



**Family Planning Medical
Provider Guide
January 1, 2014**

Washington State
Health Care Authority

About this guide*

This publication takes effect January 1, 2014, and supersedes earlier guides to this program.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Reason for Change	Effective Date	Subject	Change
Change in federal law PN 13-90	01/01/2014	All	Stylistic updates
		TAKE CHARGE	TAKE CHARGE eligibility expanded to those whose income is 260 percent of the federal poverty level or less
		TAKE CHARGE	Applicants must apply and be rejected for Medicaid before applying for TAKE CHARGE
		Delayed Pelvic Visits	Added language clarifying delayed pelvic protocol
		Who is eligible for services	Applicants must not be covered by other public or private insurance.

* This publication is a billing instruction.

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's [Provider Publications](#) website.


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Resources Available

Topic	Resource
Becoming a provider	Contact the TAKE CHARGE/Family Planning Program Manager:
TAKE CHARGE providers wanting to submit a change of address, phone number, or fax number	Phone: 360-725-1652 Family Services Section PO Box 45530 Olympia, WA 98504-5530
Obtaining the TAKE CHARGE Application form, HCA 13-781 (for clients)	Medicaid agency forms
Obtaining information regarding the Family Planning program	Visit the Family Planning website . Contact the Customer Service Center . Contact the TAKE CHARGE/Family Planning Program Manager: Phone: 1-360-725-1652 Family Services Section PO Box 45530 Olympia, WA 98504-5530
Obtaining information about sterilization	See the agency's Sterilization Supplemental Medicaid Provider Guide and WAC 182-531-1550 .
Obtaining pharmacy information	See the agency's online Pharmacy Information and the Prescription Drug Program Medicaid Provider Guide .
Additional agency resources	See the agency's Resources Available web page.
Obtaining agency provider notices and medicaid provider guides	See the Provider Publications website

Definitions

This section defines select terms used in this guide. Refer to the agency's online [Medical Assistance Glossary](#) and chapter [182-500](#) WAC for additional definitions.

340B dispensing fee – The Medicaid agency's established fee paid to a registered and Medicaid-participating 340B drug program provider under the public health service (PHS) act for expenses involved in acquiring, storing and dispensing prescription drugs or drug-containing devices (see [WAC 182-530-7900](#)). A dispensing fee is not paid for nondrug items, devices or supplies (see [WAC 182-530-7050](#)).

Actual acquisition cost (AAC) – The actual cost a provider pays for a drug marketed in the package size of drug purchased or sold by a particular manufacturer or labeler. The AAC must reflect special discounts or pricing arrangements through the manufacturer, wholesaler or buying cooperative. ([WAC 182-530-1050](#))

Applicant – A person applying for TAKE CHARGE family planning services.

Complication – An unintended, adverse condition occurring subsequent to and directly arising from the family planning services received.

Comprehensive prevention visit for family planning – A comprehensive, preventive, contraceptive visit that includes evaluation and management of an individual, such as: age appropriate history, examination, counseling/anticipatory guidance, risk factor reduction interventions, and labs and diagnostic procedures that are covered under the client's respective

Medicaid agency program. These services may only be provided by and paid to TAKE CHARGE providers.

Contraception – Prevention of pregnancy through the use of contraceptive methods.

Contraceptive – A device, drug, product, method, or surgical intervention used to prevent pregnancy.

Delayed pelvic protocol – The practice of allowing a woman to postpone a pelvic exam during a contraceptive visit to facilitate the start or continuation of a hormonal contraceptive method.

Education and Counseling for Risk Reduction (ECRR) – Client-centered education and counseling services designed to strengthen decision making skills and support a client's safe and effective use of a chosen contraceptive method. For women, ECRR is part of the comprehensive prevention visit for family planning. For men, ECRR is a stand-alone service for those men seeking family planning services and whose partners are at moderate to high-risk of unintended pregnancy.

Family Planning Only program – The program providing an additional 10 months of family planning services to eligible women at the end of their pregnancy. This benefit follows the 60-day postpregnancy coverage for women who received medical assistance benefits during the pregnancy.

Family planning provider” – For this guide, a physician or physician’s assistant, advanced registered nurse practitioner (ARNP), or clinic that, in addition to meeting the requirements in [Chapter 182-502 WAC](#), is approved by the Medicaid agency to provide family planning services to eligible clients as described in this guide.

Family planning services – Medically safe and effective medical care, educational services, and/or contraceptives that enable individuals to plan and space the number of children and avoid unintended pregnancies.

Informed consent – When an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- Disclosed and discussed the client’s diagnosis
- Offered the client an opportunity to ask questions about the procedure and request information in writing
- Given the client a copy of the consent form
- Communicated effectively using any language interpretation or special communication device necessary per [42 CFR 441.257](#)
- Given the client oral information about all of the following:
 - ✓ The client’s right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure
 - ✓ Alternatives to the procedure including potential risks, benefits, and consequences

- ✓ The procedure itself, including potential risks, benefits, and consequences

Medicaid agency – Health Care Authority

Natural family planning (also known as fertility awareness method) – Methods to identify the fertile days of the menstrual cycle and avoid unintended pregnancies, such as observing, recording, and interpreting the natural signs and symptoms associated with the menstrual cycle.

“Over-the-counter (OTC)” – Drugs that do not require a prescription before they can be sold or dispensed. (See [WAC 182-530-1050](#).)

Public Health Service Act (PHS) – The federal act governing the 340B program administered through the Office of Pharmacy Affairs. Per Washington Administrative Code (WAC), any drugs or items purchased through this program must be billed at the actual acquisition cost. ([WAC 182-530-7900](#)).

Sexually Transmitted Infection (STI) –A disease or infection acquired as a result of sexual contact.

TAKE CHARGE – The Medicaid agency’s demonstration and research program approved by the federal government under a Medicaid program waiver to provide family planning services.

TAKE CHARGE Provider – A family planning provider who has a TAKE CHARGE agreement to provide TAKE CHARGE family planning services to eligible clients under the terms of the federally approved Medicaid waiver for the TAKE CHARGE program. (See [TAKE CHARGE provider requirements](#) in this guide and WAC 182-532-730.)

U.S. Citizenship and Immigration Services (USCIS) – Refer to [USCIS](#) for a definition.

About these Programs

Reproductive health is a state of physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems across the life span. It also includes sexual health.

It is important for men and women to be informed and have access to safe and effective methods of family planning. This includes access to early and appropriate health care services that will allow women to safely go through pregnancy and childbirth, and provide couples the best chance of having a healthy infant.

Washington State Medicaid pays for over half of the births in Washington State and over half of those pregnancies were unintended at the time of conception.

The consequences of unintended pregnancy can be serious, even life altering, particularly for women who are young or unmarried, have just recently given birth, or already have the number of children they want. An unplanned pregnancy can be a barrier to obtaining timely prenatal care because it may take weeks or months for a woman to realize or accept that she is pregnant. Lack of prenatal care—along with poor birth spacing, or giving birth before or after one’s childbearing prime—can pose health risks for the woman and for her newborn. In addition, an unintended pregnancy can interfere with a young woman’s education, limiting her employment possibilities and her ability to support herself and her family. Largely for reasons such as these, half of women who unintentionally become pregnant decide to have an abortion.

The goal of the Medicaid family planning services is to improve the health of women, children and families in Washington by decreasing unintended pregnancies and lengthening intervals between births, and to reduce state and federal Medicaid expenditures for births from unintended pregnancies.

Book resource: For more information on the impacts of an unintended pregnancy, read *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* by Sara S. Brown and Leon Eisenberg.

This Medicaid provider guide describes requirements for three programs: [Reproductive Health Services](#), [Family Planning Only](#), and [TAKE CHARGE](#).

Reproductive Health Services

What are reproductive health services?

([WAC 182-532-001](#))

The Medicaid agency defines Reproductive Health Services as those services that:

- Assist clients in avoiding illness, disease, and disability related to reproductive health.
- Provide related, appropriate, and medically necessary care when needed.
- Assist clients in making informed decisions about using medically safe and effective methods of family planning.

What are the requirements for providers?

([WAC 182-532-110](#))

To be paid by the Medicaid agency for Reproductive Health Services provided to eligible clients, family planning providers, including licensed midwives, must:

- Meet the requirements in [Chapter 182-502 WAC](#).
- Provide only those services that are within the scope of their licenses.
- Comply with the required general Medicaid agency policies and specific Reproductive Health provider policies, procedures, and administrative practices in this guide.
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods, over-the-counter (OTC) birth control supplies, and related medical services.
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request.
- Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request.
- Refer the client to available and affordable nonfamily planning primary care services as needed.

Note: Providers who are unable to meet all of the requirements above must refer the client to an appropriate provider.

Who is eligible for services?

(WACs [182-532-100\(1\)](#) and [182-501-0060](#))

The Medicaid agency covers limited, medically necessary Reproductive Health Services for clients who are on a Benefit Package (BP) covering Reproductive Health Services.

Alert! Family Planning Only and TAKE CHARGE clients are **only** eligible to receive services that are related to preventing unintended pregnancy and are **not** eligible for other Reproductive Health Services.

Limited coverage

Under [WAC 182-507-0115](#), the Medicaid agency covers Reproductive Health Services under Alien Emergency Medical programs only when the services are directly related to an emergency medical condition.

Managed care clients

(WAC 182-532-100(2))

Clients enrolled in an agency-contracted managed care plan may self-refer to providers not contracted with their plan for:

- Family planning services (excluding sterilizations for clients 21 years of age or older)
- Abortions
- Sexually transmitted infection (STI) services

These clients may seek services from any of the following:

- Medicaid-approved family planning providers
- Medicaid agency-contracted local health departments or STI clinics
- Medicaid agency-contracted providers who provide abortion services
- Medicaid agency-contracted pharmacies

(See [how providers bill for managed care services](#) and WAC [182-532-140\(2\)](#))

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Washington Apple Health. For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Washington Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Health Care Coverage—Program Benefit Packages and Scope of Service Categories](#) web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

What services are covered?

(WACs [182-532-120](#), [-123](#), and [-125](#))

Along with services listed in [WAC 182-531-0100](#), the Medicaid agency covers all reproductive services listed in this section.

Covered services for women

(WACs [182-532-120](#) and [-123](#))

Yearly exams

Every female Medicaid client needing contraception and a yearly exam, as medically necessary, is eligible every 12 months for either:

- A cervical, vaginal, and breast cancer screening, which follows the guidelines of a nationally recognized protocol and may be billed by a provider other than a TAKE CHARGE provider.

-OR-

- An initial or yearly comprehensive prevention visit for family planning if provided (and billed) by one or more qualified [TAKE CHARGE providers](#).

Alert! A Medicaid client who is sterilized or otherwise not at risk for pregnancy does *not* qualify for a comprehensive prevention visit for family planning.

Bill one of these diagnosis codes with HCPCS code G0101 for women not needing or seeking contraception:

- V72.31 routine gynecological exam with Pap cervical smear;
- V76.47 routine vaginal Pap smear; or
- V76.2 cervical Pap smear without general gynecological exam.

Bill diagnosis code in the V25 series for the yearly comprehensive prevention visit for family planning.



The comprehensive prevention visit for family planning:

- ✓ Must include:
 - A clinical breast examination and a pelvic examination that follows the guidelines of a nationally recognized protocol.
 - Client-centered counseling that incorporates risk factor reduction for unintended pregnancy and anticipatory guidance about the advantages and disadvantages of all contraceptive methods. See [education and counseling for risk reduction \(ECRR\)](#) for more details.
- ✓ May include a pap smear according to current, nationally recognized clinical guidelines.

- ✓ Must be documented in the client’s chart with detailed information that allows for a well-informed follow-up visit.

For providers who have a delayed pelvic examination protocol, the comprehensive prevention visit may be divided between two visits. See [delayed pelvic examination](#) for more information.

