



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Family Planning Eligibility Program

LIBRARY REFERENCE NUMBER: PROMOD00053
PUBLISHED: MARCH 28, 2017
POLICIES AND PROCEDURES AS OF APRIL 1, 2016
(CoreMMIS UPDATES AS OF FEBRUARY 13, 2017)
VERSION: 1.2

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: October 13, 2016	Semiannual update: <ul style="list-style-type: none"> Removed reference to the National Drug Code (NDC) from the requirements for EOB 2058 in Table 1 – EOBs Applicable to the Family Planning Eligibility Program Added cervical caps to the list of covered services in the Contraceptives section Removed specific codes for oral and injectable contraceptives, vaginal ring, and hormone patch, and replaced them with a reference to the <i>Code Sets</i> page Added Tubal Ligations subheading Added procedure code for vasectomy in the Vasectomy section 	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 28, 2017	<ul style="list-style-type: none"> Changed Automated Voice Response (AVR) system reference to Interactive Voice Response (IVR) system and updated the telephone number for the IVR system Changed Web interChange reference to Provider Healthcare Portal Removed ICD-9 codes Updated billing information with Portal options throughout the module Updated the EOB information in Table 1 – EOBs Applicable to the Family Planning Eligibility Program Updated Table 2 – Family Planning Eligibility Program – Billing Instructions for the Hysteroscopic Sterilization Procedure with Implant Device 	FSSA and HPE

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Family Planning Eligibility Program

Introduction

In accordance with *Indiana Code IC 12-15-46 Medicaid Waivers and State Plan Amendments*, the Indiana Health Coverage Programs (IHCP) Family Planning Eligibility Program provides coverage limited to family planning services to men and women of any age who meet the following criteria:

- Do not qualify for any other category of Medicaid
- Are not pregnant
- Have not had a hysterectomy or sterilization
- Have income that is at or below 141% of the federal poverty level
- Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens

Family Planning Eligibility Program members receive services through the IHCP fee-for-service delivery system.

Program Coverage and Limitations

The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy. Services and supplies 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, if performed according to the United States Preventative Services Task Force (USPSTF) guidelines, which specify cervical cancer screening every one to three years (frequency may be reduced if three or more annual smears are normal)
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- 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 human immunodeficiency virus (HIV)
- Tubal ligations
- Hysteroscopic sterilization with an implant device
- Vasectomies

Services and supplies *not* covered under the Family Planning Eligibility Program include:

- Abortions
- Any drug or device intended to terminate fertilization
- Artificial insemination
- In vitro fertilization (IVF)
- 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
- Emergency room services
- Services unrelated to family planning

Note: Providers must check for Family Planning Eligibility Program coverage before rendering services, using one of the following eligibility verification system (EVS) options:

- [Provider Healthcare Portal](http://indianamedicaid.com) (Portal) at indianamedicaid.com
- Interactive Voice Response (IVR) system at 1-800-457-4584
- Electronic Data Interchange (EDI) 270/271 Eligibility Benefit Transaction

Billing and Reimbursement Requirements

IHCP reimbursement is available for Family Planning Eligibility Program-covered 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.

When billing for services provided to Family Planning Eligibility Program members, providers must use all appropriate procedure codes and the appropriate primary diagnosis codes identified in *Family Planning Eligibility Program Codes* on the [Code Sets](http://indianamedicaid.com) page at indianamedicaid.com:

- Outpatient and outpatient crossover claims must include one of the Family Planning Eligibility Program diagnosis codes in the **primary** position.
- Professional and professional crossover claims must include the Family Planning Eligibility Program diagnosis codes on each claim detail.
- Physicians bill professional services using all appropriate procedure codes on the *CMS-1500* claim form or electronic equivalent (Portal professional claim or 837P transaction).
- Clinics and ambulatory surgical centers (ASCs) bill using the most appropriate procedure and revenue codes on the *UB-04* claim form or electronic equivalent (Portal institutional claim or 837I electronic transaction).

