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NC Medicaid COVID-19 Proposed Policy Revision Communication Overview Template: Continuing Temporary Flexibilities

Clinical Coverage Policy 1E-7: Family Planning Services

Overview of Proposed Revisions

This overview provides the background and context for policy changes proposed by NC Medicaid.

Public Comment Period: Aug. 07, 2020 to Sept. 22, 2020

NC Medicaid is proposing telehealth-related changes to Clinical Coverage Policy 1E-7: Family Planning Services to complement and build upon the new 1H: Telehealth, Virtual Patient Communications and Remote Patient Monitoring policy, which expands coverage of remote physical and behavioral health care to Medicaid and North Carolina Health Choice (NCHC) beneficiaries. Revised 1E-7 also includes several non-telehealth changes outlined below.

Proposed revised 1E-7:

- Includes the following telehealth changes:
  - Enables select family planning services to be delivered to beneficiaries via telehealth.
- Includes the following non-telehealth changes:
  - Adds coverage for Kyleena IUD and ultrasounds to locate string-less IUDs.
  - Revises the required services for inter-periodic and annual visits (removed pap test as an annual exam requirement, added Hepatitis B screening and Comprehensive Metabolic Panel requirements).
  - Adds coverage for NAAT testing for Trichomonas Vaginalis and Mycoplasma Genitalium.
  - Adds referral guidelines for interventions in HIV through Ready Set PrEP.
  - Adds screening recommendations from the United States Preventive Services Task Force (USPSTF).

When revisions to Policy 1E-7 are approved, the former policy will be replaced in its entirety on a date to be determined later in 2020. Additionally, NC Medicaid has issued several temporary Special Medicaid COVID-19 Bulletins related to telehealth coverage that remain in effect until further notice. A list of Special Medicaid COVID-19 Bulletins can be found on the NC Medicaid COVID-19 Guidance and Resources web page.

NC Medicaid will provide 30 days' notice before this policy becomes effective and when the temporary Special Medicaid COVID-19 Bulletins will be retired.

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To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related clinical coverage policies listed below:

1E-3, *Sterilization Procedures*
1E-5, *Obstetrics*
1D-4, *Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics*
1A-38, *Special Services: After Hours*
1S-3 *Laboratory Services*
9, *Outpatient Pharmacy* ~~*Program*~~
1E-2, *Therapeutic and Non-therapeutic Abortions*
1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

1.0 Description of the Procedure, Product, or Service

Medicaid Family Planning is designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina.

1.1 Definitions

1.1.1 Traditional Medicaid and North Carolina Health Choice (NCHC) Family Planning

Traditional Medicaid and NCHC family planning services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner**,** or furnished by or under the physician's supervision, laboratory examinations and tests, FDA-approved family planning supplies and devices to prevent conception.

1.1.2 "Be Smart" Family Planning Medicaid (FP Medicaid)

FP Medicaid serves eligible beneficiaries regardless of age or gender. FP Medicaid provides limited coverage to beneficiaries with MAFDN eligibility. These beneficiaries are only eligible for family planning and family planning-related services, as described in this policy. Beneficiaries with MAFDN eligibility are not eligible for any other Medicaid program or categories of service.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

a. Medicaid

A traditional Medicaid, FP Medicaid and NCHC beneficiary **may be eligible** for family planning and family planning-related services when the beneficiary meets **ALL** of the following eligibility criteria:

1. is a North Carolina resident; is a U.S. citizen or qualified alien;
2. is childbearing age;
3. is not pregnant, and;
4. is not incarcerated.

FP Medicaid shall cover an individual who meets the above criteria and the income eligibility requirements defined in 42 CFR 435.214.

b. NCHC

NCHC shall cover a beneficiary who meets the income eligibility requirement as stated in G.S. § 108A-70.21(a) (1) (d).

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or

ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for a NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for a NCHC beneficiary.

2.2.4 Undocumented Aliens

Undocumented aliens are eligible for emergency medical services as found in 42 CFR 440.255(c). ~~and 10A NCAC 23E.0102.~~

2.2.5 Retroactive Eligibility

Retroactive eligibility applies to FP Medicaid.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Telehealth Services

As outlined in **Attachment A**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: *Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.*

3.2 Specific Criteria Covered

Beneficiaries eligible for family planning services must be free from coercion or mental pressure and free to choose the method of family planning to be used, Refer to 42 CFR §441.20.

3.2.1 Specific criteria covered by both Medicaid and NCHC

Family planning services consist of consultation, examination, laboratory tests, FDA approved contraceptive methods, supplies, and devices to prevent conception, as described in this policy.

~~Family planning-related services include:~~

~~a. HIV (human immunodeficiency virus) screening~~
~~b. and~~
~~d. c.. Screening and treatment for STI (sexually transmitted infections). screening and treatment.~~

Traditional Medicaid, FP Medicaid and NCHC shall cover the following when the eligibility criteria ~~are met, as stated~~ in **Section 2.0** are met:

a. The "fitting" of diaphragms;
b. Birth control pills;
c. Intrauterine Devices (IUD's) (Mirena, Paragard, Liletta, Kyleena and Skyla);
d. Contraceptive injections (Depo-Provera);
e. Implantable contraceptive devices (Nexplanon);
f. Contraceptive patch (norelgestromin and ethinyl estradiol transdermal system);
g. Contraceptive ring (Nuva Ring);
h. Emergency Contraception (Plan B One Step and Ella);
i. Screening, early detection and education for STIs, including Hepatitis B, HIV and Acquired Immune Deficiency Syndrome (AIDS);
j. Treatment for STIs (refer to Attachment C for specific coverage); ~~and~~
k. Lab services (refer to **Attachment A, C1**); and
l. Ultrasounds ~~are covered~~ when the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are also covered to locate string-less IUDs. Ultrasounds are not intended for the purpose of routine checking of placement after IUD insertion.

Note: The above-named contraceptive methods may not be all inclusive for Traditional Medicaid and NCHC beneficiaries.

3.2.2 Medicaid Additional Criteria Covered

In addition to the **Specific Criteria** covered in **Section 3.2.1**, traditional Medicaid and FP Medicaid shall cover the following Family Planning Services:

a. Sterilization procedures for male and female beneficiaries. Refer to Clinical Policy *1E-3, Sterilization Procedures* on the NC Medicaid website at https://medicaid.ncdhhs.gov/ for requirements related to sterilization procedures; and
b. Non-emergency medical transportation, as needed, to and from family planning appointments.