See the [coverage table](#) for HCPCS and CPT® codes needed for billing and [reimbursement](#) for payment requirements and limitations.

Note: Only TAKE CHARGE providers can bill preventive CPT codes for the yearly comprehensive prevention visit for family planning. See the [coverage table](#). The comprehensive prevention visit for family planning cannot be billed on the same date of service as a cervical, vaginal and breast cancer examination (HCPCS code G0101) or a surgery.

Other covered services for women

Medicaid women also may receive the following Reproductive Health Services:

- Office visits when medically necessary
- Food and Drug Administration (FDA)-approved prescription and nonprescription contraception methods (see the [Prescription Drug Program Medicaid Provider Guide](#) for more information)
- Over-the-Counter (OTC) family planning drugs, devices, and drug-related supplies (as described in the Medicaid agency’s [Prescription Drug Program Medicaid Provider Guide](#))
- Emergency contraception, such as Plan B (as described in the agency’s [Prescription Drug Program Medicaid Provider Guide](#))
- Sterilization procedures that meet the requirements of [WAC 182-531-1550](#) and are:
 - ✓ Requested by the client
 - ✓ Performed in an appropriate setting for the procedure(s)

The surgeon’s initial office visit for sterilization is covered when billed with diagnosis code V25.2.



Alert! The sterilization consent form, mandated by federal law, must be completed at least 30 days, but no longer than 180 days prior to surgery.

See the [Sterilization Supplemental Medicaid Provider Guide](#) for more information.

- Screening and treatment for STI, including lab tests and procedures

Family Planning

- Education and supplies for FDA-approved contraceptives, natural family planning and abstinence
- Mammograms:
 - ✓ For clients 40 years of age and older, once every 12 months
 - ✓ For clients 39 years of age and younger with prior authorization

See the [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

- Colposcopy and related medically necessary follow-up services
- Maternity-related services (see “Maternity Care and Services” in the [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#))
- Abortion (see the [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).)

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations.

Covered services for men

In addition to those services listed in [WAC 182-531-0100](#), the Medicaid agency covers the following Reproductive Health Services for men:

- Office visits when there is a medical concern, including contraceptive and vasectomy counseling
- OTC contraceptive supplies (as described in the [Prescription Drug Program Medicaid Provider Guide](#))
- Sterilization procedures that meet the requirements of [WAC 182-531-1550](#) and are:
 - ✓ Requested by the client
 - ✓ Performed in an appropriate setting for the procedure(s)

The surgeon's initial office visit for sterilization is covered when billed with diagnosis code V25.2.



Alert! The sterilization consent form, mandated by federal law, must be completed at least 30 days, but no longer than 180 days, prior to surgery.

See the [Sterilization Supplemental Medicaid Provider Guide](#) for more information.

- Screening and treatment for STI, including lab tests and procedures
- Education and supplies for FDA-approved contraceptives, natural family planning, and abstinence
- Prostate cancer screening for men once per year, when medically necessary (see [billing and claim forms](#) for billing specifics)
- Diagnostic mammograms for men when medically necessary

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations.

What services are not covered?

(WAC [182-532-130](#))

The Medicaid agency does not cover the Reproductive Health Services listed as noncovered in the Medicaid agency's [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#) and [WAC 182-531-0150](#). The Medicaid agency reviews requests for noncovered services under [WAC 182-501-0160](#).

Family Planning Only Program

What is the purpose of the program?

(WAC [182-532-500](#))

The purpose of the Family Planning Only program is to provide family planning services to:

- Increase the healthy intervals between pregnancies.
- Reduce unintended pregnancies in women who received medical assistance coverage while pregnant.

Women receive these services automatically regardless of how or when the pregnancy ends. This 10-month coverage follows the Medicaid agency's 60-day postpregnancy coverage.

Men are not eligible for the Family Planning Only program.

What are the requirements for providers?

(WAC [182-532-520](#))

To be paid by the Medicaid agency for services provided to clients eligible for the Family Planning Only program, family planning providers must:

- Meet the requirements in [Chapter 182-502 WAC](#).
- Provide only those services within the scope of their licenses.
- Comply with the required general Medicaid agency policies and specific Family Planning Only provider policies, procedures, and administrative practices in this guide.
- Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services.
- Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies as medically necessary.

- Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies as medically appropriate.
- Refer the client to available and affordable nonfamily planning primary care services as needed.

Note: Providers who are unable to meet all of the provider requirements must refer the client to an appropriate provider.

Who is eligible for services?

(WAC [182-532-510](#))

A woman is eligible for Family Planning Only services if either:

- She received medical assistance coverage during her pregnancy.
- She is determined eligible for a retroactive period covering the end of the pregnancy.
- Her full scope medical coverage has ended.
- She is now enrolled for 10 months of the Family Planning Only Program.

She will continue to use the same medical Services Card that she received when she applied for pregnancy-related medical services.

What services are covered?

(WAC [182-532-530](#))

Yearly exams for Family Planning Only

Every Family Planning Only client needing contraception and a yearly exam, as medically necessary, is eligible every 12 months for either:

- A cervical, vaginal, and breast cancer screening.

-OR-

- An initial or yearly comprehensive prevention visit for family planning if provided (and billed) by one or more qualified [TAKE CHARGE providers](#).

Alert! A Medicaid client who is sterilized or otherwise not at risk for pregnancy does *not* qualify for a comprehensive prevention visit for family planning.

Cervical, vaginal, and breast cancer screening

These screenings:

- Must follow the guidelines of a nationally recognized protocol.
- Must be conducted at the time of an office visit with a primary focus and diagnosis of family planning.
- May be billed by a provider other than a TAKE CHARGE provider.

The comprehensive prevention visit for family planning

The comprehensive prevention visit for family planning:

- Must include:
 - ✓ A clinical breast examination and a pelvic examination that follows the guidelines of a nationally recognized protocol
 - ✓ Client-centered counseling that incorporates risk factor reduction for unintended pregnancy, and anticipatory guidance about the advantages and disadvantages of all contraceptive methods. See [education and counseling for risk reduction \(ECRR\)](#) for more details
- May include:
 - ✓ A Pap smear according to current, nationally recognized clinical guidelines
 - ✓ For women between the ages of 13 through 25, routine gonorrhea (GC) and chlamydia (CT) testing and treatment
- Must be documented in the client's chart with detailed information that allows for a well-informed follow-up visit

For providers who have a delayed pelvic examination protocol, the comprehensive prevention visit may be divided between two visits. (See [delayed pelvic examination](#) for more information.)

Note: Only TAKE CHARGE providers can bill preventive CPT codes for the yearly comprehensive prevention visit for family planning. See the [coverage table](#). The comprehensive prevention visit for family planning cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (G0101) or an office visit.

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations.

Other covered Family Planning Only services

Female clients also may receive the following Reproductive Health Services:

- Office visits directly related to family planning problems, when medically necessary
- Food and Drug Administration (FDA)-approved prescription and nonprescription contraceptive methods, as identified in [Chapter 182-530 WAC](#), including, but not limited to, the following items:
 - ✓ Birth control pills
 - ✓ Birth control patch
 - ✓ Birth control vaginal ring
 - ✓ Injectable and implantable hormonal contraceptives
 - ✓ Diaphragm and cervical cap and cervical sponge
 - ✓ Male and female condoms
 - ✓ Intrauterine devices (IUDs)
 - ✓ Spermicides (foam, gel, suppositories, and cream)
 - ✓ Emergency contraception

Note: Pap smears, while not technically related to any contraceptive method, may be provided according to the current standard of care and schedule. Providers must have and follow a Pap smear protocol based on the guidelines of a nationally recognized organization, such as the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), or the U.S. Preventive Services Task Force (USPSTF).

- Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies, as described in [chapter 182-530 WAC](#)
- Sterilization procedures that meet [WAC 182-531-1550](#) and are:
 - ✓ Requested by the client
 - ✓ Performed in an appropriate setting for the procedure

The surgeon's initial office visit for sterilization is covered when billed with diagnosis code V25.2.

Dx

Alert! The sterilization consent form, mandated by federal law, must be completed at least 30 days, but no longer than 180 days prior to surgery.

(See the [Sterilization Supplemental Medicaid Provider Guide](#) for more information.)

- Screening and treatment for sexually transmitted infection(s) (STI), including lab tests and procedures only when the screening and treatment either are:
 - ✓ For chlamydia and gonorrhea as part of the comprehensive prevention visit for family planning for women 13 through 25 years of age (GC or CT only)
- OR-
- ✓ Part of an office visit that has a primary focus of family planning, and is medically necessary for the client's safe and effective use of her chosen contraceptive method
- Education or supplies for FDA-approved contraceptives, natural family planning, and abstinence

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations.

Complications from contraceptive methods

Both inpatient and outpatient costs are covered when they result from a complication arising from covered Family Planning Only services. An example of a contraceptive complication is an IUD that migrated out of the uterus and needed to be removed by laparoscopy.

For the Medicaid agency to consider payment when complications occur, providers of Family Planning Only-related inpatient or outpatient services must submit to the Medicaid agency a claim with a complete report of the circumstances and conditions that caused the need for the inpatient or outpatient services (see [WAC 182-501-0160](#) and [WAC 182-532-540](#)).

A complete report includes:

- Letter of explanation
- Discharge summary
- Operative report (if applicable)

Notes: For information on how to submit a claim with attachments, see the [ProviderOne Resource and Billing Guide](#). For complications due to a birth control method, write "birth control complication" in field 19 in the CMS-1500 claim form.

What drugs and supplies are covered?

For the Family Planning Only program, the Medicaid agency pays for the family planning-related drugs and contraceptives within the following therapeutic classifications:

Contraceptives and supplies that may be dispensed from a Family Planning clinic	Family Planning related drugs and supplies that may be dispensed from a pharmacy
Azithromycin Condoms Contraceptives, implantable, systemic Contraceptives, injectables Contraceptives, intravaginal Contraceptives, transdermal Diaphragms/cervical caps Foams, gels, sponge, spermicides, vaginal film, creams. Intrauterine devices Oral contraceptives Vaginal lubricant preparations	Absorbable Sulfonamides Anaerobic antiprotozoal – antibacterial agents Antibiotics, misc. other Antifungal Agents Antifungal Antibiotics Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rd generation Condoms Contraceptives, implantable, systemic Contraceptives, injectables Contraceptives, intravaginal Contraceptives, transdermal Diaphragms/cervical caps Foams, gels, spermicides, vaginal film, creams. Intrauterine devices Macrolides Nitrofurans Derivatives Oral contraceptives Quinolones Tetracyclines Vaginal antibiotics Vaginal antifungals Vaginal lubricant preparations Vaginal Sulfonamides

Alert! For drugs related to sterilization procedures, see the [Sterilization Supplemental Medicaid Provider Guide](#).

Over-the-counter, nonprescribed contraceptive supplies (for example, condoms, spermicidal foam, cream, and gel) may also be obtained in a 30-day supply through a pharmacy or a family planning clinic using a Services Card.

Hormonal contraceptives dispensed from family planning clinics

The agency requires family planning clinics to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply (13 cycles). The agency encourages prescribers to include a dispensing quantity of a 12-month supply (13 cycles) on oral, transdermal, and intra-vaginal contraceptive prescriptions. For prescriptions written with a dispensing quantity less than a 12-month supply (13 cycles) you will begin receiving requests from pharmacies to change the dispensing quantity. Clinics may dispense or write the prescription for a lesser amount if either:

- the client does not want a 12 month supply all at once
- there is a clinical reason, documented in the chart, for the client to receive a smaller supply

Quantity required for twelve-month (13 cycles) to be dispensed	
Contraceptive type	Quantity
Oral contraceptives, e.g. pills	364 pills
Transdermal contraceptives, e.g. patch	39 transdermal patches
Intra-vaginal contraceptives, e.g. ring	13 intra-vaginal rings

This new requirement is for both fee-for-service and managed care clients.

