



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Family Planning Eligibility Program

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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: October 13, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 28, 2017	CoreMMIS update	FSSA and HPE
2.0	Policies and procedures as of July 1, 2017 Published: November 21, 2017	<p>Scheduled update:</p> <ul style="list-style-type: none"> <li>• Reorganized and edited text as needed for clarity</li> <li>• Updated the <a href="#">Program Coverage and Limitations</a> section <ul style="list-style-type: none"> <li>– Replaced specific Pap smear/ cytology guidelines with reference to the <i>Obstetrical and Gynecological Services</i> module</li> <li>– Added reference to <i>Laboratory Services</i> module for HIV testing guidelines</li> <li>– Added reference to <i>Family Planning Eligibility Program Codes</i> for complete list of covered procedure codes</li> </ul> </li> <li>• Added <a href="#">Eligibility Verification</a> heading and added specifics of how this coverage appears in the Eligibility Verification System</li> <li>• Updated the <a href="#">Billing and Reimbursement Requirements</a> section: <ul style="list-style-type: none"> <li>– Updated examples of eligible IHCP-enrolled providers</li> <li>– For professional billing, changed “physicians” to “practitioners” (to encompass all applicable provider types) and added that <b>only</b> Family Planning Eligibility Program diagnosis codes are allowed on the claim</li> <li>– For institutional billing, added hospitals as billers and added the term <i>principal</i> to define primary diagnosis code</li> </ul> </li> </ul>	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> <li>• Added an introduction paragraph under the <a href="#">Description of Services</a> heading, including a reference to the new, combined table of Family Planning Eligibility Program procedure codes (and removed from the subsections references to individual code tables based on type of service)</li> <li>• Updated the <a href="#">Annual Examinations and Office Visits</a> section</li> <li>• Updated billing instructions in the <a href="#">Contraceptives</a> section including clarifying that NDC information is required on the claim when applicable</li> <li>• Added reimbursement information regarding insertion and removal of implants in the <a href="#">Contraceptive Implants</a> section</li> <li>• In the <a href="#">Sterilization</a> section, added reference to the <a href="#">Family Planning Services</a> module for information about the <i>Consent for Sterilization</i> form and related issues and incorporated information about covered anesthesia codes from the former <i>Anesthesia for Sterilization</i> section</li> <li>• Streamlined text in the <a href="#">Hysteroscopic Sterilizations with an Implant Device (Essure)</a> section (including incorporating former Table 2 into the body of the section) and added reimbursement information from the <i>Family Planning Services</i> module</li> </ul>	

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# Family Planning Eligibility Program

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## Introduction

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 the following:

- Annual family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods
- Limited history and physical examinations
- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods
- 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
- 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), within the parameters described in the [Laboratory Services](#) module
- Tubal ligation
- Hysteroscopic sterilization with an implant device
- Vasectomy

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

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

- Abortion
- 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

## Eligibility Verification

Before rendering services, providers must verify coverage using one of the following eligibility verification system (EVS) options:

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

The EVS identifies the coverage described in this module as “Family Planning Eligibility Program” or, for presumptively eligible members, “Presumptive Eligibility Family Planning Services Only.”

## 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, 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 diagnosis codes identified in *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com:

- Practitioners bill professional services using all appropriate procedure codes on the *CMS-1500* claim form or electronic equivalent (Portal professional claim or 837P transaction). Professional and professional crossover claims must include a Family Planning Eligibility Program International Classification of Diseases (ICD) diagnosis code on each claim detail; diagnosis codes other than those designated as Family Planning Eligibility Program diagnosis codes are not allowed.
- Hospitals, 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). Outpatient and outpatient crossover claims must include one of the Family Planning Eligibility Program diagnosis codes in the *principal* (primary) position.



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 Eligibility Program diagnosis code in the primary position.

## Description of Services

The following sections provide additional information about specific services covered under the Family Planning Eligibility Program. Applicable procedure codes appear in *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com.