3.2.3 NCHC Additional Criteria Covered

None Apply.

3.3 United States Preventive Services Task Force (USPSTF) Recommendations

NC Medicaid encourages screening for the following United States Preventative Services Task Force (USPSTF) recommendations in all Family Planning Medicaid beneficiaries:

a. Increased blood pressure in adults aged 18 years or older and obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment. Beneficiaries with elevated blood pressure should be referred for follow up.
b. BRCA risk assessment- clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (*BRCA1/2)* gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should be referred for genetic counseling and, if indicated after counseling, genetic testing. Women with Family Planning Medicaid should be referred to the BCCP program.
c. Cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing). Women with Family Planning Medicaid should be referred to the BCCP program.
d. Chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
e. Gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
f. Hepatitis B virus infection in persons at high risk for infection.
g. HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened.
h. Screening and referral for preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
i. Intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services.
j. Obesity, referring adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.
k. Postpartum depression referring persons who are at increased risk of postpartum depression for counseling interventions.
l. Sexually transmitted infections counseling referring for intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
m. Syphilis infection in persons who are at increased risk for infection.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover procedures, products, and services related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Traditional Medicaid, FP Medicaid and NCHC

Traditional Medicaid, FP Medicaid and NCHC shall not cover the following:

a. Infertility services and related procedures;
b. Reversals of sterilizations;
c. Diaphragms;
d. Contraceptives that can be purchased without a prescription or do not require the services of a physician for fitting or insertion; and
e. Ultrasounds ~~are not covered~~ for MAFDN beneficiaries, unless performed to verify that the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are not covered for the purpose of routine checking of placement after IUD insertion.

4.2.2 Medicaid Additional Criteria Not Covered

a. MAFDN eligible beneficiaries are ONLY eligible for services described in **Subsection 3.2.1**. If a medical condition unrelated to family planning or family planning-related services occur, or the beneficiary has no need for family planning services, the provider shall refer the beneficiary to:
   1. the local department of social services,
   2. health department,
   3. federally qualified health center (community health center),
   4. or rural health clinic in their county.

   If one of the above primary care providers is not available in the county where the beneficiary resides, they may seek services in nearby or surrounding counties. MAFDN beneficiaries may request services not described in **Subsection 3.2.1**, but they would be responsible for the cost of those services.

b. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, FP Medicaid shall not cover the following:
   1. Abortions;
   2. Ambulance Services;
   3. Hospital Emergency room or emergency department services;
   4. Inpatient hospital services;
   5. Surgical procedures or hospital services requiring outpatient beneficiary registration other than sterilizations.
   6. Treatment for HIV or AIDS;
   7. Treatment for Hepatitis B
   8. Treatment for cancer;
   9. Remove of IUDs outside of the office setting

10. Services provided to manage or treat medical conditions (Not including STIs):
    i. Discovered during the screening;
    ii. Caused by or following a family planning procedure (including urinary tract infections, diabetes, hypertension, breast lumps);
    iii. Complications of women's health care problems, including heavy bleeding or infertility; and
    iv. Hysterectomy.
11. Services for beneficiaries who have been sterilized or no longer have a need for family planning services; and
12. Any specialty health care services not related to family planning services (including dental, mammography, cardiology, physical therapy, neurology, radiology, behavior health services).

e. **Note**: The cost of any service(s) provided in a hospital setting is the responsibility of the beneficiary, except for a beneficiary who has been referred to the hospital for an outpatient sterilization procedure.

Note: EPSDT does not apply to 42 CFR §441.253 (a) Sterilization of a mentally competent individual aged 21 or older. Federal financial participation (FFP) is available in expenditures for the sterilization of an individual only if the individual is at least 21 years old at the time consent is obtained.

4.2.3 NCHC Additional Criteria Not Covered

a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC **shall not** cover the following:
    1. Sterilization procedures.
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
    1. No services for long-term care.
    2. No nonemergency medical transportation.
    3. No EPSDT.
    4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Traditional Medicaid, FP Medicaid and NCHC shall not require prior approval for family planning services.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

FP Medicaid beneficiaries are limited to the following:

a. FP Medicaid beneficiaries are limited to one annual periodic exam per 365 calendar days. This exam must occur prior to the rendering of any other services covered by the program.
b. FP Medicaid beneficiaries are limited to a total of six inter-periodic visits per 365 calendar days, after the annual exam.

~~**5.4 Provider(s) Eligible to Bill for the Procedure, Product, or Service**~~

~~To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:~~

~~a. meet Medicaid or NCHC qualifications for participation;~~
~~b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and~~
~~c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.~~

~~Provider(s) shall comply with 10A NCAC 22J.0106, regarding when it is acceptable to bill a Medicaid beneficiary for Medicaid services.~~

~~**5.5 Provider Qualifications and Occupational Licensing Entity Regulations**~~

~~None Apply.~~

~~**5.6 Provider Certifications**~~

~~None Apply~~.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Note: Provider(s) shall comply with 10A NCAC 22J.0106, regarding when it is acceptable to bill a Medicaid beneficiary for Medicaid services.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: January 1, 1974

History:

Date	Section Revised	Change
10/01/2014	All sections and attachment(s)	New policy documenting current Medicaid FP and NCHC coverage. Family Planning Waiver (FPW) demonstration project began operation October 1, 2005. Information incorporated throughout this policy referred to as the "Be Smart" program was approved by CMS on **June 7, 2013** to convert the FPW project to a State Plan Amendment (SPA) under the Affordable Care Act (ACA) legislation.
05/01/2015	Attachment A	Added updated CPT codes 87623, 87624, and 87625 to replace CPT code 87621
05/01/2015	Attachment A	Added Revenue Codes 0301 and 0302
05/01/2015	Attachment B	Added sections "Billing the Beneficiary" and "Emergency Departments and Emergency Room Services" to further clarify program services and non-covered services
05/01/2015	Attachment B Section E (4)	Repeat Pap for Insufficient Cells information added
05/01/2015	Attachment B Section F	Pharmacy –Post operative medications for sterilization information added
05/01/2015	Attachment B Section I	Clarified "Miscellaneous Billing Instructions" for contraceptive methods and devices.
05/01/2015	Attachment B Section J (5)	Specific billing instruction for Private Providers added
05/01/2015	Attachment B Section K (8)	Specific billing instructions for FQHCs and RHCs added
05/01/2015	Attachment B Section L (6)	Specific billing instructions to LHDs added
05/01/2015	Attachment B Section M (6)	Specific billing instructions to Outpatient Hospitals added
05/01/2015	Attachment B Section N (6)	Specific billing instructions to Outpatient only Pharmacies added
05/01/2015	Attachment C	Added "Be Smart" Family Planning Program Billing Codes
05/01/2015	Attachment D	Added "Be Smart" STI Medications
05/01/2015	Attachment E	Added Postoperative Sterilization Medications list
05/01/2015	Attachment F	Added Primary Care "Safety Net" Providers
08/01/2015	Attachment D	Added additional medications to the list of "Be Smart" STI Medications to reflect current provider practice
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Date	Section Revised	Change
11/15/2015	Attachment C	Changed, "Providers must include the **ICD-10-CM Diagnosis 042** as the secondary diagnosis on the appropriate claim," to "Providers must include the **ICD-10-CM Diagnosis B20** as the secondary diagnosis on the appropriate claim." This amendment is clarification of information from ICD-10 transition.
02/01/2016	Attachments A	Consolidated "Be Smart" comprehensive list of ICD-10-CM diagnosis codes from Attachment B with the list in Attachment A.
02/01/2016	Attachments B	Deleted "Be Smart" comprehensive list of ICD-10-CM diagnosis codes in Attachment B.
02/10/2015	Attachment A	Corrected code Z00.89 to Z01.89
04/01/2016	Attachments A	Added Z11.4 to list of MAFDN ICD-10-CM diagnosis codes.
04/01/2016	Attachments A	Added J7297 and J7298 to list of MAFDN HCPCS codes, already in NCTracks for MAFDN, but omitted from the Family Planning Services policy. Deleted code J7302.
04/01/2016	Attachment C	Replaced diagnosis code B20 with diagnosis code Z11.4
04/01/2016	Attachment C	Added J7297 and J7298 to list of codes for IUDs. Deleted code J7302 from this list.
04/01/2016	Attachment C	Added J7297 and J7298 to list of codes for Family Planning Supplies and Devices. Deleted duplicate code J7301 and deleted code J7302 from this list.
04/21/2016	Attachment A	Removed Revenue Code "RC0302" which was inadvertently left in during revision process
11/1/18	All Sections and Attachments	Replaced Medicaid FP and "Be Smart" with FP Medicaid. Replaced regular Medicaid with traditional Medicaid. Removed claim submission instructions. Removed Revenue Code and ICD-10 PCS Procedure code lists. "Should" changed to "shall."
11/1/18	Section 1.0	Clarified the description and removed statute 42 U.S.C. 1396d(a)(4)(C).
11/1/18	Subsection 1.1.1	Clarified language. Removed, "Family Planning (Medicaid FP)."
11/1/18	Subsection 1.1.2	Clarified the language defining "Be Smart" Family Planning Medicaid.
11/1/18	Subsection 2.1.2	Clarified the eligibility criteria. Removed, "not sterilized," per CMS guidance. Removed unnecessary language.
11/1/18	Subsection 2.2.4	Updated 10A NCAC 21B.0302 and replaced with 10A NCAC 23E.0102. Clarified language.
11/1/18	Subsection 2.2.5	Removed Presumptive Eligibility related information.
11/1/18	Subsection 3.2	Clarified language.

Date	Section Revised	Change
11/1/18	Subsection 3.2.1	Clarified language. Liletta was added to section 3.2.1 but was already covered device. Updated Plan B to Plan B One Step. Updated Attachment A to C. Added ultrasounds as a covered service for MAFDN beneficiaries.
11/1/18	Subsection 3.2.2	Clarified language and removed unnecessary language.
11/1/18	Subsection 4.2.1	Clarified language. Ultrasounds are covered for MAFDN beneficiaries if there is concern that the IUD is malpositioned.
11/1/18	Subsection 4.2.2	Clarified language regarding referral for services not covered by FP Medicaid. Clarified language.
11/1/18	Subsection 4.2.3	Clarified language.
11/1/18	Subsection 5.1, 5.2.1 and 5.2.2	Clarified language.
11/1/18	Subsection 5.3, 5.4 and 5.5	Clarified language regarding limitations and removed unnecessary language.
11/1/18	Section 6.0	Removed unnecessary language. Clarified language regarding billing a Medicaid beneficiary.
11/1/18	Subsection 7.1	Removed unnecessary language.
11/1/18	Attachment A	(B1) Clarified language. Added diagnosis codes T83.32XA, Z00.01, Z01.411, Z01.419, Z30.015, Z30.016, Z30.017, Z30.44, Z30.45, Z30.46, Z31.69, Z32.01, Z32.02, N76.0, N76.1, N76.2, N76.3. Removed diagnosis codes T83.32XD, T83.32XS. Removed ICD-10 PCS Code list. Clarified that providers and beneficiaries should refer to Clinical Policy 1E-3 Sterilization Procedures guidance on sterilization procedures. NCHC beneficiaries are not eligible for sterilization procedures." (C) HCPCS Q0111 removed from this section, as it is a duplicate procedure of CPT 87210. Removed unnecessary language. (C1) Clarified language and clarified that providers and beneficiaries should refer to Clinical Policy 1E-3 Sterilization Procedures guidance on sterilization procedures. NCHC beneficiaries are not eligible for sterilization procedures." (D)Removed unnecessary language. (F) (G) (H) Clarified language. (C) Added CPT codes 36415, 87660, 76830, 76856, 76857, 87480, 87510.

Date	Section Revised	Change
11/1/18	Attachment B	Clarified language, removed unnecessary and repetitive language throughout attachment B. Included information regarding when an annual exam is required for beneficiaries that are transitioning between Medicaid programs to FP Medicaid. Included clarifying information on billing for office visits and services that include an office visit component. Clarified that providers and beneficiaries should refer to Clinical Policy 1A-38, Special Services: After Hours. Clarified information for beneficiaries who have been permanently sterilized or no longer have need for family planning services. (D)Added information related to venipuncture. (F) Added Bacterial vaginosis and related CPT codes. (I) Added information related to ultrasounds.
11/1/18	Attachment C	Language in Attachment C was clarified, repetitive language was removed, and the relevant information was moved to appropriate subsections of the policy.
11/1/18	Attachment D	Clarified language and updated medication list. Added gentamicin 240mg IM for the treatment of gonorrhea, added medication for the treatment of Bacterial vaginosis.
11/1/18	Attachment E	Clarified language and updated medication list.
11/1/18	Attachment F	The list of Safety Net providers removed from policy.
01/01/2019	Section 3.2.1 (f)	Removed Ortho Evra and added norelgestromin and ethinyl estradiol transdermal system
01/01/2019	Attachment A	(B1) Added diagnosis A63.0. (C1) Removed CPT codes 58340, 58565 and 74740
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
	Related Coverage Policies Section	Added *1E-5 Obstetrics, 1E-2, Therapeutic and Non-therapeutic Abortions, and 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring*
	Section 2.1.2	Changed plural nouns for “individuals” and “beneficiaries” to singular nouns here and throughout policy.