Hormonal contraceptives filled at the pharmacy

The agency requires pharmacies to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply (13 cycles or 364 days). For prescriptions written with a dispensing quantity less than a 12 month supply, the agency encourages pharmacies to contact the prescriber to request a change in the dispensing quantity.

The agency is making this change as an attempt to reduce unintended pregnancy rates within our client population. According to the U.S. Selected Practice Recommendations for Contraceptive Use, MMWR volume 62, 2013, “The more pill packs given up to 13 cycles, the higher the continuation rates.” Further, the MMWR states, “In addition to continuation, a greater number of pill packs provided was associated with fewer pregnancy tests, fewer pregnancies, and lower cost per client.”

This new requirement is for both fee-for-service and managed care clients.

Note: All services and prescriptions billed for Family Planning Only clients **must** have a primary focus and diagnosis of family planning (the V25 series diagnosis codes, excluding V25.3).

What services are not covered?

(WAC [182-532-540](#))

Medical services are not covered under the Family Planning Only program unless those services are: performed in relation to a primary focus and diagnosis of family planning and are medically necessary for clients to safely and effectively use, or continue to use, their chosen contraceptive method.

Pregnancy-related services, including abortions, are not covered under the Family Planning Only program. Refer clients who become pregnant while on TAKE CHARGE or Family Planning Only to their local [Community Services Office](#).

Inpatient services

The Medicaid agency does not cover inpatient services under the Family Planning Only program except for complications arising from covered family planning services. For approval of exceptions, providers of inpatient services must submit a report to the Medicaid agency, detailing the circumstances and conditions that required inpatient services. (For details, see [complications from contraceptive methods](#).)

TAKE CHARGE Program

What is the purpose of TAKE CHARGE?

(WAC [182-532-700](#))

TAKE CHARGE is a family planning demonstration and research program. The purpose of this program is to make family planning services available to women and men with incomes at or below 260 percent of the federal poverty level. TAKE CHARGE is approved by the federal government under a Medicaid program waiver.

The goal of TAKE CHARGE is to reduce unintended pregnancies by offering family planning services to an expanded population of low-income women and men, and lower the expenditures for Medicaid-paid births.

TAKE CHARGE will increase access to family planning (birth control) services for persons who would find it difficult to become and/or remain self-sufficient because of an unintended pregnancy.

The program objectives are to:

- Decrease the number of unintended pregnancies.
- Increase the use of contraception methods.
- Increase the availability of family planning services for low-income women and men.
- Raise the provider's awareness about the importance of client-centered education, counseling, and risk reduction to increase successful use of contraception methods.

Note: A TAKE CHARGE client may be seen only by a [qualified TAKE CHARGE provider](#) and only for family planning services. Exceptions to this include sterilizations, pharmacy services, and lab services. See [when other providers give services to TAKE CHARGE clients](#) for further information. For detailed information about sterilization, see the [Sterilization Supplemental Medicaid Provider Guide](#).

What are the requirements for providers?

(WAC [182-532-730](#) and [182-532 -760](#))

Qualifications of approved providers

A TAKE CHARGE provider must:

- Be a family planning provider, which includes a registered nurse (RN), a licensed practical nurse (LPN), a trained and experienced health educator, a medical assistant, or a certified nursing assistant who assists family planning providers.
- Meet the requirements in chapter 182-502 WAC.
- Provide only those services that are within the scope of their licenses.
- Sign and comply with the TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program, according to the Medicaid agency's TAKE CHARGE program guidelines.
- Comply with the required general Medicaid agency policies and specific TAKE CHARGE provider policies, procedures, and administrative practices in this guide.
- Participate in the Medicaid agency's specialized training for TAKE CHARGE before providing TAKE CHARGE services.
- Document that each individual responsible for providing TAKE CHARGE services is trained on all aspects of the TAKE CHARGE program.
- If requested by the Medicaid agency, participate in the research and evaluation component of the TAKE CHARGE demonstration and research program.
- Provide TAKE CHARGE client files, billing, and medical records when requested by Medicaid agency staff.

Client services

Qualified TAKE CHARGE providers must:

- Provide service to eligible clients under state and federal law and in accordance with the TAKE CHARGE WACs 182-532-700 through -790.
- If requested by the client, forward the client's services card and any related information to the client's preferred address within five working days of receipt.

- Inform the client of his or her right to seek services from any TAKE CHARGE provider within the state.

Note: It is important for the client to have easy and immediate access to the TAKE CHARGE provider or pharmacy of her or his choice. A client may enroll in the TAKE CHARGE program at one TAKE CHARGE provider's office and receive services at a different TAKE CHARGE provider's office. TAKE CHARGE providers must help all potentially eligible clients enroll in the program, regardless of where they choose to receive services.

- Provide referral for clients relating to available and affordable nonfamily planning primary care services, as needed.

Confidentiality, consent, and release of information

Under the TAKE CHARGE agreement and state and federal law, TAKE CHARGE providers must:

- Follow federal [Health Insurance Portability and Accountability Act \(HIPAA\)](#) requirements in safeguarding the confidentiality of clients' records. These safeguards must:
 - ✓ Allow for timely sharing of information with appropriate professionals and agencies on the client's behalf.
 - ✓ Ensure that confidentiality of disseminated information is protected.

(Also, see [Chapter 70.02 RCW](#) for more details.)

- Ensure that all necessary forms are accurately and fully completed:
 - ✓ Informed consent as defined in [WAC 182-531-0050](#) and as required by [WAC 182-531-1550](#), as necessary
 - ✓ Consent form [HCA 13-364](#), for all sterilization procedures (see the [Sterilization Supplemental Medicaid Provider Guide](#) for requirements and instructions)
 - ✓ Authorization from clients for release of information
- Ensure the proper release of client information:
 - ✓ To transfer information to another approved TAKE CHARGE provider when a client changes providers or when the provider is unable to provide services (in a timely manner).

- ✓ To transfer information to a primary care provider when a client is in need of non-family planning related services.
- ✓ To conform to all applicable state and federal laws.

Client records

(WAC [182-532-760](#) and [182-502-0020](#))

In addition to the documentation requirements listed in [WAC 182-502-0020](#), TAKE CHARGE providers must keep all the following records:

- Chart notes reflecting that the primary focus and diagnosis of the visit was family planning
- Contraceptive methods discussed with the client
- Notes on any discussions of emergency contraception and needed prescription(s)
- The client's plan for the contraceptive method to be used, or the reason for no contraceptive method and plan
- Documentation for the [education, counseling and risk reduction](#) (ECRR) service, if provided with sufficient detail that allows for follow up
- Documentation of referrals to or from other providers
- A form signed by the client authorizing release of information for referral purposes, as necessary
- A copy of the completed Sterilization Consent form, [HCA 13-364](#), as necessary (for more information about sterilization, including the consent form, see the [Sterilization Supplemental Medicaid Provider Guide](#) or call the Family Planning Program Manager and see [resources available](#).)
- The client's written and signed consent requesting that his or her service card be sent to the TAKE CHARGE provider's office to protect confidentiality

When the alternative address is that of a TAKE CHARGE provider, the provider must notify the client within 5 business days that they have important, time-sensitive correspondence that is available for them to pick up. The provider must document this in the application and chart.

Note: If the client wishes to maintain confidentiality regarding the use of family planning services, the provider must have some way of reaching the client.

Other documentation requirements

TAKE CHARGE providers must keep the following records:

- TAKE CHARGE application forms, along with supporting documentation, if needed
- Signed supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE program
- Documentation of the agency's specialized TAKE CHARGE training and/or in-house TAKE CHARGE training for each individual providing TAKE CHARGE services

Evaluation and research responsibilities

If requested by the Medicaid agency, TAKE CHARGE providers must be willing to participate in the research and evaluation component of TAKE CHARGE.

Some services related to research and evaluation may be contracted and billed separately.

When may other providers give services to TAKE CHARGE clients?

(WAC [182-532-730\(2\)](#))

Other Medicaid providers—who are not TAKE CHARGE providers—may give certain specific services to eligible TAKE CHARGE clients. (Examples of other Medicaid agency providers are: pharmacies, labs, and surgeons performing sterilization procedures and sterilization-related services.) For details, see the [Sterilization Supplemental Medicaid Provider Guide](#).

These services may include:

- Family planning pharmacy services
- Family planning lab services
- Sterilization services
- Radiology services related to contraceptive method

Clients are allowed to enroll in TAKE CHARGE programs to obtain contraceptives appropriately prescribed by a non-TAKE CHARGE provider.

Alert! Providers without signed TAKE CHARGE agreements are reimbursed by the Medicaid agency only for a clinic visits that are related to sterilization or complications from a birth control method. (WAC 182-532-780)

The Medicaid agency pays for these services under the rules and fee schedules applicable to the specific services provided under the Medicaid agency's other programs.

Note: The family planning provider's partnership with pharmacists is especially critical since they provide immediate access to methods not received at the TAKE CHARGE clinic.

Who is eligible for services?

(WAC [182-532-720](#))

The TAKE CHARGE program is for both men and women.

- To be eligible for the TAKE CHARGE program, applicants must meet all the following requirements:
 - ✓ Be a United States citizen, U.S. National, or "qualified alien" as described in WAC 182-503-0530, and give proof of citizenship or qualified alien status and identity upon request from the Medicaid agency
 - ✓ Provide a valid Social Security Number (SSN)
 - ✓ Be a resident of the state of Washington as described in [WAC 388-468-0005](#)
 - ✓ Have income at or below 260 percent of the federal poverty level (FPL) as described in [WAC182-505-0100](#)
 - ✓ Apply voluntarily for family planning services with a TAKE CHARGE provider
 - ✓ Applicants must not be covered by other public or private insurance.
 - ✓ Need family planning services and not be currently covered by or eligible for another medical assistance program for family planning

Alert! Always check ProviderOne to make sure that a client's one-year eligibility for TAKE CHARGE is still valid, or that the client is not on another Medicaid agency program that covers family planning services. Clients who are currently pregnant, sterilized, or incarcerated are not eligible for TAKE CHARGE.

- A client who is pregnant or sterilized is not eligible for TAKE CHARGE.
- A client is authorized for TAKE CHARGE coverage for one year from the date the Medicaid agency determines eligibility. Upon reapplication for TAKE CHARGE by the client, the Medicaid agency may renew the coverage for additional periods of up to one year or for the duration of the waiver, whichever is shorter.

Specific eligibility criteria for TAKE CHARGE

Topic	Eligible	Not Eligible	Notes
Need for family planning	The applicant must state that they need family planning	The applicant is not in need of family planning and not eligible for TAKE CHARGE if the applicant: <ul style="list-style-type: none"> • Has been sterilized. • Is seeking pregnancy. • Does not plan to use birth control. • Is pregnant. 	
Health insurance including Medicaid		A current client of the Medicaid agency with family planning coverage, such as categorically needy coverage (CNP), is not eligible for TAKE CHARGE. Clients with health insurance may not apply for TAKE CHARGE.	Beginning January 1, 2014, clients with health insurance coverage are no longer eligible to apply for TAKE CHARGE. All services covered under TAKE CHARGE are now covered by insurance with no co-pays or deductibles.
Incarcerated clients		Incarcerated clients, including those in Work Release programs, are not eligible for TAKE CHARGE because their health care needs are covered by the jail/prison. They are prohibited by Medicaid rules from receiving Medicaid benefits.	
Residency requirements	The applicant for TAKE CHARGE services must reside in the state of Washington (for example, not residing in Oregon or Idaho).		