### 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. See the [Obstetrical and Gynecological Services](#) module for more information.*

For annual and follow-up examinations, Family Planning Eligibility Program providers must bill the most appropriate evaluation and management (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.

- 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.
- Covered laboratory, radiology, and surgical services performed in conjunction with the initial or annual examination are eligible for separate reimbursement.

## ***STD and STI Diagnosis and Treatment***

The Family Planning Eligibility Program covers the initial diagnosis and treatment of STDs and STIs, as well as HIV testing and counseling, provided during a family planning encounter. When an STD or STI is diagnosed during a family planning visit, the member has 180 days, from the date of the initial diagnosis, to receive treatment for the STD or STI. The treatment for the STD or STI 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 STDs and STIs after 180 days. This program covers antiviral medications for the initial treatment of an STD or STI, 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 or STIs to maintain continuity of patient care.

See *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com for a complete list of diagnosis codes and procedure codes that are billable under the Family Planning Eligibility Program, including for the diagnosis and treatment of STDs and STIs. Where applicable, procedure codes for STD or 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

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 using the professional claim type (*CMS-1500* claim form or electronic equivalent) with the appropriate Current Procedural Terminology (CPT<sup>®1</sup>) or Healthcare Common Procedure Coding System (HCPCS) codes and appropriate 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. For all covered procedure codes and diagnosis codes, see *Family Planning Eligibility Program Codes* on the [Code Sets](#) page at indianamedicaid.com.

If applicable, the claim must also include the National Drug Code (NDC), name, unit measure, and number of units of the product administered or dispensed. Providers must ensure that the member's chart contains the date of the office visit and documentation supporting information on the claim, including all NDC information.

## 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.

The Depo-Provera contraceptive injection is a long-term contraceptive for women with a recommended dose, according to the U.S. FDA of 150 mg every three months.

## Contraceptive Devices and Supplies

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.

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

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*.

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## 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; however, 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.

The IHCP also reimburses for the insertion and removal of contraceptive implants (CPT codes 11981, 11982, and 11983).

## 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.

For more information about informed consent for sterilization, including the *Consent for Sterilization* form, see the [Family Planning Services](#) module.

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

## Hysteroscopic Sterilizations with an Implant Device (Essure)

Hysteroscopic sterilization with an Essure implant device provides 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. The procedure can be performed by a doctor of medicine (MD) or a doctor of osteopathy (DO) trained in the procedure, and can take place in the office, in an outpatient hospital, or in an ASC.

Providers should bill the implantation procedure using CPT code 58565 – *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants*. For outpatient hospital or ASC billing, the procedure code should be billed along with the appropriate revenue code on the institutional claim (*UB-04* claim form or electronic equivalent). For physician’s office settings, the procedure code should be billed on the professional claim (*CMS-1500* claim form or electronic equivalent).

For separate reimbursement of the Essure device, HCPCS code A4264 – *Permanent implantable contraceptive intratubal occlusion device(s) and delivery system* must be billed on the professional claim (*CMS-1500* claim form or electronic equivalent), regardless of whether the procedure is performed in an outpatient hospital, ASC, or physician’s office. (No additional reimbursement is available for the implant device if performed in an inpatient setting.) Outpatient hospitals and ASCs bill for the device under the professional or durable medical equipment (DME) provider number. A manufacturer’s cost invoice must be submitted with the claim to support the cost of the Essure device. The IHCP reimburses 120% of the amount listed on cost invoice.

For all claims related to this service, the following additional billing requirements apply:

- Print “Essure Sterilization” in the body of the claim form (or as a claim note for electronic claims) or on the accompanying invoice.
- Submit a valid, signed *Consent for Sterilization* form with the claim.
- Enter ICD-10 diagnosis code Z30.2 – *Encounter for sterilization* as the primary (principal) diagnosis on the claim.

## Tubal Ligations

Tubal ligations may be reimbursed by the IHCP under the Family Planning Eligibility Program. 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.

## Vasectomies

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.