropriate revenue code.	<ul style="list-style-type: none"> • 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. • Submit a valid, signed <i>Consent for Sterilization</i> form with the claim. • Enter ICD-10 diagnosis code Z30.2 – <i>Encounter for sterilization</i> as the primary diagnosis on the claim. (For dates of service before October 1, 2015, use ICD-9 diagnosis code V25.2 – <i>Sterilization</i>.)
	CMS-1500	Bill for the device under the professional or durable medical equipment (DME) provider number.	
Physician	CMS-1500	Bill the procedure using 58565.	
		Bill the device on a separate line, using A4264. Include a cost invoice.	