Topic	Eligible	Not Eligible	Notes
College students	<p>Washington residents attending school out-of-state meet residency requirements if they:</p> <ul style="list-style-type: none"> • Are attending college out-of-state. • Primarily reside in Washington. • Intend to remain to Washington after college. 	<p>Out-of-state college students attending school in Washington State are not considered permanent Washington residents if they do not plan to remain in Washington when their schooling is complete. They do not qualify for the TAKE CHARGE program.</p> <p>Foreign students or visiting foreign nationals are not considered legal permanent residents; they are temporarily in Washington State and are not eligible for TAKE CHARGE.</p>	

Family Planning

Topic	Eligible	Not Eligible	Notes
Income requirements and family size	Applicant meets the eligibility requirement of 260 percent of Federal Poverty Level (FPL) or below	<ul style="list-style-type: none"> • Adult clients, 19 and over, who are below 150% of the FPL, must apply for Apple Health (Medicaid) and be denied before applying for TAKE CHARGE. • (It is advantageous to both providers and clients for a client to have expanded Medicaid coverage.) 	<ul style="list-style-type: none"> • Married clients—Use both the client’s and spouse’s incomes to determine potential financial eligibility, entering both income separately. • Single clients—Use gross income to determine potential financial eligibility. • To check the current Federal Poverty Level (FPL) Rates, see the TAKE CHARGE provider web page. • If the client reports “0” income, the client must explain on the application how they meet their basic needs, such as food, clothing, shelter, and other necessities. <p>Examples of explanations for “0” income:</p> <p>“Parents support me.”</p> <p>“My boyfriend/girlfriend supports me.”</p> <p>Alert! Remind all clients that their reported gross income will be verified.</p>
Adolescents	Applicant meets the eligibility requirement of 260 percent of FPL or below		For adolescents 17 years of age or younger, use the client’s income to determine income eligibility regardless of the parents’ income.

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations; and [billing for third-party liability and “good cause”](#) for more information.

How can clients apply for TAKE CHARGE?

Applicants must apply in person for TAKE CHARGE at a Medicaid agency-approved TAKE CHARGE clinic. Final client eligibility is determined by the agency.

- Only applicants seeking and needing family planning services and supplies should be given a TAKE CHARGE application.

Some clients may apply at a TAKE CHARGE provider and intend to see their usual physician and will use TAKE CHARGE to cover their contraceptives at the pharmacy. This is a legitimate use of TAKE CHARGE.

- Clinic staff should not routinely give TAKE CHARGE applications to every client who comes in to the office or clinic. Applications must be given only to clients seeking to avoid an unintended pregnancy.
- Sometimes, the client applies for TAKE CHARGE after seeing a clinician, who determines that enrolling in TAKE CHARGE is appropriate for the client.

It's to the provider's benefit to:

- Help the client (applicant) accurately complete the required TAKE CHARGE application on a question-by-question basis, if needed. (This may mean reading the entire application for clients with low literacy skills or translating each question and answer for clients who use English as a second language.)
- Help clients 19 and over apply for Washington Apple Health (Medicaid) before applying for TAKE CHARGE to determine that the client is not eligible for more comprehensive coverage.
- Counsel clients about the importance of being accurate and honest on their application.
- Inform clients that the eligibility information, they provide—including income, Social Security Number, and residency—will be verified by the Medicaid agency.
- Inform clients that they may give their permission for an authorized representative (an AREP) to talk with the Medicaid agency about the client's application and benefits.
 - ✓ This representative may be a specific person or the client's TAKE CHARGE provider.
 - ✓ If a client chooses an AREP, they may still receive TAKE CHARGE information at their mailing address.

Alert! Providers must not complete the AREP section of the application for their clients. If providers offer a stamp with the clinic's name and address, clients must initial the stamped information to indicate that they are requesting the assistance of an AREP if needed.

- Counsel clients about their choice for alternate ways to receive their TAKE CHARGE information, which can be written on the TAKE CHARGE application. Clients may:
 - ✓ Have the information come directly to their home or mailing address.
 - ✓ Have the information sent to the TAKE CHARGE clinic, the AREP's mailing address, or another address of their choice for reasons of privacy or confidentiality.

Alert! If an alternative address is requested by the client, the provider must forward the client's service card and any related information to the client's preferred address within 5 working days of receipt. (See WAC 182-532-730 (g)) The provider must document this in the application and chart. A copy of the client's request must be kept in the [client records](#).

Reviewing the client's application

Providers should review the TAKE CHARGE client application for completeness and accuracy before the client signs the application and leaves the office. See the [TAKE CHARGE provider web page](#) for a checklist to use in reviewing a client's application.

- If it appears the client does not meet eligibility requirements, for instance, if a client is not a U.S. citizen:
 - ✓ Do not have the client sign the application.
 - ✓ Inform the client they do not meet the eligibility requirements.
 - ✓ Inform them about other Medicaid agency programs that may fit the client's needs and eligibility.
 - ✓ Shred the application.
- If it is likely that the client meets the eligibility requirements:
 - ✓ Make a copy of the client's U.S. Citizenship and Immigration Services (USCIS) paperwork and photo ID if the client is a U.S. national or qualified alien. Retain a copy of these documents with the client's application.

- ✓ Have the client sign the application.
- ✓ Within 5 business days of the client's signature, mail or fax the application and any other required documents to the TAKE CHARGE eligibility unit at:

TAKE CHARGE Eligibility Unit
Medical Eligibility Determination Services
PO Box 45531
Olympia, Washington 98504
Fax: 866-841-2267

The Medicaid agency's TAKE CHARGE eligibility unit determines client eligibility.

Processing the client's application

Every application that comes into the Medicaid agency's eligibility unit is thoroughly reviewed.

- The TAKE CHARGE eligibility unit must process applications within 45 days of receipt.
- Providers may check [ProviderOne](#) after 45 days to see if the client has been enrolled.

Note: Clients can contact the eligibility unit at 1-800-562-3022 and say "TAKE CHARGE" from the main menu when prompted, or use extension 15481.

Notifying the client about eligibility status

Approval

If the Medicaid agency approves eligibility, the client will receive an approval letter for services and a client service card in the mail, along with any related information from the Medicaid agency. If, on the application, the client has elected to use an alternative address, the Medicaid agency will send the information to that address.

One year of eligibility starts at the beginning of the month the approved application was signed by the client.

Note: At the end of the eligibility year, the client may reapply for services. The client may reapply every 12 months until the TAKE CHARGE program ends or the client is no longer eligible. If a client enrolls in another Medicaid agency program that covers family planning services, the client is no longer eligible for TAKE CHARGE.

Denial or pending status

The client receives a letter from the TAKE CHARGE eligibility unit if the Medicaid agency denies eligibility, or if eligibility is pending for more information. After receiving a letter indicating eligibility is pending, clients must respond to the agency with verification within 10 days or the application will be denied.

What services are covered?

(WAC [182-532-740](#))

The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. All services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.

Covered services for women in TAKE CHARGE

Yearly exam

Every female TAKE CHARGE client needing contraception and a yearly exam, as medically necessary, is eligible every 12 months for either:

- A cervical, vaginal, and breast cancer screening.

-OR-

- An initial or yearly comprehensive prevention visit for family planning if provided (and billed) by one or more [qualified TAKE CHARGE providers](#).

Alert! A Medicaid client who is sterilized or otherwise not at risk for pregnancy does *not* qualify for a comprehensive prevention visit for family planning.

Cervical, vaginal, and breast cancer screening

These screenings:

- Must follow the guidelines of a nationally recognized protocol.
- Must be conducted at the time of an office visit with a primary focus and diagnosis of family planning.
- Must be provided by a TAKE CHARGE provider.

The comprehensive prevention visit for family planning

The comprehensive prevention visit for family planning:

- Must include:
 - ✓ A clinical breast examination and a pelvic examination that follows the guidelines of a nationally recognized protocol.
 - ✓ Client-centered counseling that incorporates risk factor reduction for unintended pregnancy, and anticipatory guidance about the advantages and disadvantages of all contraceptive methods. See [education and counseling for risk reduction \(ECRR\)](#) for more details.
- May include:
 - ✓ A Pap smear according to current, nationally recognized clinical guidelines.
 - ✓ For women between the ages of 13 through 25, routine gonorrhea (GC) and chlamydia (CT) testing and treatment .
- Must be documented in the client's chart with detailed information that allows for a well-informed follow-up visit.

For providers who have a delayed pelvic examination protocol, the comprehensive prevention visit may be divided between two visits. (See [delayed pelvic examination](#) for more information.)

Note: Only TAKE CHARGE providers can bill preventive CPT codes for the yearly comprehensive prevention visit for family planning. See the [coverage table](#). The comprehensive prevention visit for family planning cannot be billed on the same date of service with a cervical, vaginal and breast cancer examination (HCPCS code G0101) or an office visit.

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations.

Other covered services for women in TAKE CHARGE

Women also may receive the following Reproductive Health Services:

- Office visits directly related to a family planning problem, when medically necessary
- Food and Drug Administration (FDA)-approved prescription and nonprescription contraceptives as provided in [Chapter 182-530 WAC](#), including, but not limited to, the following items:
 - ✓ Birth control pills
 - ✓ Birth control patch
 - ✓ Birth control vaginal ring
 - ✓ Injectable and implantable hormonal contraceptives
 - ✓ Diaphragm and cervical cap and cervical sponge
 - ✓ Male and female condoms
 - ✓ Intrauterine devices (IUDs)
 - ✓ Spermicides (foam, gel, suppositories, and cream)
 - ✓ Emergency contraception

Note: Pap smears, while not technically related to any contraceptive method, may be provided according to the current standard of care and schedule. Providers must have and follow a Pap smear protocol based on the guidelines of a nationally recognized organization, such as the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), or the U.S. Preventive Services Task Force (USPSTF).

- Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies, as described in [chapter 182-530 WAC](#)
- Sterilization procedures that meet the requirements of [WAC 182-531-1550](#) and are:
 - ✓ Requested by the client
 - ✓ Performed in an appropriate setting for the procedure(s)

The surgeon's initial office visit for sterilization is covered when billed with diagnosis code V25.2.

Dx

Alert! The sterilization consent form, mandated by federal law, must be completed at least 30 days, but no longer than 180 days prior to surgery.

(See the [Sterilization Supplemental Medicaid Provider Guide](#) for more information.)

- Screening and treatment for STIs, including lab tests and procedures *only* when the screening and treatment are:
 - ✓ For chlamydia and gonorrhea as part of the comprehensive prevention visit for family planning for women 13 through 25 years of age.

-OR-

- ✓ Part of an office visit that has a primary focus of family planning and is medically necessary for the client's safe and effective use of her chosen contraceptive method.
- Education and supplies for FDA-approved contraceptives, natural family planning and abstinence

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations.

Covered services for men in TAKE CHARGE

Men may be enrolled in TAKE CHARGE if they are specifically seeking family planning services (such as sterilization), and/or contraceptive supplies (such as condoms and spermicides) for the purposes of preventing unintended pregnancy. TAKE CHARGE offers limited services to men:

- Office visits or physical exams are covered only when related to and necessary for sterilization
- STI screening or treatment is covered only when related to and necessary for a sterilization procedure

Alert! HIV counseling and testing are not covered under TAKE CHARGE.

The Medicaid agency offers all of the following TAKE CHARGE services for men:

- Over-the-counter (OTC) contraceptive supplies (as described in the Medicaid agency's [Prescription Drug Program Medicaid Provider Guide](#))
- Sterilization procedures that meet the requirements of [WAC 182-531-1550](#), if the service is:
 - ✓ Requested by the TAKE CHARGE client
 - ✓ Performed in an appropriate setting for the procedure

The surgeon's initial office visit for sterilization is covered when billed with diagnosis code V25.2.

Dx

Alert! The sterilization consent form, mandated by federal law, must be completed at least 30 days, but no longer than 180 days, prior to surgery.

