INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

# Family Planning Eligibility Program

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# Revision History

| Version | Date | Reason for Revisions | Completed By |
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| 1.0 | Policies and procedures as of Oct. 1, 2015<br>Published: Feb. 25, 2016 | New document | FSSA and HPE |
| 1.1 | Policies and procedures as of April 1, 2016<br>Published: Oct. 13, 2016 | Scheduled update | FSSA and HPE |
| 1.2 | Policies and procedures as of April 1, 2016<br>(*Core*MMIS updates as of Feb. 13, 2017)<br>Published: March 28, 2017 | *Core*MMIS update | FSSA and HPE |
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| 7.0 | Policies and procedures as of Oct. 1, 2023<br>Published: TBD | Scheduled update:<br>• Edited text as needed for clarity<br>• Removed Essure references<br>• Updated IVR system to GABBY<br>• Updated the *Sterilization* section<br>• Updated the *Hysteroscopic Sterilizations with an Implant Device* section | FSSA and Gainwell |

# Table of Contents

# Family Planning Eligibility Program

*Note: The Indiana Health Coverage Programs (IHCP) Family Planning Eligibility Program is provided under the **fee-for-service (FFS)** delivery system.*

*The information in this module pertains to **professional** and **institutional** claims. For billing and reimbursement requirements related to **pharmacy** claims for Family Planning Eligibility Program members, contact the fee-for-service pharmacy benefit manager, Optum Rx. For general information about pharmacy billing, see the Pharmacy Services module.*

*For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.*

## Introduction

The Indiana Health Coverage Programs (IHCP) Family Planning Eligibility Program provides coverage limited to *only* family planning services[1] to men and women of any age who meet all the following criteria:

- Do not qualify for any other category of Medicaid
- Are not pregnant
- Have not had a hysterectomy or sterilization
- Have family 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 (FFS) 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

[1] *Note: In response to the coronavirus disease 2019 (COVID-19) public health emergency, Family Planning Eligibility Program coverage has been expanded to include certain services related to COVID-19 vaccination, testing and diagnosis. This expanded coverage is temporary and, when deemed appropriate, these services will no longer be covered for Family Planning Eligibility Program members.*

- 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 in.gov/medicaid/providers.

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:

- IHCP Provider Healthcare Portal (IHCP Portal) accessible from the homepage at in.gov/medicaid/providers
- Virtual assistant (GABBY) at 800-457-4584, option 2
- 270/271 Eligibility Benefit Inquiry and Response electronic transaction using approved vendor software

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.

When billing for services provided to Family Planning Eligibility Program members, providers must use only appropriate procedure codes and the appropriate International Classification of Diseases (ICD) diagnosis code, identified in *Family Planning Eligibility Program Codes* accessible from the *Code Sets* page at in.gov/medicaid/providers. Claims should be billed as follows:

- Professional and professional crossover claims must include a Family Planning Eligibility Program diagnosis code on each claim detail; diagnosis codes other than those designated as Family Planning Eligibility Program diagnosis codes are not allowed.

  In addition, the professional claim must include a Family Planning indicator for each detail:
  - On the *CMS-1500* claim form, enter a **Y** (for yes) in the unshaded lower portion of field 24H – *EPSDT/Family Plan*.
  - On the IHCP Portal, select the Family Plan check box.
- Outpatient and outpatient crossover claims must include one of the Family Planning Eligibility Program diagnosis codes in the principal (primary) position.

> *Note: As an exception to the preceding requirements, for Family Planning Eligibility Program members who also have Qualified Medicare Beneficiary (QMB) coverage, the IHCP will continue to pay Medicare deductibles and copayments or coinsurance for Medicare covered services, including those without a Family Planning Eligibility Program diagnosis or procedure code.*
>
> *The IHCP follows the standard reimbursement policy for dually eligible members, as outlined in the Third-Party Liability module.*

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. See *Procedure Codes That Require NDCs* accessible from the *Code Sets* page at in.gov/medicaid/providers. 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. |

# Additional Information About Covered 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*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

## *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 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.

The Family Planning Eligibility Program does not cover ongoing treatment of STDs and STIs after 180 days. This program covers certain anti-infective agents for the initial treatment of an STD or STI. 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.

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, see *Family Planning Eligibility Program Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. Where applicable, procedure codes for STD or STI treatment must be billed along with the appropriate NDC.

## *Contraceptives*

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

- Birth control pills
- Injectable contraceptive drugs
- Emergency contraception
- Male condoms
- Female condoms
- Spermicides
- Contraceptive vaginal rings
- Contraceptive patches
- Diaphragms
- Cervical caps
- Intrauterine devices (IUDs)
- Contraceptive implants

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, spermicide, 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. 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 IHCP.

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 as needed.

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, Portal professional claim or 837P electronic transaction) with the appropriate Current Procedural Terminology (CPT®[2]) or Healthcare Common Procedure Coding System (HCPCS) procedure codes and NDC information (if applicable). All claims must include an appropriate diagnosis codes for services rendered or condition treated; for example, ICD-10 diagnosis codes Z30.011 through Z30.9 are used for contraceptive management. For all covered procedure codes and diagnosis codes, see *Family Planning Eligibility Program Codes* accessible from the *Code Sets* page at in.gov/medicaid/providers.

[2] *CPT copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

### Contraceptive 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.

Reimbursement for condoms is available for both male and female Family Planning Eligibility Program members.

Cervical caps and diaphragms for contraceptive use may be reimbursed separately, in addition to the service of fitting and providing instructions for using the device.

### 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.

### Contraceptive Implants

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

> *Note: 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*

> *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. Therefore, hysterectomies are not covered under the Family Planning Eligibility Program.*

Sterilization renders a person unable to reproduce. The IHCP reimburses for sterilizations for men and women only when consent requirements are met.

See the *Family Planning Services* module for information about informed consent for sterilization, including instructions for completing the *Consent for Sterilization* form, which must accompany all claims connected with the service in accordance with *Indiana Administrative Code 405 IAC 5-28-8*.

See *Family Planning Eligibility Program Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers, for all procedure codes covered under the Family Planning Eligibility Program, including covered sterilization services and related anesthesia codes.

### Hysteroscopic Sterilizations with an Implant Device

Hysteroscopic sterilization with an implant device 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 physician's office or in an outpatient hospital or ambulatory surgical center (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*, and the implant device using HCPCS code A4264 – *Permanent implantable contraceptive intratubal occlusion device(s) and delivery system*, as follows:

- When the procedure is performed in a physician's office setting, both codes should be billed on the professional claim (*CMS-1500* claim form or electronic equivalent).
- For outpatient hospital or ASC billing, CPT code 58565 should be billed along with the appropriate revenue code on the institutional claim (*UB-04* claim form or electronic equivalent). For separate reimbursement of the implant device, HCPCS code A4264 must be billed on the professional claim (*CMS-1500* claim form or electronic equivalent). 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 implant device. The IHCP reimburses 120% of the amount listed on cost invoice.

> *Note: Effective Jan. 7, 2024, the maximum age for a cost invoice is two years from the date of service. Providers will be required to submit the most current cost invoice that is not older than two years with claims for HCPCS code A4264.*

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

- Write "**Implant Sterilization**" in the body of the paper claim form, in a claim note for an electronic claim 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 Ligation

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

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.