See the [Claim Submission and Processing](#) module for general billing and coding information. The following explanation of benefits (EOB) codes are applicable to claim denials when billing for services provided to Family Planning Eligibility Program members.

Table 1 – EOBs Applicable to the Family Planning Eligibility Program

EOB Code	EOB Description	Submission Requirements
2033	Invalid claim type for the program billed	Family Planning Eligibility Program services are not applicable for inpatient, inpatient crossover, long-term care, home health, or dental claims.
2057	Diagnosis not covered for the member's benefit plan	Professional and professional crossover claims must include only Family Planning Eligibility Program diagnosis codes on each claim detail. If multiple diagnosis codes are applicable per detail, every diagnosis code must be a Family Planning Eligibility Program diagnosis.
2060	Service billed is not covered as a Family Planning Service benefit	A Family Planning Eligibility Program procedure code must be included on each detail to allow payment.
4167	Primary diagnosis is not covered for the benefit plan billed	Outpatient and outpatient crossover claims must include a family planning diagnosis code in the primary position.

Description of Services

Annual Examinations and Office Visits

Under the Family Planning Eligibility Program, 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.

Note: The Family Planning Eligibility Program covers Pap smears if performed according United States Preventative Services Task Force (USPSTF) guidelines. The USPSTF recommends cervical cancer screenings for women ages 21 to 65, with cytology every three years. For women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and HPV testing is recommended every five years. See the [Obstetrical and Gynecological Services](#) module for more information.

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.

See *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com for the tables referenced in the following list:

- Evaluation and management (E/M) services** – 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, along with the modifier **FP**, in addition to a Family Planning Eligibility Program primary diagnosis code. For a complete list of appropriate procedure codes, see the *Evaluation and Management (E/M) Procedure Codes for the Family Planning Eligibility Program* table.

- **Laboratory procedures** – Laboratory services may be reimbursed separately when performed in conjunction with the initial or annual examinations under the Family Planning Eligibility Program. See the *Laboratory Procedure Codes for the Family Planning Eligibility Program* table.
- **Radiology services** – Under the Family Planning Eligibility Program, radiology services may be reimbursed separately when performed in conjunction with the initial or annual examination. For a list of billable radiology procedure codes under the program, see the *Radiology Procedure Codes for the Family Planning Eligibility Program* table.
- **Surgical procedures** – For surgical procedure codes (other than sterilization procedures) billable under the Family Planning Eligibility Program, see the *Surgical Procedure Codes for the Family Planning Eligibility Program* table. For information about billing for sterilization procedures, see the [Sterilization](#) section of this document.

STI and STD Diagnosis and Treatment

The Family Planning Eligibility Program covers the initial diagnosis and treatment of STIs and STDs, as well as HIV testing and counseling, provided during a family planning encounter. 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 after 180 days. This program covers antiviral medications for the initial treatment of an STI or STD, 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.

See *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com for diagnosis codes and procedure codes that are billable, under the Family Planning Eligibility Program, for the diagnosis and treatment of STDs and STIs. Where indicated, procedure codes for STD/STI treatment must be billed along with the appropriate National Drug Code (NDC).

Contraceptives

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
- Cervical caps

For applicable procedure codes, see *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com.

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 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. However, brand name drugs may be dispensed, even if generic drugs are available, if the IHCP 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 when 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.

Providers must bill contraceptive services and supplies not classified as drugs or biologicals using the professional claim type (*CMS-1500* claim form or electronic equivalent) with the appropriate Current Procedural Terminology (CPT^{®1}) or Healthcare Common Procedure Coding System (HCPCS) codes and appropriate International Classification of Diseases (ICD) diagnosis codes for services rendered or condition treated. For example, use ICD-10 diagnosis codes Z30.011 through Z30.9 for contraceptive management and use ICD-10 diagnosis codes A56.00 through A56.3 for acute chlamydial diseases of the genitourinary system.

Providers must ensure that the member's chart contains the date of the office visit, the 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).