See the [Sterilization Supplemental Medicaid Provider Guide](#) for more information.

- Screening and treatment for sexually transmitted infections (STI), including lab tests and procedures, only when the screening and treatment are related to and medically necessary for a sterilization procedure
- Education and supplies for FDA-approved contraceptives, natural family planning and abstinence

- One [education and counseling for risk reduction \(ECRR\)](#) session per client every 12 months for those male clients whose female partners are at moderate or high risk for unintended pregnancy. ECRR must be:
 - ✓ Provided by one or more [qualified TAKE CHARGE providers](#).
 - ✓ Documented in the client’s chart with detailed information that allows for a well-informed follow-up visit.

See the [coverage table](#) for HCPCS and CPT codes needed for billing and [reimbursement](#) for payment requirements and limitations

Complications from contraceptive methods

Both inpatient and outpatient costs are covered when they result from a complication arising from covered TAKE CHARGE services. An example of a contraceptive complication is an IUD that migrated out of the uterus and needed to be removed by laparoscopy.

Providers do not have to be TAKE CHARGE providers if they are seeing a client for complications related to their birth control method.

For the Medicaid agency to consider payment when complications occur, providers of TAKE CHARGE-related inpatient or outpatient services must submit to the Medicaid agency a claim with a complete report of the circumstances and conditions that caused the need for the inpatient or outpatient services (see [WAC 182-501-0160](#) and [WAC 182-532-780](#)).

A complete report includes:

- Letter of explanation
- Discharge summary
- Operative report (if applicable)

Notes: For information on how to submit a claim with attachments, the [ProviderOne Resource and Billing Guide](#). For complications due to a birth control method, write “birth control complication” in field 19 in the CMS-1500 claim form.

What drugs and supplies are covered?

The Medicaid agency pays for the family planning-related drugs and contraceptives within the following therapeutic classifications:

Contraceptives and supplies that may be dispensed from a Family Planning clinic	Contraceptives and supplies that may be dispensed from a pharmacy	Family Planning-related drugs that <i>may</i> be dispensed from a pharmacy
Azithromycin Condoms Contraceptives, implantable, systemic Contraceptives, injectables Contraceptives, intravaginal Contraceptives, transdermal Diaphragms/cervical caps Foams, gels, sponge, spermicides, vaginal film, creams. Intrauterine devices Oral contraceptives Vaginal lubricant preparations	Condoms Contraceptives, implantable, systemic Contraceptives, injectables Contraceptives, intravaginal Contraceptives, transdermal Diaphragms/cervical caps Foams, gels, spermicides, vaginal film, creams. Intrauterine devices Oral contraceptives Vaginal lubricant preparations	Absorbable Sulfonamides Anaerobic antiprotozoal – antibacterial agents Antibiotics, misc. other Antifungal Agents Antifungal Antibiotics Cephalosporins – 1st generation Cephalosporins – 2nd generation Cephalosporins – 3rd generation Macrolides Nitrofurans Derivatives Quinolones Tetracyclines Vaginal Antibiotics Vaginal antifungals Vaginal Sulfonamides

Note: For drugs related to sterilization procedures, see the [Sterilization Supplemental Medicaid Provider Guide](#).

Over-the-counter, nonprescribed contraceptive supplies (for example, condoms, spermicidal foam, cream, or gel) may also be obtained in a 30-day supply through a pharmacy or a family planning provider using a Services Card.

Hormonal contraceptives dispensed from family planning clinics

The agency requires family planning clinics to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply (13 cycles). The

agency encourages prescribers to include a dispensing quantity of a 12-month supply (13 cycles) on oral, transdermal, and intra-vaginal contraceptive prescriptions. For prescriptions written with a dispensing quantity less than a 12-month supply (13 cycles) you will begin receiving requests from pharmacies to change the dispensing quantity. Clinics may dispense or write the prescription for a lesser amount if either:

- the client does not want a 12 month supply all at once
- there is a clinical reason, documented in the chart, for the client to receive a smaller supply

Quantity required for twelve-month (13 cycles) to be dispensed	
Contraceptive type	Quantity
Oral contraceptives, e.g. pills	364 pills
Transdermal contraceptives, e.g. patch	39 transdermal patches
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This new requirement is for both fee-for-service and managed care clients.

Hormonal contraceptives filled at the pharmacy

The agency requires pharmacies to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply (13 cycles or 364 days). For prescriptions written with a dispensing quantity less than a 12 month supply, the agency encourages pharmacies to contact the prescriber to request a change in the dispensing quantity.

The agency is making this change as an attempt to reduce unintended pregnancy rates within our client population. According to the U.S. Selected Practice Recommendations for Contraceptive Use, MMWR volume 62, 2013, “The more pill packs given up to 13 cycles, the higher the continuation rates.” Further, the MMWR states, “In addition to continuation, a greater number of pill packs provided was associated with fewer pregnancy tests, fewer pregnancies, and lower cost per client.”

This new requirement is for both fee-for-service and managed care clients.

Note: All services provided to TAKE CHARGE clients must have a primary focus and diagnosis of family planning (that is, a diagnosis code within the V25 series, excluding V25.3). All services related to sterilization must be billed with the sterilization diagnosis code V25.2.

What services are not covered?

(WAC [182-532-750](#))

The Medicaid agency does not cover medical services under the TAKE CHARGE program unless those services are performed in relation to a primary focus and diagnosis of family planning; and are medically necessary for clients to safely and effectively use, or continue to use, their chosen contraceptive method.

Pregnancy-related services, including abortions, are not covered under the TAKE CHARGE program. Refer clients who become pregnant while on TAKE CHARGE or Family Planning Only to their local [Community Services Office](#).

Note: The purpose of the TAKE CHARGE program is to prevent unintended pregnancies. Services provided under TAKE CHARGE must be related to the prevention of unintended pregnancy.

Inpatient services

The Medicaid agency does not cover inpatient services under the TAKE CHARGE program except for complications arising from covered family planning services. For approval of exceptions, providers of inpatient services must submit a report to the Medicaid agency, detailing the circumstances and conditions that required inpatient services. (For details, see [complications from contraceptive methods](#).)

Education and Counseling for Risk Reduction (ECRR)

The cornerstone of Medicaid family planning services is the client-centered education and counseling for risk reduction service (ECRR). ECRR is designed to strengthen decision making skills and support a client's safe and effective use of the chosen contraceptive method. ECRR must be provided by a [qualified TAKE CHARGE provider](#).

Note: The counseling intervention must be clearly documented in the client's chart with detailed information that would allow for a meaningful, well-informed follow-up visit.

What ECRR services are available for women?

ECRR services are offered as part of the annual comprehensive prevention visit for family planning in the Reproductive Health Services, Family Planning Only and TAKE CHARGE programs when provided by a TAKE CHARGE provider. ECRR is not a stand-alone, billable service. This visit, focusing on the prevention of unintended pregnancy, should be client centered. There are some women who have a history of consistent and effective use of their contraceptive method. If, at the time of their visit, all indications are that they will continue to use their contraceptives successfully, then these clients will need minimal counseling.

Some clients are generally satisfied and successful with their chosen method, but may have an occasional problem or lapse with their method that could result in them being at moderate risk for unintended pregnancy. These clients need some counseling and help with strategizing about back-up methods.

There are other, high-risk clients who have significant problems that interfere with their ability to use contraceptives consistently or effectively. These clients are at significantly increased risk for an unintended pregnancy and often need lengthy counseling and referrals for psycho-social issues that complicate their lives and their ability to use contraception.

The reimbursement for education and risk reduction counseling for unintended pregnancy is the same, regardless of the risk of unintended pregnancy.

Notes: The counseling intervention must be clearly documented in the client’s chart, with detailed information that would allow for a meaningful, well-informed, follow-up visit. For clients at high risk of contraceptive failure and unintended pregnancy, bill using the modifier SK to enable the Medicaid agency to evaluate the reimbursement of the preventive codes.

What ECRR services are available for men?

Men are eligible for one session of ECRR in TAKE CHARGE once every 12 months when they are seeking family planning services and have female sexual partners who are at moderate to high risk for unintended pregnancy. Men are not eligible for ECRR services if their partners have had a tubal ligation or are using an IUD, Depo-Provera, or Implanon/Nexplanon. ECRR must be:

- Provided by one or more of [qualified TAKE CHARGE providers](#).
- Documented in the client’s chart with detailed information that allows for a well-informed follow-up visit.

ECRR must be appropriate and individualized to the client’s needs, age, language, cultural background, risk behaviors, and psychosocial history.

ECRR is not an automatic service for every male seen by a TAKE CHARGE provider. This service should not be used to cover the cost of providing other Reproductive Health Services for men. This includes STI counseling, testing and treatment, which are not covered by TAKE CHARGE. The Medicaid agency will closely monitor the provision of this service to men.

Note: The only office visit the agency allows on the same day as ECRR is the initial preoperative sterilization visit. TAKE CHARGE offers very limited services to men.

What are the components for the ECRR intervention?

Five critical components, labeled A-E in this section, are a part of the ECRR intervention. Integrate these five components into the counseling process by following the client’s lead. Individual components may overlap with the other components. For high-risk clients, family planning providers must address and document all five components by the close of the client/provider interaction.

Clients may have just one factor in their life that puts them at increased risk for pregnancy, but most often, risk factors occur in clusters. Below is a list (not all-inclusive) of some of the critical components and factors that would indicate that a client will likely need some in-depth education and counseling to support the safe and effective use of the chosen contraceptive method.

Charting both the client’s history and counseling intervention must be detailed and thorough. This will facilitate a more meaningful and effective follow-up at the client’s next visit.

Component A: Method

Help the client (male or female) critically evaluate which contraceptive method is most acceptable and which method they can most effectively use.

- Focus first on the client’s choice of method.
- Assess and clarify knowledge, assumptions, misinformation, and myths about their chosen method(s).
- Describe method benefits, including noncontraceptive benefits.
- Address potential side effects and health risks.
- Provide written materials that are culturally sensitive, clear, relevant, and easy to understand.
- Provide a telephone number to call if the client has questions.

High Risk	Low or No Risk
<ul style="list-style-type: none"> • Ambivalent about using birth control • Ambivalent about having sex • Fearful/concerned about side effects • Difficulty reading/understanding written materials • No partner support • Pattern of no follow through on previous birth control methods • Method of choice has contraindications (for example, a smoker wants the pill) • Younger teens • Belief that she cannot get pregnant (or that he cannot get her pregnant) • Ambivalent about preventing pregnancy 	<ul style="list-style-type: none"> • Use and continual use of successful method • Already knowledgeable and motivated • Access easy (teen clinic nearby or at school) • Method easy to use • Goal oriented (will not let anything get in the way, such as, college or business venture) • Confident, self-assured

Component B: Personal

Assess and address other client personal considerations, risk factors, and behaviors impacting their use of contraception, and Make community referrals as necessary (for example, domestic violence shelters and hotlines, food bank, mental health, substance abuse, other primary care needs).

At a minimum, assess the following:

- History of abuse
- Current exploitation or abuse
- Current living situation
- Need for confidentiality

High Risk	Low or No at Risk
<ul style="list-style-type: none"> • Low literacy level/education level • Transportation issues/other access issues • Confidentiality of method • Substance abuse • Abusive relationship • History of sexual abuse • Relationship status (such as length) • Inability to meet basic needs • Living conditions • Low self-esteem • No life goals (goals for future) • Apathetic about future • Mental health issues • Maturity level • Age at first intercourse • Number of pregnancies • Cultural beliefs • Negative peer pressure • Family history of teen pregnancy 	<ul style="list-style-type: none"> • Stable living environment • No negative history of abuse • Determination/intent not to become pregnant • Good support system • Positive peer pressure

Component C: Partner

Facilitate a discussion of the male role in successfully using a chosen contraceptive method as appropriate (for himself or for his female partner).