Date	Section Revised	Change
	Section 2.2.4	Removed NC Administrative Code 10A NCAC 23E.0102 - repealed in June 2019.
	Added Subsection 3.1.1	As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.
	Section 3.2.1	Added Hepatitis B screening as specific criteria covered. Added references to Attachments for specific covered criteria. Added that ultrasounds covered to locate string less IUDs. Added Kyleena IUD for coverage. Removed repetitive language.
	Section 3.3	Added section with United States Preventive Services Task Force (USPSTF) Recommendations.
	Section 4.2.2	Hepatitis B treatment added as specific criteria not covered. Also added "surgical procedures or hospital services requiring outpatient beneficiary registration other than sterilization" as a noncovered item. Clarified removal of IUDs outside of the office setting as a noncovered service. Reformatted into lists for readability.
	Section 5.4	Removed this section as was duplicate to section 6.0
	Sections 5.5	Removed this section as was exact duplication of Sections 6.1.
	Sections 5.6	Removed this section as was exact duplication of Section 6.2.
	Section 6.0	Moved NC Administrative Code 10A NCAC 22J.0106 reference for Medicaid Billing from Section 5.4 to Section 6.0.

Date	Section Revised	Change
	Attachment A, Letter B1	Added ICD-10-CM diagnosis codes N41.0, N45.1-N45.3, Z72.51-Z72.53 and Z86.10 for coverage related to NAAT testing for Trichomonas Vaginalis. Added ICD-10-CM diagnosis codes A49.3, N72, N73.0, N73.1, and N73.9 and Z86.19 for NAAT diagnostic testing for Mycoplasma Genitalium. Added ICD-10-CM diagnosis codes Z11.59, Z72.51-Z72.53, and Z72.89 for use with Hepatitis B screening. Added clarifying language to reference to sterilization procedures under table in this section.
	Attachment A, Letter C1	Removed end dated CPT procedure codes 71010 and 88154. Removed incorrectly entered CPT code 78657 and added correct CPT code 76857. Added new covered CPT code 58661, 87661, 87563, 80053, 86704, 86706 and 87340. Added new covered HCPCS J7296 to HCPCS code table. Removed repetitive instruction under table C1 regarding sterilization procedures. Added table for CPT Codes Eligible for Telehealth Services with **Note:** Telehealth eligible services may be provided to established patients by the eligible providers listed within this policy. Added MAFDN approved Revenue Codes back to policy.
	Attachment A, Letter D	Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.
	Attachment A, Letter F	Added instruction for Outpatient Place of Service, that "the only surgical procedure or hospital services allowed requiring outpatient beneficiary registration is sterilization". Also added clarification to specified POS "Office." Added the following language for telehealth services: Telehealth Claims: Place of Service 02 (Telehealth).
	Attachment B, Letter A	Changed "FP Medicaid Program" to "FP Medicaid" for policy consistency in this section and throughout policy attachments. Formatted with lists for readability.

Date	Section Revised	Change
	Attachment B, Letter B	Reformatted into lists for readability. Added Hepatitis B screening to list of services provided during inter-periodic visit. Added the following language requirement for Inter-Periodic visits: Each in-person or telehealth encounter will count as one of a beneficiary's allotted six inter-periodic visits, per 365 days.
	Attachment B, Letter C	Clarified billing language related to after-office hours services.
	Attachment B, Letter D	Removed end dated pap test CPT procedure code 88154. Removed pap test as a requirement only at time of annual exam and clarified that can be offered at time of annual exam or during an inter-periodic visit. Added Comprehensive Metabolic Panel (CMP) for coverage with guidelines. Added Hepatitis B test for coverage during an inter-periodic visit or annual exam.
	Attachment B, Letter F	Added Hepatitis B screening to title of Section F. Added coverage requirements and CPT codes for Hepatitis B screening. Created new section for Trichomonas Vaginalis and added coverage for NAAT screening code 87661. Clarified Bacterial Vaginosis (Gardnerella) and Candida screening section. Removed CPT 87660 from this section as this was added to the newly created Trichomonas section. Added coverage for new CPT code 87563 for diagnostic Mycoplasma Genitalium testing. Added referral guidelines for interventions in HIV by prophylactic prescription meds through the Ready, Set PrEP program.
	Attachment B, Letter H	Removed "Ortho Evra" from contraceptive patch. Removed unnecessary wording. Added Kyleena IUD for coverage.
	Attachment B, Letter I	Added clarification that no waiting period exists for IUD placement when ultrasound confirms IUD has been expelled. Removed repetitive language.
	Attachment C	Added coverage for Moxifloxacin, 400mg to Approved FP Medicaid STI Medications list.

Date	Section Revised	Change
	Attachment C-Addendum to 11/1/2018 Entry	Remainder of Attachment C was combined with Attachment B to form Attachment B: FP Medicaid (MAFDN eligible) Billing Requirements.
	Attachment D	Specified pharmacy program as "Outpatient" pharmacy drug program.
	Attachment D-Addendum to 11/1/2018 Entry	Attachment D became Attachment C: Approved FP Medicaid STI Medications List
	Attachment E-Addendum to 11/1/2018 Entry	Attachment E became Attachment D: Postoperative Sterilization Medication List.
	Attachment F-Addendum to 11/1/2018 Entry	Attachment F was removed all together from the policy.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

B1. Providers serving MAFDN eligible beneficiaries are limited to the following diagnosis codes:

ICD-10-CM Code(s)			
A49.3	A56.11	B37.49	Z30.012
A51.0	A56.19	B85.3N34.1	Z30.013
A51.1	A56.2	N34.2	Z30.014
A51.2	A56.3	N34.3	Z30.015
A51.5	A56.4	N41.0	Z30.016
A51.9	A56.8	N45.1-N45.3	Z30.017
A54.00	A59.00	N72	Z30.018
A54.01	A59.01	N73.0	Z30.019
A54.02	A59.02	N73.1	Z30.02
A54.03	A59.03	N73.9	Z30.09
A54.09	A59.09	N76.0	Z30.2
A54.1	A59.8	N76.1	Z30.40
A54.21	A59.9	N76.2	Z30.41
A54.22	A60.00	N76.3R87.615	Z30.42
A54.23	A60.01	T83.32XA	Z30.430
A54.24	A60.02	Z00.00	Z30.431
A54.29	A60.03	Z00.01	Z30.432
A54.30	A60.04	Z01.411	Z30.433
A54.31	A60.09	Z01.419	Z30.44
A54.32	A60.1	Z01.812	Z30.45
A54.33	A60.9	Z01.84	Z30.46
A54.39	A63.0	Z01.89Z11.3	Z30.49
A54.5	A74.0	Z11.4	Z30.8
A54.6	A74.81	Z11.51	Z30.9

ICD-10-CM Code(s)			
A54.89	A74.89	Z11.59	Z31.69
A54.9	A74.9	Z11.8	Z32.01
A55	B33.8	Z30.011	Z32.02
A56.00	B37.3		Z72.51-Z72.53
A56.01	B37.41		Z72.89
A56.02	B37.42		
A56.09			

Male and female beneficiaries with FP Medicaid (MAFDN) are eligible for sterilization procedures. Refer to NC Medicaid Clinical Coverage Policy 1E-3, Sterilization Procedures ~~*1E-3, Sterilization Procedures* on the NC Medicaid website~~ at ~~https://medicaid.ncdhhs.gov/~~ for CPT codes, ICD-10 procedure codes and diagnosis codes related to sterilization procedures. NCHC beneficiaries are not eligible for sterilization procedures.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code

Information for FQHCs and RHCs billing for Medicaid FP services are located in clinical coverage policy 1D-4, *"Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics"* on NC Medicaid's website at https://medicaid.ncdhhs.gov/.

C1. Providers serving MAFDN eligible beneficiaries are limited to the following procedure codes:

CPT Code(s)			
00851	85013	87528	88175
00921	85014	87529	88302
00952	85018	87530	89310
11976	85027	87534	93000
11981	86592	87535	93010
11982	86593	87536	96372
11983	86631	87537	99050
17000	86632	87538	99051
36415	86689	87539	99053
54050	86694	87563	99201
56501	86695	87590	99202
57170	86696	87591	99203
58300	86701	87592	99204
58301	86702	87623	99205

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CPT Code(s)			
58600	86703	87624	99211
58615	86704	87625	99212
58661	86706	87660	99213
58670	87340	87661	99214
58671	86780	87798	99215
~~71010~~	87070	87810	99241
76830	87071	87850	99242
76856	87081	88141	99243
76857	87110	88142	99244
~~78657~~	87207	88143	99245
80053	87210	88147	99383
81000	87270	88148	99384
81001	87273	88150	99385
81002	87274	88152	99386
81003	87285	88153	99387
81005	87320	~~88154~~	99393
81007	87389	88155	99394
81015	87390	88164	99395
81025	87391	88165	99396
84702	87480	88166	99397
84703	87490	88167	
	87491	88174	
	87492		
	87510		

~~**Male and female beneficiaries with FP Medicaid (MAFDN) are eligible for sterilization procedures. Refer to clinical coverage policy, 1E-3, *Sterilization Procedures*, for CPT codes, ICD-10 procedure codes and diagnosis codes related to sterilization procedures. NCHC beneficiaries are not eligible for sterilization procedures.**~~

CPT Codes Eligible for Telehealth Services	
99211	**99241**
99212	**99242**
99213	**99243**
99214	**99244**
99215	**99245**

Note: Telehealth eligible services may be provided to established patients by the eligible providers listed within this policy.

HCPCS Code(s)	
J1050	J7307
J7296	S4993
J7297	
J7298	
J7300	
J7301	

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

Revenue: Institutional provider(s) billing on a UB claim, shall bill one of the following revenue codes (RC). When billing revenue codes for a MAFDN beneficiary, a procedure code is required on the line item. If no procedure code is found on the line item or the procedure code is not covered under the Family Planning Services, the line item will be denied.

Revenue Code(s)			
RC0250	RC0278	RC0312	RC0371
RC0251	RC0279	RC0314	RC0372
RC0252	RC0300	RC0319	RC0379
RC0254	RC0301	RC0320	RC0490
RC0255	RC0305	RC0324	RC0499
RC0258	RC0306	RC0329	RC0510
RC0259	RC0307	RC0360	RC0519
RC0270	RC0309	RC0361	RC0730
RC0271	RC0310	RC0369	RC0739
RC0272	RC0311	RC0370	

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Non-Telehealth Claims:
Family planning services must be billed with the appropriate code using the FP modifier.

All providers, except ambulatory surgical centers, must append modifier FP to the procedure code for family planning services.

N.C. Medicaid **requires** the UD modifier to be billed on the CMS-1500/837P and the UB04/837I claims forms, with applicable HCPCS code and National Drug Code (NDCs) to properly identify 340B drugs. All non-340B drugs are billed using the associated HCPCS and NDC pair without the UD modifier.

Telehealth Claims:

Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

Family planning services must be billed with the appropriate code using the FP modifier.
All providers, except ambulatory surgical centers, must append modifier FP to the procedure code for family planning services.

N.C. Medicaid **requires** the UD modifier to be billed on the CMS-1500/837P and the UB04/837I claims forms, with applicable HCPCS code and National Drug Code (NDCs) to properly identify 340B drugs. All non-340B drugs are billed using the associated HCPCS and NDC pair without the UD modifier.

E. Billing Units

The provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Non-Telehealth Claims:

1. Inpatient hospitals (not applicable for an FP Medicaid beneficiary;
2. Outpatient hospital - For an FP Medicaid beneficiary, the only surgical procedure or service allowed requiring outpatient beneficiary registration is sterilization. ~~(applicable for FP Medicaid beneficiaries for sterilization procedures **only**);~~
3. Office- (utilizing offices within places of service 11(Office), 19 (Off Campus-Outpatient) or 22 (On Campus- Outpatient)); and
4. Ambulatory Surgical Centers (applicable for a FP Medicaid beneficiary for a sterilization procedure only).

Telehealth Claims:
Telehealth claims should be filed with the provider's usual place of service code(s) and not place of service 02 (Telehealth).