Oral and Injectable Contraceptives

Reimbursement is available for oral and injectable contraceptives under the Family Planning Eligibility Program. Providers must bill the appropriate NDC for the drug dispensed or administered, along with appropriate procedure code.

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.

Contraceptive Devices and Supplies

Contraceptive device and supply procedure codes must be billed with a primary Family Planning Eligibility Program diagnosis code, which are listed in the *Family Planning Eligibility Program Codes*.

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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 Family Planning Eligibility Program 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*.

Intrauterine Devices

Under the Family Planning Eligibility Program, the IHCP reimburses for intrauterine devices (IUDs) and the insertion of IUDs, including insertions on the same date of service as a dilation and curettage. The Family Planning Eligibility Program also covers 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 date of service.

Procedure codes for the IUD device itself must be billed along with the NDC of the product administered.

Vaginal Ring and Hormone Patch

The Family Planning Eligibility Program covers vaginal ring and hormone patch contraceptive devices. To receive reimbursement, providers must bill using the procedure code for the specific device being supplied, not a miscellaneous supply code.

The NDC of the product dispensed or administered must be included along with the procedure code.

Contraceptive Implants

The IHCP reimburses for contraceptive implants under the Family Planning Eligibility Program. 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 Systems

Norplant systems are no longer available in the United States. However, under the Family Planning Eligibility Program, the IHCP reimburses the removal of the implanted contraceptive capsule (procedure code 11976 – *Removal, implantable contraceptive capsules*) when billed with ICD-10 diagnosis code Z30.49 – *Encounter for surveillance of other contraceptives*.

Sterilization

The IHCP Family Planning Eligibility Program reimburses for sterilizations for men and women when the consent form accompanies claims connected with the service, according to *Indiana Administrative Code 405 IAC 5-28-8*, and when all of the following conditions are met:

- Sterilization procedures must comply with the mandates of federal rules.
- The member must be 21 years of age or older at the time the informed consent form is signed.
- The member must be competent and not institutionalized.

- The member 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.

Hysteroscopic Sterilizations

Hysteroscopic sterilizations with an implant device provide for a permanent sterilization option that does not require an incision. The Family Planning Eligibility Program covers this procedure for eligible female members 21 years of age and older. 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*. CPT code 58579 – *Unlisted hysteroscopy procedure, uterus* is **not** appropriate billing for the hysteroscopic sterilization procedure with an implant device, and claims billed with this code 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 doctor of medicine (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 professional claim type (CMS-1500 claim form or electronic equivalent) using HCPCS code A4264 – *Permanent implantable contraceptive intratubal occlusion device(s) and delivery system*. An outpatient hospital or ASC must adhere to the billing instructions in Table 2 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 2 – Family Planning Eligibility Program – Billing Instructions for the Hysteroscopic Sterilization Procedure with Implant Device

Provider	Claim Type	Bill for the Procedure and the Supply	Additional Billing Requirements
Outpatient hospital or ASC	Institutional (UB-04 claim form or electronic equivalent)	CPT code 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.
	Professional (CMS-1500 claim form or electronic equivalent) Bill for the device under the professional or durable medical equipment (DME) provider number.	<ul style="list-style-type: none"> • Bill the device using A4264. • Include a cost invoice with the claim to support the actual cost of the device. 	
Physician	Professional (CMS-1500 claim form or electronic equivalent)	CPT code 58565 <ul style="list-style-type: none"> • Bill the device on a separate line using HCPCS code A4264. • Include a cost invoice. 	

Tubal Ligations

Tubal ligations may be reimbursed by the IHCP under the Family Planning Eligibility Program. See *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com 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.

Vasectomy

The IHCP may reimburse for a vasectomy for sterilization that is performed on a male by an IHCP-enrolled provider. Providers should bill the procedure using CPT code 55250 – *Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)*.

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.

Anesthesia for Sterilization

See *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com for anesthesia procedure codes that may be billed along with the sterilization procedure under the Family Planning Eligibility Program.