- With both female and male clients, assess and address partner issues (for example, attitudes about birth control methods and how much the partner will be involved).
- Reinforce male involvement in pregnancy prevention.
- Discuss the male’s role in supporting a partner’s use of an individual method, as appropriate.

High Risk	Low or No Risk
<ul style="list-style-type: none"> • Multiple partners • Lack of communication • Abusive partner • Drug-using partner • Controlling partner • Unsupportive/uninvolved partner • Apathetic • Partner unwilling to help with cost 	<ul style="list-style-type: none"> • Involved partner/interested • Supportive partner • Communicative partner • Monogamous or long-term partner • Trustworthy partner • Responsible partner • Partner comes to appointment • Impotent partner • Information seeking partner • Consistent method used by partner • Offers financial support

Component D: Contingency Planning

- Facilitate the client’s contingency planning (the “back-up method”) regarding the client’s use of contraception, including planning for emergency contraception.
- Address side effects of the client’s chosen method, and make sure the client knows what to do if there are side effects.
- Discuss back-up methods with the client.
- Provide information about access to emergency contraception as it relates to errors or problems with the chosen method.
- Provide a telephone number for the client to call with questions or concerns.

High Risk	Low or No Risk
<ul style="list-style-type: none"> • Mental illness • Developmental delays • Substance abuse • Transportation issues/other access issues • Uncooperative partner • Secretive seeking of contraception • Contraception in conflict with personal/religious beliefs • Misinformation • Allergies (such as latex) • Ambivalence about sex/contraception 	<ul style="list-style-type: none"> • Mentally healthy • No developmental delays • No substance abuse • Access to transportation • Supportive partner • Openness about contraceptive use • No conflict with personal/religious beliefs • Well informed • No allergies

Component E: Follow Up

When medically necessary, schedule follow-up appointments for birth control evaluation at or before three months, or as appropriate for the method chosen.

- Address questions about method use and follow-up appointment, as needed.
- Reinforce positive contraceptive and other self-protective behaviors.
- Follow up on any community referrals, as necessary.

High Risk	Low or No Risk
<ul style="list-style-type: none"> • Transportation challenges • Problems getting child care • Lack of accessibility for phone • Lack of support or opposition from partner • No sick leave from work • Chaos or instability in personal life 	<ul style="list-style-type: none"> • Access to transportation • Good child care options • Adequate phone access • Supportive partner • Adequate sick leave • Stable and organized in personal life

Coverage Table

Note: For sterilization procedure codes, see the [Sterilization Supplemental Medicaid Provider Guide](#).

Note: For billable codes and fees for nonfamily planning Reproductive Health Services, refer to the [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#). Only the provider who rendered the services is allowed to bill for those services, except in the case where a client self-refers outside the Medicaid agency-contracted managed care plan for family planning services.

Note: Due to its licensing agreement with the American Medical Association, the agency publishes only the official, short CPT™ code descriptions. To view the full descriptions, refer to a current CPT book.

Office visits

HCPCS/ CPT Code	Short Description	Comments
99201	Office/outpatient visit, new	
99202	Office/outpatient visit, new	
99203	Office/outpatient visit, new	
99204	Office/outpatient visit, new	
99211	Office/outpatient visit, est	
99212	Office/outpatient visit, est	
99213	Office/outpatient visit, est	
99214	Office/outpatient visit, est	
G0101	CA screen; pelvic/breast exam	Once every 11-12 months

Comprehensive prevention visit for family planning

Note: Use modifier FP when billing for comprehensive prevention visit for family planning. Without this modifier, the claim will be denied for family planning services.

HCPCS/ CPT Code	Modifier	Short Description	Comments
99384	FP	Adolescent (age 12 through 17)	New (female) patient. Once every 11-12 months. Only TAKE CHARGE providers can bill.
99385	FP	18-39 years	New (female) patient. Once every 11-12 months. Only TAKE CHARGE providers can bill.
99386	FP	40-64 years	New (female) patient. Once every 11-12 months. Only TAKE CHARGE providers can bill.
99394	FP	Adolescent (age 12 through 17)	Established (female) patient. Once every 11-12 months. Only TAKE CHARGE providers can bill.
99395	FP	18-39 years	Established (female) patient. Once every 11-12 months. Only TAKE CHARGE providers can bill.
99396	FP	40-64 years	Established (female) patient. Once every 11-12 months. Only TAKE CHARGE providers can bill.

Delayed pelvic visits

Many clinics have protocols for clients who wish to initiate contraception or continue an additional year of contraception and delay their clinically indicated breast and pelvic exam. TAKE CHARGE providers may provide all the other components of the comprehensive prevention visit for family planning and schedule the breast and pelvic exam for a subsequent visit. See the following tables for appropriate billing procedures for delayed pelvic visits.

Delayed Pelvic Visits – New Client

Visit	Performed by	Billing codes
First clinic visit for an initial or annual gynecological visit that includes detailed history, physical exam (excluding pelvic exam) counseling, contraceptive choice and contraceptive start.	ARNP, PA, MD	Preventive CPT codes 99384 – 99386 with modifier 52
Subsequent visits (different date of service than initial visit) that includes the initial/annual women’s pelvic and breast exam (may also include Pap smear) and evaluation of client’s satisfaction and compliance with chosen birth control method.	ARNP, PA, MD	Bill HCPCS code G0101. Must be billed with a diagnosis from V25 series, excluding V25.3.

Delayed Pelvic Visits – Established Client

Visit	Performed by	Billing codes
Clinic visit for an annual gynecological visit that includes detailed history, physical exam (excluding pelvic exam) counseling, contraceptive choice and contraceptive start.	ARNP, PA, MD	Preventive CPT codes 99394 – 99396 with modifier 52
	RN, LPN, medical assistant, certified nurse assistant or a trained and experienced health educator.	CPT code 99211
Subsequent visits (different date of service than return visit) that includes the annual women’s pelvic and breast exam (may also include Pap smear) and evaluation of client’s satisfaction and compliance with chosen birth control method.	ARNP, PA, MD	Bill HCPCS code G0101. Must be billed with a diagnosis from V25 series, excluding V25.3.

Prescription birth control methods

Notes:

- The 340B dispensing fee can be billed only for designated drugs which must be purchased and dispensed by a family planning provider participating with Medicaid in the 340B drug program under the Public Health Service (PHS) Act and billing the 340B drugs at actual acquisition cost.
- Any drug provided free of charge (for example, samples obtained through special manufacturer agreements) is not reimbursable. A dispensing fee in these cases is not reimbursable either.
- The 340B dispensing fee can be billed on a unit-by-unit basis only with HCPCS codes S4993, J7303, J7304, and J3490. J3490 must be billed with modifier FP. For example, if the provider dispenses 12 units of S4993 and 1 unit of J3490, then the dispensing fee (S9430) would be billed for 13 units. The number of billed units for S9430 must **always** equal the number of units dispensed by the provider for codes S4993, J7303, J7304 and/or J3490; **and** be billed on the same day of service and on same claim.

HCPCS Code	Short Description	Comments
Oral Contraceptives		
S4993	Contraceptive pills for birth control	1 unit = each 28-day supply (Seasonale should be billed as 3 units.) Participating 340B provider: Bill with S9430 (that is, 1 unit of S4993 must be billed with 1 unit S9430).
S9430	Pharmacy compounding and dispensing services	A dispensing fee for a participating 340B provider: bill with S4993 (birth control pills), J7303 (contraceptive rings), J7304 (patches) and J3490 (emergency contraception only)

CPT/ HCPCS Code	Short Description	Comments
Cervical Cap/Diaphragm		
A4261	Cervical cap for contraceptive use	
A4266	Diaphragm	
57170	Fitting of diaphragm/cap	
Injectables		

Family Planning

CPT/ HCPCS Code	Short Description	Comments
J1050	Injection, Medroxyprogesterone acetate 1 mg (Depo-Provera)	150 mg is the therapeutic dose for contraception. Allowed once every 67 days and only with V25, V25.02, V25.49, V25.9.
Intrauterine Devices (IUD)		
J7300	Intrauterine copper device (Paragard)	No 340B dispensing fee allowed.
J7302	Levonorgestrel-releasing IUD (Mirena)	No 340B dispensing fee allowed.
J7301	Skyla 13.5 mg	No 340B dispensing fee allowed.
58300	Insertion of intrauterine device (IUD)	No 340B dispensing fee allowed.
58301	Removal of intrauterine device (IUD)	No 340B dispensing fee allowed.
Miscellaneous Contraceptives		
J7303	Contraceptive ring, each (Nuvaring)	Participating 340B provider: Bill with S9430 (that is, 1 unit of J7303 should be billed with 1 unit S9430).
J7304	Contraceptive patch, each (Ortho-Evra)	Participating 340B provider: Bill with S9430 (that is, 1 unit of J7304 should be billed with 1 unit S9430). One patch = one unit.

Nonprescription over-the-counter (OTC) birth control methods

HCPCS/ CPT Code	Short Description	Comments
A4267	Male Condom, each	
A4268	Female Condom, each	
A4269	Spermicide (for example, foam, sponge), each	For example, includes gel, cream and vaginal film

Implants: Implanon/Nexplanon

HCPCS/ CPT Code	Diagnosis Code	Short Description	Comments
J7307	V25.5	Etonogestrel (contraceptive) implant system, Implanon/Nexplanon	Enter the NDC in Box 19 on the CMS-1500 Claim Form and send in an invoice with the billing. Do not bill a 340B dispensing fee for the device.
11981	V25.5	For the insertion of the device	
11982	V25.43	For removal of the device.	
11983	V25.43	For removal of the device with reinsertion on the same day	

Implants: Norplant Removal

CPT Code	Short Description	Comments
11976	Removal of contraceptive capsule	Norplant only

Note: The Medicaid agency pays for Implanon/Nexplanon (J7307) only once every three years, per client.

Unlisted contraceptive drugs and supplies

Note: The Medicaid agency requires family planning providers to list the 11-digit National Drug Code (NDC) number in the appropriate field on the claim form when billing for all drugs administered in or dispensed from the family planning clinic.

The Medicaid agency has established coding requirements for the contraceptive drugs and supplies listed in the following tables.

Emergency contraceptive pills

Providers must bill the Medicaid agency for emergency contraceptive pills as detailed below:

HCPCS/ CPT Code	Modifier	Short Description	Comments
J3490	FP	Unlisted drug	Use for emergency contraception only. Each 1 unit equals one course of treatment. Participating 340B provider: Bill with S9430 (that is, 1 unit of S4993 should be billed with 1 unit S9430).

Nondrug contraceptive supplies

Providers must bill the Medicaid agency for unlisted nondrug contraceptive supplies as detailed below:

HCPCS/ CPT Code	Modifier	Short Description	Comments
T5999	FP	Unlisted supply	Use for cycle beads only. Each 1 unit equals one set of cycle beads.
99071	FP	Unlisted supply	Use for natural family planning booklet only. Each 1 unit equals one booklet.
A4931	FP	Reusable, oral thermometer	Use for basal thermometer only. Each 1 unit equals one thermometer.

Radiology services

HCPCS/ CPT Code	Modifier	Short Description	Comments
77080		Dual energy x-ray absorptiometry (DXA)	Covered only for clients according to standard of care for clients using or considering <i>Depo-Provera</i> .
77081		Radius, wrist-heel	Covered only for clients according to standard of care for clients using or considering <i>Depo-Provera</i> .
76830		Ultrasound, transvaginal	
76830	26	Professional Component	
76830	TC	Technical Component	
76856		Ultrasound, pelvic, complete	
76856	26	Professional Component	
76856	TC	Technical Component	
76857		Ultrasound, pelvic, limited	
76857	26	Professional Component	
76857	TC	Technical Component	
76977		Ultrasound bone density measurement and interpretation, peripheral site(s)	Covered only for clients according to standard of care for clients using or considering <i>Depo-Provera</i> .