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

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Attachment B: FP Medicaid (MAFDN-eligible) Billing Requirements:

I. Annual Exam

A comprehensive annual examination must be performed for a FP Medicaid beneficiary prior to the rendering of any other family planning and family planning-related services. If emergent or urgent contraceptive services are needed, a beneficiary is allowed limited office visits prior to their annual examination.

A beneficiary who has received a comprehensive annual or physical exam under Medicaid within 365 calendar days prior to transitioning to FP Medicaid ~~program.~~ has met the annual exam requirement for FP Medicaid and is not required to receive another comprehensive annual exam.

It is the expectation that a beneficiary with Medicaid for Pregnant Women (MPW) coverage shall receive a postpartum exam by the last day of the month in which the 60th postpartum day occurs. A MPW beneficiary who received her postpartum exam within 365 calendar days prior to enrolling in FP Medicaid shall not be required to receive another comprehensive annual exam to begin receiving services under FP Medicaid ~~program.~~

If the beneficiary has not received an annual exam within 365 calendar days under Medicaid or MPW, they are required to~~must~~ receive a comprehensive annual exam under FP Medicaid **prior** to receiving any family planning and family planning-related services.

The Annual Examination Date (AED), containing a valid month, day and year, is required to be documented on **all claims,** with the exception of:

a. pregnancy tests; and
b. prescriptions for FDA approved and Medicaid covered contraceptive devices and supplies, post-operative medications for sterilization procedures; and additional sterilization services such as ~~including~~ anesthesia, x-rays, electrocardiogram and surgical pathology when provided with a sterilization procedure.

One (1) annual examination is allowed per 365 calendar days

Annual Examination Codes	
99383	99393
99384	99394
99385	99395
99386	99396
99387	99397

If during an annual exam, the beneficiary requests:

a. an IUD insertion (CPT procedure code 58300);
b. an IUD removal (CPT procedure code 58301);
c. insertion, non-biodegradable drug delivery implant (CPT procedure code 11981);
d. removal, non-biodegradable drug delivery implant (CPT procedure code 11982);
e. removal with reinsertion, non-biodegradable drug delivery implant (CPT procedure code 11983);
f. diaphragm or cervical cap fitting with instructions (CPT procedure code 57170); or
g. or during the annual visit the beneficiary decides to switch from birth control pills to an IUD.

The provider may bill for the annual exam and the applicable CPT procedure code 58300, 58301, 57170, 11981, 11982 or 11983. An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a **separately identifiable service provided by the same provider on the same day of service**. The provider's documentation must support that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

If the only reason that the beneficiary is seen in the office is to request the following:
a. an IUD insertion, an IUD removal);
b. insertion, non-biodegradable drug delivery implant removal;
c. non-biodegradable drug delivery implant removal with reinsertion;
d. non-biodegradable drug delivery implant; or
e. diaphragm or cervical cap fitting with instructions.

The providers shall not bill a separate inter-periodic office visit. An office visit component is contained in the reimbursement for CPT procedure codes 58300, 58301, 57170, 11981, 11982 and 11983. However, if during the same visit, services are rendered for **a separately identifiable service provided by the same provider on the same day of service**, the provider may bill for the inter-periodic visit and CPT procedure code 58300, 58301, 57170, 11981, 11982 or 11983. The providers documentation must support that the service rendered was a separately identifiable service.

J. Inter-Periodic Visits

Six (6) inter-periodic visits are allowed per 365 calendar days. Each in-person or telehealth encounter will count as one of a beneficiary's allotted six inter-periodic visits, per 365 days.
The purpose of inter-periodic visits is:

a. to evaluate the beneficiary's contraceptive needs,
b. to renew or change the contraceptive prescription,
c. STI screening and treatment,
d. HIV and Hepatitis B screening; and
e. to provide additional opportunities for counseling as follow-up to the annual exam.

Inter-Periodic Visit	
99201	99211
99202	99212
99203	99213
99204	99214
99205	99215

K. Office "Special Services: After Hours" Visits

Refer to Clinical Coverage Policy *1A-38, Special Services: After Hours*, for guidelines related to Office "after hours" visits on the NC Medicaid website at https://medicaid.ncdhhs.gov/.

When billing after-office hours services, ~~P~~ providers are required to ~~must~~ report an office visit CPT code along with an after-office hours CPT code (~~i.e.,~~ 99211+99050=1 visit). An FP modifier must be appended to both the office visit code and the office "after hours" code.

Office "after hours" codes are not allowed ~~covered~~ when the service is provided in a hospital emergency room or department (Refer to Sub section 4.2.2 (c) of this policy).

Office After-Hours Visit
99050
99051
99053

L. Laboratory Tests

The following laboratory tests are **only allowable for FP Medicaid ~~program~~ when performed "in conjunction with" or pursuant to an annual examination**. For the purpose of FP Medicaid "in conjunction with" has been defined as the day of the annual exam or 30 calendar days after the annual exam.

a. Urinalysis; and
b. blood count.; ~~and~~
~~c. pap test.~~

Providers are allowed one urinalysis and one blood count procedure code per 365 calendar days in conjunction with an annual examination.

Urinalysis
81000
81001
81002
81003
81005
81007
81015
Blood Count
85013
85014
85018
85027

Clinical Laboratory Improvement Amendments (CLIA) certified laboratories and physicians are allowed to bill for one pap test procedure per 365 calendar days during ~~in conjunction with~~ an annual examination visit or during any of the six (6) inter-periodic visits allowed under FP Medicaid. **One repeat pap test is allowed due to insufficient cells.** Provider(s) shall perform the repeat pap test within 180 calendar days of the first pap test.

Pap Test	
88141	~~88154~~
88142	88155
88143	88164
88147	88165
88148	88166
88150	88167

Pap Test	
88152 88153	88174 88175

Pregnancy tests, sexually transmitted infection (STI), Hepatitis B and HIV screening can be performed during an annual examination visit or during any of the six (6) inter-periodic visits allowed under the program. Provider (s) are allowed to bill for a total of any combination of six (6) HIV or STI screenings per 365 calendar days.

Pregnancy Tests
81025 84702 84703

Providers are allowed to bill one Comprehensive Metabolic Panel per 365 calendar days in conjunction with an annual exam or one of the six (6) inter-periodic visits as indicated prior to prescribing oral contraceptives or for HIV prophylactic medications.