Lab services

Note: See [reimbursement](#) for information more details about payment for lab services.

HCPCS/ CPT Code	Modifier	Short Description	Comments
36415		Drawing blood venous	Payment limited to one draw per day.
36416		Drawing blood capillary	
80061		Lipid profile	
80076		Hepatic function panel	
81000		Urinalysis, nonauto w/scope	
81001		Urinalysis, auto w/scope	

HCPCS/ CPT Code	Modifier	Short Description	Comments
81002		Urinalysis nonauto w/o scope	
81003		Urinalysis, auto, w/o scope	
81025		Urine pregnancy test	
82120		Amines, vaginal fluid, qualitative	
82465		Assay, bld/serum cholesterol	
83718		Lipoprotein, direct measurement; high density cholesterol (HDL)	
84132		Potassium; serum	
84146		Prolactin	
84443		Thyroid stimulating hormone (TSH)	
84703		Chorionic gonadotropin assay	
85013		Hematocrit	
85014		Hematocrit	
85018		Hemoglobin	
85025		Automated hemogram	
85027		Automated hemogram	
86255		Fluorescent antibody, screen	
86255	26	Professional Component	
86631		Chlamydia antibody	
86632		Chlamydia igm antibody	
86692		Hepatitis, delta agent	
86706		Hep b surface antibody	
87110		Chlamydia culture	
87140		Cultur type immunofluoresc	
87147		Culture type, immunologic	
87210		Smear, wet mount, saline/ink	
87270		Infectious agent antigen detection by immuno-fluorescent technique; chlamydia trachomatis	
87320		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative; chlamydia trachomatis	
87340		Hepatitis b surface ag, eia	
87490		Chylmd trach, dna, dir probe	
87491		Chylmd trach, dna, amp probe	
87590		N.gonorrhoeae, dna, dir prob	
87591		N.gonorrhoeae, dna, amp prob	
87800		Detect agnt mult, dna, direc	
87810		Chylmd trach assay w/optic	
88141		Cytopath, c/v, interpret	
88142		Cytopath, c/v, thin layer	
88143		Cytopath, c/v, thin lyr redo	
88147		Cytopath, c/v, automated	

HCPCS/ CPT Code	Modifier	Short Description	Comments
88148		Cytopath, c/v, auto rescreen	
88150		Cytopath, c/v, manual	
88152		Cytopath, c/v, auto redo	
88153		Cytopath, c/v, redo	
88154		Cytopath, c/v, select	
88164		Cytopath tbs, c/v, manual	
88165		Cytopath tbs, c/v, redo	
88166		Cytopath tbs, c/v, auto redo	
88167		Cytopath tbs, c/v, select	
88174		Cytopath, c/v auto, in fluid	
88175		Cytopath, c/v auto fluid redo	
88300		Level 1 surgical pathology, gross examination only	
88302		Tissue exam by pathologist, level II	
88302	26	Professional Component	
88302	TC	Technical Component	

Note: If the provider is an Infertility Prevention Project (IPP) provider, the gonorrhea (GC) and chlamydia (CT) test for a Medicaid client must be sent to a lab enrolled as a Medicaid agency provider.

Injectable drugs and injection fee

These drugs are given in the family planning clinic. These are not take-home drugs or drugs obtained by prescription through a pharmacy. The following table contains the names of the only drugs that the Medicaid agency pays directly to family planning clinics. All other covered drugs, must be obtained and billed by a pharmacy.

HCPCS/ CPT Code	Modifier	Short Description	Comments
96372		Ther/proph/diag inj, sc/im (Specify substance or drug)	May not be billed with an office visit.
J0456		Azithromycin inj, 500 mg	
J0558		Injection penicillin g and penicillin g procaine, 100,000 units	
J0690		Cefazolin sodium inj, 500 mg	
J0694		Cefoxitin sodium inj, 1 g	
J0696		Ceftriaxone sodium inj, 250 mg	
J0697		Sterile cefuroxime inj, 750 mg	
J0698		Cefotaxime sodium inj, per gram	
J0710		Cephapirin sodium inj, up to 1 g	

HCPCS/ CPT Code	Modifier	Short Description	Comments
J1050		Injection, Medroxyprogesterone acetate 1 mg (Depo-Provera)	150 mg is the therapeutic dose for contraception. Allowed once every 67 days and only with V25, V25.02, V25.49, V25.9.
J1890		Cephalothin sodium inj, up to 1 g	
J2460		Oxytetracycline inj, up to 50 mg	
J2510		Penicillin g procaine inj, to 600,000 u	
J2540		Penicillin g potassium inj, to 600,000 u	
J3320		Spectinomycin di-hcl inj, up to 2 g	
Oral Medication			
Q0144		Azithromycin dihydrate, oral, 1 g	
J3490	FP	Unlisted drugs	Use for emergency contraception only. Each 1 unit equals one treatment.

TAKE CHARGE Clients Only

HCPCS/ CPT Code	Modifier	Short Description	Comments
99401	FP	PT education noc individ	Use for male contraceptive counseling – ECRR Only for TAKE CHARGE clients. Once every 12 months.

Fee schedule

See the agency's online [Family Planning Fee Schedule](#).

Reimbursement

General reimbursement

([WAC 182-502-0100](#))

Bill the Medicaid agency the usual and customary fee (the fee providers bill the general public). The Medicaid agency's payment is either the usual and customary fee or the Medicaid agency's maximum allowable fee, whichever is less.

Reproductive Health Services

([WAC 182-532-140](#))

- The Medicaid agency pays providers for covered Reproductive Health Services using the Medicaid agency's [Family Planning Fee Schedule](#).
- Family planning pharmacy services, family planning lab services, and sterilization services are reimbursed by the Medicaid agency under the rules and fee schedules applicable to these specific programs.
- The Medicaid agency pays a dispensing fee only for contraceptive drugs that are purchased through the 340B program of the Public Health Services Act. (See [chapter 182-530 WAC](#).)
- Family planning providers under contract with the agency's managed care plans must directly bill the plans for family planning or STI services received by clients enrolled in the plan.
- Family planning providers not under contract with the agency's managed care plans must bill using fee for service when providing services to managed care clients who self-refer outside their plans.
- Family planning providers or agency-contracted local health department STI clinics under contract with the agency's managed care plans must abide by their contract regarding lab services needed by clients from that plan.
- Family planning providers or agency-contracted local health department STI clinics not under contract with the agency's managed care plans must pay a lab directly for services provided to clients who self-refer outside of their managed care plan. Providers then must bill the Medicaid agency for reimbursement for lab services.

- ✓ Labs must be certified through the Clinical Laboratory Improvements Act (CLIA).
- ✓ Documentation of current CLIA certification must be kept on file.
- Under WAC 182-501-0200, the Medicaid agency requires a provider to seek timely reimbursement from a third party when a client has available third-party resources. The exceptions to this requirement are described under WAC [182-501-0200](#) (2) and (3).

Family Planning Only and TAKE CHARGE

(WACs [182-532-140](#), [182-532-550](#), [182-532-780](#), and [182-530-7250](#))

- The Medicaid agency limits reimbursement under the Family Planning Only and TAKE CHARGE program to visits and services that:
 - ✓ Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner (ICD-9-CM V25 series diagnosis codes).
 - ✓ Are medically necessary for the client to safely and effectively use, or continue to use, their chosen contraceptive method.
- The Medicaid agency pays providers for covered Family Planning Only and TAKE CHARGE services using the Medicaid agency's [Family Planning Fee Schedule](#).
- Providers without signed TAKE CHARGE agreements are reimbursed by the Medicaid agency only for clinic visits that are related to sterilization or complications from a birth control method.
- Family planning pharmacy services, family planning lab services, and sterilization services are reimbursed by the Medicaid agency under the rules and fee schedules applicable to these specific programs.
- The Medicaid agency pays a dispensing fee only for contraceptive drugs that are purchased through the 340B program of the Public Health Service Act. (See [chapter 182-530 WAC](#).)
- The Medicaid agency limits reimbursement for TAKE CHARGE research and evaluation activities to selected research sites.
- Federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health providers who are TAKE CHARGE providers must bill the Medicaid agency for TAKE CHARGE services without regard to either:
 - ✓ Their special rates and fee schedules
 - ✓ The encounter rate structure

- The Medicaid agency requires TAKE CHARGE providers to meet the billing requirements of [WAC 182-502-0150](#).
- Under WAC 182-501-0200, the Medicaid agency requires a provider to seek timely reimbursement from a third party when a client has available third-party resources. The exceptions to this requirement are described under [WAC 182-501-0200](#) (2) and (3) and in [billing for third-party liability and “good cause.”](#)

Contraceptive devices and drugs

(WACs [182-530-7250](#) and [182-530-7900](#))

If the Medicaid agency fee schedule lists a drug or item as “actual acquisition cost,” the provider must bill its actual acquisition cost and not a usual and customary fee or maximum allowable fee.

Participating providers under the 340B drug pricing program

The provider must be listed on the Medicaid Exclusion File.

Bill the Medicaid agency the actual acquisition cost (AAC) for all drugs as required by laws governing the 340B Drug Pricing Program. Reimbursement is the AAC plus a 340B dispensing fee set by the Medicaid agency. (See [WAC 182-530-7900](#) for details.)

Nonparticipating providers under 340B drug pricing program

Bill the Medicaid agency the usual and customary fee. Reimbursement is the usual and customary fee or the Medicaid agency’s maximum allowable fee, whichever is less.

Note: Any noncontraceptive take-home drugs dispensed at a family planning clinic are not reimbursable.

Payment limitations

For TAKE CHARGE clients, the Medicaid agency limits reimbursement to only enrolled and approved TAKE CHARGE providers.

Billing and Claim Forms

Providers must follow the billing requirements listed in the Health Care Authority's [ProviderOne Billing and Resource Guide](#). The guide explains how to complete the CMS-1500 Claim Form.

Note: Billing adjustments related to the TAKE CHARGE program must be completed no later than two years after the TAKE CHARGE program ends.

How do providers bill for managed care services?

(WAC [182-532-140\(2\)](#))

When a client is enrolled in a Medicaid agency-contracted managed care plan, the family planning or local health department or STI-services provider must bill the client's services directly to that managed care plan.

Billing for third-party liability and “good cause”

(WAC [182-532-790](#))

The Medicaid agency requires a provider under [WAC 182-501-0200](#) to seek timely reimbursement from a third party when a client has available third-party resources, except when “good cause” exists.

Under the TAKE CHARGE program, two groups of clients may request an exemption from the Medicaid requirement to bill third-party insurance due to “good cause.” The two groups are:

- TAKE CHARGE applicants who meet all the following criteria:
 - ✓ Are 18 years of age or younger
 - ✓ Are covered under their parent's health insurance
 - ✓ Do not want their parents to know that they are seeking and/or receiving family planning services
- Individuals who are domestic violence victims and are covered under their perpetrator's health insurance

Note: Clients must make the self-declaration on the TAKE CHARGE client application to qualify for this exception.

“Good cause” means that use of the third-party coverage would violate a client's confidentiality because the third party:

- Routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the applicant.
- Requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to another subscriber.

If either of these conditions apply, the applicant is considered for TAKE CHARGE without regard to the available third-party family planning coverage.

At the time of application, providers must make a determination about “good cause” on a case-by-case basis.

Note: To preserve confidentiality, when billing for family planning services for either exception above, do not indicate on the claim form that the client has other insurance.

When billing for an unlisted contraceptive, the Medicaid agency requires family planning providers to list:

- The National Drug Code (NDC) number on all drug claims.
- The amount of drug given to the client in Box 19 of the CMS-1500 Claim Form, or in the “Comments” section of the electronic CMS-1500 Claim Form.

Alert! TAKE CHARGE providers must bill using taxonomy 261QA0005X for all services provided to TAKE CHARGE clients.

Appendix A

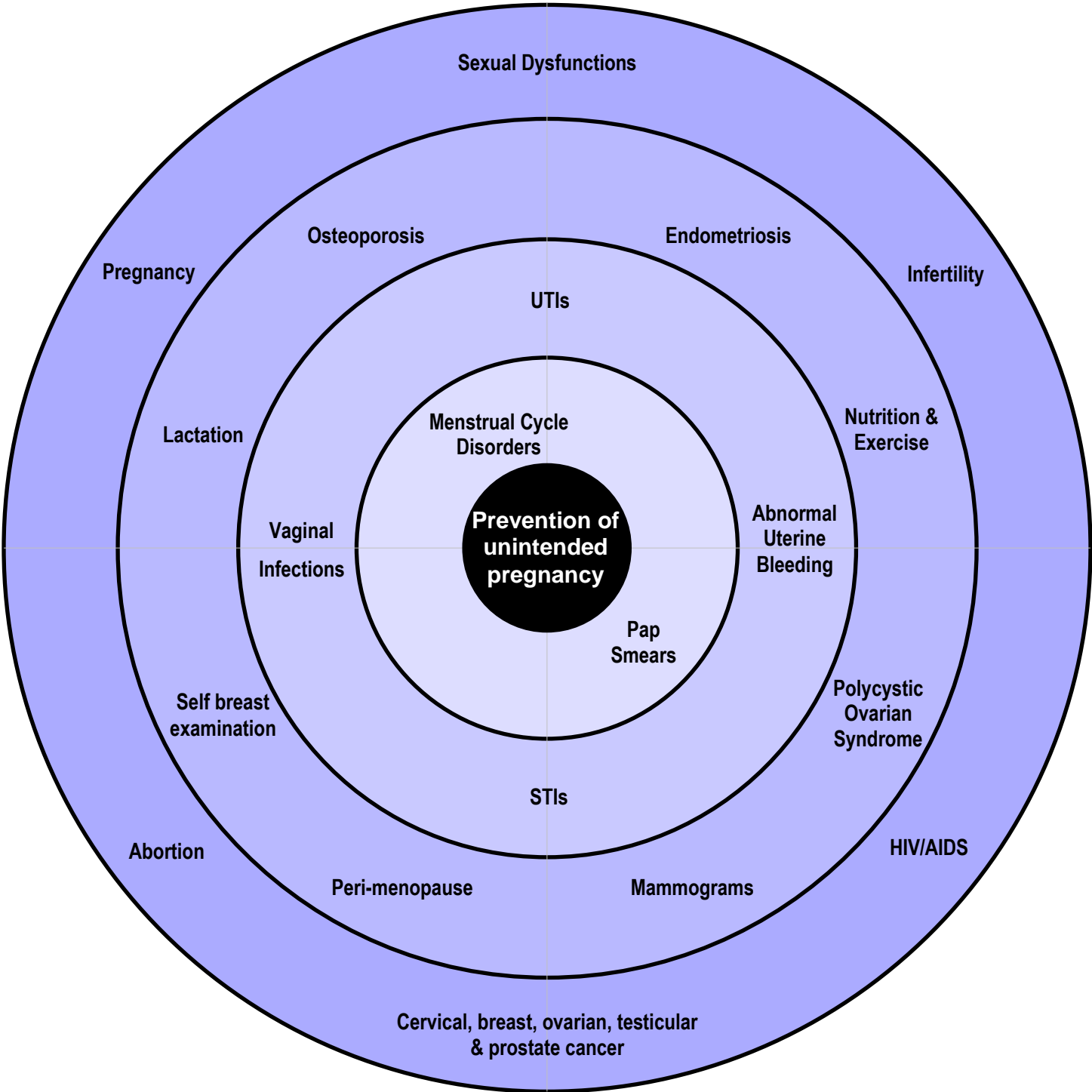
Aiming for the bull’s eye: preventing unintended pregnancy

As a provider, sometimes it is difficult to discern whether a service is directly related to the safe and effective use of contraceptives. Using contraceptives can be complicated. When determining coverage under the TAKE CHARGE or Family Planning Only programs, the provider must consider the relationship between both:

- The presenting issues and diagnosis at the time of a client’s visit.
- The safe and effective use of the client’s chosen contraceptive method.

Consider the Bull’s Eye illustration on the next page. The services covered under the TAKE CHARGE and Family Planning Only programs are *part of* reproductive health care (the target) but they must be directly related to preventing unintended pregnancy (the bull’s eye).

When a service falls into an area that feels “gray” or unclear, ask how the services provided are assisting this client to prevent unintended pregnancy. Detailed and thorough charting will be the justification. (For examples, see [clinic visit scenarios](#).)



Appendix B

Clinic visit scenarios for Family Planning Only and TAKE CHARGE

The purpose of the Family Planning Only and the TAKE CHARGE program is to prevent unintended pregnancy.

Documentation in the client's chart must reflect that the majority of the time was spent with the client with the focus of family planning (ICD-9-CM V25 series diagnosis codes, excluding V25.3).

Example A

Amanda has chosen to use an IUD. It is the standard of practice to screen for chlamydia/gonorrhea prior to IUD insertion. This STI screening (and treatment if necessary) **would** be covered under TAKE CHARGE as it is not medically safe to insert an IUD into a potentially infected uterus.

Example B

Beatriz has been a client at your clinic for several years. She has been an inconsistent condom and oral contraceptive user and at high risk for unintended pregnancy. She decides to try the *Nuvaring* and has been using it safely and successfully for six months. She comes into the clinic with complaints of spotting and bleeding especially after intercourse, which she believes is caused by the hormones in the ring. She wants to quit the ring and go back to condoms. She mentions something about her new boyfriend and how he won't be too happy about having to use condoms.

You are concerned that the bleeding may be caused by chlamydia/gonorrhea and not her hormonal contraceptive *and* that she will again be at risk for pregnancy with a method that she didn't use well previously. You test her for chlamydia/gonorrhea, treat her presumptively, explain the importance of her partner getting treated and tested as well, discuss the importance of condoms for STI prevention, and continue her with the *Nuvaring*.

Her office visit, lab tests and treatment would be covered because your thorough charting makes the link to the safe and effective use of her birth control method.

Example C

Callie comes into the clinic stating that she heard that her recent past partner "had something" and she wanted to be checked just to be sure. She is in a new relationship, using oral

contraceptives and also using condoms for STI prevention. She is having no problems with her birth control method. She just wants to be screened for STIs. This visit would not be covered under TAKE CHARGE or Family Planning Only.

Example D

Deirdre was taken off hormonal contraceptives when she was diagnosed with severe mononucleosis. She was jaundiced and her liver was enlarged during the acute phase of her illness. She is not happy using condoms, has had unprotected sex a couple of times and wants to resume her oral contraceptive use. You order lab work to determine that her liver function has returned to normal before restarting her on pills. This visit and labs tests would be covered under TAKE CHARGE and Family Planning Only. Again, your thorough charting of this clients history and current presenting issues is your justification for requesting payment from the Medicaid agency for these services.

Example E

Evelyn has come into the clinic seeking her annual exam and contraception. She now has coverage with a Medicaid-contracted managed care plan. Your clinic is a contracted provider with this managed care plan. Your biller, Sherm, asks, “Who pays for these services? Medicaid? Or the plan?” Because your clinic is a contracted provider with the client’s plan, Sherm must bill the plan.

Appendix C

Frequently asked questions

If a client changes from TAKE CHARGE coverage to full scope Medicaid coverage, are they covered under the TAKE CHARGE program?

No, the client now is eligible for Reproductive Health Services. (See [Reproductive Health Services](#).)

Are prostate cancer screenings, digital rectal examinations, and prostate-specific antigen tests (PSA) covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Prostate cancer screenings are covered under Reproductive Health Services with the following procedure codes and diagnoses:

- Males are covered for HCPCS procedure code G0103 for prostate-specific antigen test (PSA) with diagnosis code V76.44 (special screening for malignant neoplasms prostate).
- A digital rectal exam (HCPCS procedure code G0102) is bundled into the reimbursement for the office visit.

These prostate cancer screenings are not covered under the Family Planning Only program (which is for women only) or under TAKE CHARGE.

Are mammograms covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Mammograms are covered for clients under Reproductive Health Services for women 40 years of age or older (one screening mammogram is covered annually). Diagnostic mammograms are covered for men when medically necessary. Mammograms *are not* covered under the Family Planning Only program or TAKE CHARGE.

Are abortions covered under Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE?

Abortions are covered for clients under Reproductive Health Services. Bill for these services with a medical taxonomy, not a family planning taxonomy. (See [billing and claim forms](#).) Abortions *are not* covered under the Family Planning Only program or TAKE CHARGE.

Note: If a Family Planning Only or TAKE CHARGE client becomes pregnant, refer her to her local [Community Services Office](#) to determine if she qualifies for medical services under another program.

Appendix D

Quick reference list of covered CPT/HCPCS codes

Note: Refer to [billing and claim forms](#) for details on how to submit claims for payment.

For Family Planning Only clients

CPT codes

00840 00851 11976 11981 11982 11983 36415 36416 55250 55450 57170 58300 58301
 58340 58565 58600 58615 58670 58671 74740 76075 76076 76830 76856 76857 76977
 77080 77081 80061 80076 81000 81001 81002 81003 81025 82120 82465 83718 84132
 84146 84443 84703 85013 85014 85018 85025 85027 86255 86631 86632 86692 86706
 87110 87140 87147 87210 87270 87320 87340 87490 87491 87590 87591 87800 87810
 88141 88142 88143 88147 88148 88150 88152 88153 88154 88164 88165 88166 88167
 88174 88175 88300 88302 90772 90774 96372 99071 99201 99202 99203 99204 99211
 99212 99213 99214 99384 99385 99386 99394 99395 99396 99401 99605

HCPCS codes

A4261 A4264 A4266 A4267 A4268 A4269 A4931 G0101 J0456 J0580
 J0690 J0694 J0696 J0697 J0698 J0710 J1055 J1890 J2460 J2510
 J2540 J3320 J3490 J7300 J7302 J7303 J7304 J7307 Q0144 S0180
 S4993 S9430 S9445 T1015 T1023 T5999

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For TAKE CHARGE clients seen by TAKE CHARGE providers

CPT codes

00840 00851 11976 11981 11982 11983 36415 36416 55250 55450 57170 58300 58301
58340 58565 58600 58615 58670 58671 74740 76075 76076 76830 76856 76857 76977
77080 77081 80061 80076 81000 81001 81002 81003 81025 82120 82465 83718 84132
84146 84443 84703 85013 85014 85018 85025 85027 86255 86631 86632 86692 86706
87110 87140 87147 87210 87270 87320 87340 87490 87491 87590 87591 87800 87810
88141 88142 88143 88147 88148 88150 88152 88153 88154 88164 88165 88166 88167
88174 88175 88300 88302 90772 90774 96372 99071 99201 99202 99203 99204 99211
99212 99213 99214 99384 99385 99386 99394 99395 99396 99401 99605

HCPCS codes

A4261	A4264	A4266	A4267	A4268	A4269	A4931	G0101	J0456	J0580
J0690	J0694	J0696	J0697	J0698	J0710	J 1050	J1890	J2460	J2510
J2540	J3490	J7300	J7302	J7303	J7304	J7307	J3320	Q0144	S0180
S9430	S4993	S9445	T1015	T5999					

For TAKE CHARGE clients seen by nonTAKE CHARGE providers

CPT codes

00840 00851 55250 55450 58600 58615 58670 58671

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