Comprehensive Metabolic Panel
80053

Note: Providers billing for a venipuncture should follow guidelines outlined in Clinical Policy *1S-3 Laboratory Services*. Medicaid and NCHC shall allow venipuncture specimen collection to the provider who extracted the specimen only when it is sent to an independent laboratory for testing and no testing is done in the office.

M. Pharmacy

For a complete list of approved antibiotics and pain medications for FP Medicaid beneficiaries, refer to **Attachment C**.

1. FDA approved, and Medicaid-covered pharmaceutical supplies and devices, consisting of oral contraceptive pills, intrauterine devices, implantable contraceptive devices, contraceptive patch, contraceptive ring, emergency contraception and contraceptive injections are covered under FP Medicaid ~~program~~ if provided for family planning purposes. The AED is not required on claims for approved contraceptive supplies and devices.
2. **There is a six (6) prescription limit per month with no override capability for FP Medicaid prescriptions.** Providers shall ~~are~~ not ~~allowed to~~ distribute "brand medically necessary" dispense as written (DAW1) drugs, if a generic is available. All claims must be submitted via Point of Sale (POS) and must have the approved ICD-10-CM diagnosis code.
3. Birth control pills can be dispensed through a pharmacy. A beneficiary can receive up to a three-month supply of birth control pills. FDA approved contraceptive supplies and devices may also be obtained through a pharmacy for FP Medicaid ~~program~~.
4. All approved antibiotic treatment and pain medications must have the appropriate ICD-10-CM diagnosis written on the prescription.

Other Screenings or Procedures	
17000	87071
54050	93000
56501	93010
87070	96372

N. HIV ~~Screening~~ and Hepatitis B Screening and STI Screening and Treatment

Provider(s) are allowed to bill for a total of any combination of six HIV, Hepatitis B and STI screenings per 365 calendar days. Screenings for HIV, Hepatitis B and STI can be performed during the annual examination or any of the six inter-periodic visits allowed under the program, after an annual exam has been performed.

HIV Screening

FP Medicaid allows screening for HIV during the annual examination or during the six inter-periodic visits allowed under the FP Medicaid program. Providers are required to report an appropriate **ICD-10-CM Diagnosis *for HIV screening*** as the secondary diagnosis on the claim.

A beneficiary who meets enrollment requirements for the Ready, Set, PrEP (Pre-Exposure Prophylaxis) program can be referred to participating drug stores or the LHD for interventions in HIV by prophylactic prescription medication.

HIV Screening	
86689	87534
86701	87535
86702	87536
86703	87537
87389	87538
87390	87539
87391	

Hepatitis B Screening

FP Medicaid allows screening for Hepatitis B during the annual examination or during the six inter-periodic visits allowed under the FP Medicaid program. Providers are required to report an appropriate **ICD-10-CM Diagnosis *for Hepatitis B screening*** as the secondary diagnosis on the claim.

Hepatitis B Screening
86704
86706
87340

STI Screening, Diagnostic Testing and Treatment

The FP Medicaid ~~Program~~ allows STI screenings during the annual examination or during the six inter-periodic visits. Providers are required to ~~must~~ report ~~include~~ an appropriate ICD-**10-CM Diagnosis *for STI screening*** as the secondary diagnosis on the claim.

FP Medicaid allows a ~~A~~ total of six courses of STI antibiotic treatments from the approved list identified in this policy ~~are allowed~~ per 365 calendar days ~~for the FP Medicaid~~ program. All approved antibiotics must have the appropriate ICD-10-CM on the prescription. All prescriptions for STI treatment must be filled on the same day. This day is not required to be the same day as the Annual Exam Date (AED). The AED is not required on STI prescriptions.

STI Screening CPT codes:

Gonorrhea	
87590	87592
87591	87850

Syphilis
86592
86593

General STI Screening
87081
87210

,

Chlamydia	
86631	87490
86632	87491
87110	87492
87270	87810
87320	

Herpes	
86694	87274
86695	87528
86696	87529
87207	87530
87273	

Trichomonas Vaginalis
87210
87660
87661

Treponema
86780
87285

Papillomavirus
87623
87624
87625

Bacterial Vaginosis (Gardnerella and Candida)
87210 87480 87510 ~~87660~~
Miscellaneous
87798

Mycoplasma Genitalium Diagnostic Testing

FP Medicaid allows Mycoplasma Genitalium diagnostic testing for diagnoses of urethritis, cervicitis, and Pelvic Inflammatory Disease (PID) during the annual exam or during the six inter-periodic screenings allowed per 365 days. Providers are required to report an appropriate ICD-10-CM Diagnosis code on the claim.

Mycoplasma Genitalium
87563

O. Sterilization

Male and female beneficiaries with FP Medicaid are eligible for sterilization procedures. Refer to Clinical Policy *1E-3, Sterilization Procedures* on the NC Medicaid website at https://medicaid.ncdhhs.gov/ for requirements related to sterilization procedures.
Once a beneficiary with FP Medicaid has had a permanent sterilization procedure and the necessary post-surgical follow-up has occurred, the beneficiary is no longer eligible for FP Medicaid program services. If the beneficiary has no need for family planning services, but requires further medical care, the provider shall refer the beneficiary to the local department of social services, health department, federally qualified health center (community health center), or rural health clinic in their county. If one of the above primary care providers is not available in the county where the beneficiary resides, they may seek services in nearby or surrounding counties.

NCHC shall **not cover** sterilization procedures.

P. Contraceptive Services, Supplies and Devices

Medicaid covered ~~pharmaceutical supplies and devices, including~~ oral contraceptive pills, intrauterine devices, implantable contraceptive devices, contraceptive patch, contraceptive ring, emergency contraception and contraceptive injections are covered under the FP Medicaid program **if provided for family planning purposes.**

There is no co-payment for beneficiaries in the Family Planning program for Medicaid-covered contraceptive supplies and devices.

All eligible drugs for Family Planning have a family planning indicator on the drug file (including birth control pills, Depo-Provera, ~~Ortho Evra~~ contraceptive patch, Nuva Ring). The dispensing fee is based on traditional Medicaid rules. **There is a six-prescription limit per month with no override capability.** Providers shall ~~are~~ not ~~allowed to~~ distribute "brand medically necessary"

(DAW1 (dispense as written)) drugs, if a generic is available. All claims must be submitted via Point of Sale (POS) and must have the approved ICD-10-CM code.

Post-operative medications are covered for sterilization procedures. All approved post-operative medications must have the appropriate **ICD-10-CM Diagnosis for sterilization** on the prescription.

The AED is not required on FP Medicaid program prescriptions.

Emergency Contraceptives

Emergency contraceptives are a covered service. The appropriate office visit code may be billed separately.

Birth Control Pills

Birth control pills may be dispensed through a pharmacy.
A beneficiary may receive up to a 3-month supply.

Birth Control Pills provided by a Local Health Department
S4993

Diaphragm Fitting

A FP Medicaid beneficiary can choose a diaphragm as a birth control method.

A provider shall fit the beneficiary and bill using the appropriate CPT code for diaphragm fitting. However, FP Medicaid **does not cover the actual diaphragm device**.

Diaphragm Fitting
57170

Injectable Drugs

Depo-Provera contraceptive injection is a covered service.
Use the diagnosis code for contraceptive management.

Injectable Drugs
J1050

Intrauterine Devices (IUDs)

When billing for IUD insertion, CPT code 58300 is used.
The CPT code for removal of IUD is 58301.

IUDs
J7296
J7297
J7298
J7300
J7301

Implantable Devices

~~The~~ FP Medicaid ~~program~~ covers Nexplanon implantable contraceptive device.

Implantable Devices
J7307

Norplant Removal

FP Medicaid covers **only** the removal of Norplant.

Norplant Removal
11976

Q. Ultrasounds

During the annual exam or inter-periodic visit, if the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing, providers may check IUD placement by performing an ultrasound. Health record documentation must indicate the reason that the ultrasound was performed~~ (malpositioned or missing strings).~~ Ultrasounds are not intended for the purpose of routine checking of placement after IUD insertion. If it is confirmed by ultrasound that an IUD has been expelled, providers may reinsert a replacement IUD without any waiting period.

If it is determined that additional medical care is necessary due to an IUD complication, the provider shall refer the MAFDN eligible beneficiary to the local department of social services, health department, federally qualified health center (community health center), or rural health clinic in their county. If one of the above primary care providers is not available in the county where the beneficiary resides, they may seek services in nearby or surrounding counties.

R. Miscellaneous Instructions

a. If a provider discovers that a beneficiary is pregnant or does not have family planning needs, the provider shall refer the beneficiary to the local Department of Social Services (DSS) to determine eligibility that may be available to the beneficiary.
b. Provider(s) shall include the AED on all claims for an annual examination and laboratory procedures, with the exception of the pregnancy test.
c. An ICD-10-CM diagnosis related to family planning services must be the primary diagnosis on the claim forms.

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Attachment C: Approved FP Medicaid STI Medications List

Medications for the FP Medicaid program are only provided by a prescription through the pharmacy drug program. However, birth control pills can be provided in a Local Health Department. **All prescriptions for STI medications must document ~~include~~ the appropriate ICD-10-CM code.**

For additional information regarding Sexually Transmitted Diseases (STDs), refer to the Center for Disease Control and Prevention website at https://www.cdc.gov/std/.

FP Medicaid approved medications	
STI Diagnosis	
Herpes	Acyclovir 200mg, 400mg, 800 mg Famciclovir 125mg, 250mg, 500mg Valacyclovir 500mg, 1.0gm
Chlamydia	Azithromycin, 250mg, 500mg, 1gm Doxycycline 100mg Erythromycin 250mg, 400mg, 500mg, 800mg Ofloxacin 200mg, 300mg, 400mg Levofloxacin 500mg Tetracycline 250mg, 500mg
Syphilis	Azithromycin 1gm Benzathine penicillin G 2.4 million units Ceftriaxone 250mg Ciprofloxacin 500mg Doxycycline 100mg Erythromycin 500mg Tetracycline 500mg
Gonorrhea	Azithromycin 250mg, 500mg, 1gm Cefixime 400mg Ceftriaxone 125 mg, 250mg, 500mg Cefotaxime 500mg Cefoxitin 2gm with probenecid 1gm Ciprofloxacin 250mg, 500mg Cefpodoxime 200 mg Doxycycline 100 mg Gatifloxacin 400mg Levofloxacin 250mg Ofloxacin 400mg Sulfamethoxazole/TMP Gentamicin 240mg IM

Other Sexually Transmitted Infections	Azithromycin 250mg, 500mg, 1gm Doxycycline 100mg Erythromycin 500mg, 800mg Gatifloxacin 400mg Levofloxacin 250mg, 500mg Ofloxacin 200mg, 300mg, 400mg Moxifloxacin 400 mg
Candidiasis	Butoconazole 2% cream Fluconazole 50mg, 100mg, 150mg, 200mg Miconazole 200mg suppository Terconazole 80mg suppository Terconazole cream 0.4%, 0.8%
Trichomoniasis	Metronidazole 250mg, 500mg, 750mg, 2gm Tinidazole 2000mg
Bacterial vaginosis	Metronidazole 250mg, 500mg Metronidazole gel 0.75% Clindamycin cream 2% Clindamycin oral 150mg, 300mg Clindamycin ovules 100mg Tinidazole 2gm, 1 gm, 500mg, 250mg
Pubic Louse	Permethrin 5% cream Lindane 1% shampoo

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Attachment D: Postoperative Sterilization Medication List

Medications for sterilization procedures for the FP Medicaid program are ~~will only~~ be provided by prescription through the Outpatient Pharmacy drug program. **All prescriptions for postoperative sterilization medications must contain a sterilization diagnosis.**

Sterilization Procedure (vasectomy and tubal ligation)
Antibiotics for sterilization procedures
Amox TR-K CLV 500-125mg, 1000-62.5 Amoxicillin 250mg, 500mg Cephalexin 250mg, 500mg Ciprofloxacin HCL 250mg, 500mg Doxycycline 100mg Erythromycin ES 400mg Levofloxacin 500mg Metronidazole 500mg Penicillin VK 500mg Sulfamethoxazole/TMP DS Azithromax 250mg
Analgesics for sterilization procedures
Acetaminophen/Cod #2, #3 Hydrocodone/Apap-5/325, 5/500, 7.5/325, 7.5/500, 7.5/650, 7.5/750, 10/325, 10/500, 10/650, 10/660, 10/750 Hydrocodone/IBU 2.5/200, 5/200, 7.5/200, 10/200 Ibuprofen 400mg, 600mg, 800mg Ketorolac 10mg Naproxen 500mg Naproxen Sodium 550mg Oxycodone 5mg Oxycodone w/Apap 2.5/325, 5/325, 5/325, 7.5/325, 7.5/500, 10/325, 10/650
Antiemetic for sterilization procedures
Promethazine 25mg