Washington State Health Care Authority

Washington Apple Health (Medicaid)

Family Planning Billing Guide

Including:

- Reproductive Health Services
- Family Planning Only – Pregnancy Related program
- Family Planning Only program (formerly referred to as TAKE CHARGE)

October 1, 2019

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect October 1, 2019, and supersedes earlier guides to this program.

This billing guide includes billing information for the following programs:

- Reproductive Health Services
- Family Planning Only – Pregnancy Related
- Family Planning Only (formerly referred to as TAKE CHARGE)

The Health Care Authority (the agency) is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> 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?

Subject	Change	Reason for Change
Entire document	Housekeeping changes	To improve usability
Definitions	Revised "Over-the-counter (OTC)" definition. Added definitions for "Reproductive health care services" and "Reproductive system"	To remove "and are approved by the Food and Drug Administration (FDA)" from the definition, which was previously added to the definition in error Added due to stakeholder comments on WAC 182-532-001 proposed under WSR 19-14-062.
What are the requirements for providers?	Removed the word "prescription" and replaced the word "services" with "products" in the third, fourth, and fifth bullets in the section	To change the language so it better reflects the definitions of "contraceptive" and "over-the-counter"

* This publication is a billing instruction.

Subject	Change	Reason for Change
What reproductive health services are covered?	Removed "prescription and nonprescription" and other unnecessary words from the section	To simplify and clarify information
Family Planning Only program (formerly referred to as TAKE CHARGE)	Removed the restriction of having been denied Apple Health coverage through www.wahealthplanfinder.org	This language did not address situations in which applicants who submitted paper applications were denied coverage.
What are the requirements for providers?	Removed the word "prescription" and replaced the word "services" with "products" in the third, fourth, and fifth bullets in the section	To change the language so it better reflects the definitions of "contraceptive" and "over-the-counter"
What services are covered under Family Planning Only programs?	Removed "prescription and nonprescription" from section	To remove an unnecessary distinction

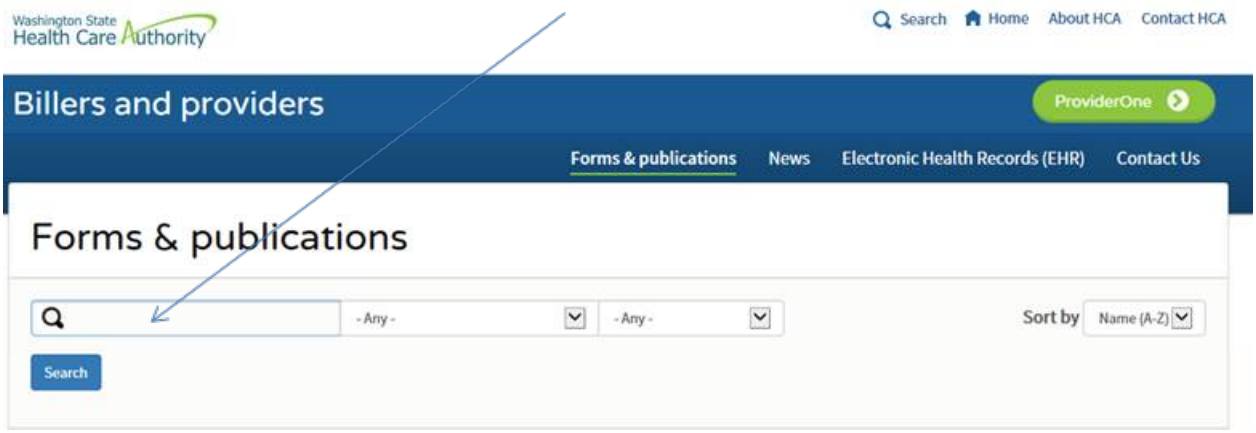
How can I get agency provider documents?

To access provider alerts, go to the agency's Provider alerts webpage.

To access provider documents, go to the agency's Provider billing guides and fee schedules webpage.

Where can I download agency forms?

To download an agency provider form, go to the agency's Forms & publications webpage. Type the agency's form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Resource
Information about reproductive health services, the Family Planning Only and Family Planning Only-Pregnancy Related programs	Contact the Billers, providers, and partners "Contact us" webpage. Contact the Family Planning Program: PO Box 45506 Olympia, WA 98504-5506 Phone: 360-725-1652 Fax: 360-725-1152 familyplanning@hca.wa.gov
For additional billing guidance	See the following billing guides: • Outpatient Hospital Billing Guide • Physician-Related/Professional Services Billing Guide • Professional Administered Drugs Fee Schedule
Family Planning Only Application form, HCA 13-781 (for clients)	Application for Family Planning Only Services.
Information about sterilization	See the agency's Sterilization Supplement Billing Guide and WAC 182-531-1550.
Pharmacy information	See the agency's Pharmacy Information and the Prescription Drug Program Billing Guide.
Additional agency resources	See the agency's Billers, providers, and partners webpage.

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

340B dispensing fee – The 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). (WAC 182-532-001)

Applicant – A person applying for Family Planning Only services.

Comprehensive preventive family planning visit – 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 laboratory and diagnostic procedures that are covered under the client's respective agency program. (WAC 182-532-001)

Contraception – Prevention of pregnancy through the use of contraceptive methods. (WAC 182-532-001)

Contraceptive – Food and Drug Administration (FDA)-approved prescription and nonprescription methods, including devices, drugs, products, methods, or surgical interventions used to prevent pregnancy, as described in WAC 182-530-2000. (WAC 182-532-001)

Family planning clinic – A clinic that is designated by the agency to provide family planning services to eligible people as described in this guide. Other types of providers may offer family planning services within their scope of practice.

Family Planning Only program - The program that covers family planning only services for eligible clients for 12 months from the date the agency determines eligibility. This program was formerly referred to as TAKE CHARGE. (WAC 182-532-001)

Family Planning Only – Pregnancy Related program – The program that covers family planning only services for eligible clients for 10 months following the 60-day post pregnancy period. (WAC 182-532-001)

Family planning services – Medically safe and effective medical care, educational services, and contraceptives that enable individuals to plan and space the number of children they have and avoid unintended pregnancies. (WAC 182-532-001)

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

(WAC 182-531-0050)

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. (WAC 182-532-001)

Over-the-counter (OTC) – Drugs, devices, and products that do not require a prescription to 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 (see WAC 182-530-7900).

Reproductive health - The prevention and treatment of illness, disease, and disability related to the function of reproductive systems during all stages of life, and includes:

- Related, appropriate, and medically necessary care
- Education of clients in medically safe and effective methods of family planning
- Pregnancy and reproductive health care

(WAC 182-532-001)

Reproductive health care services - Any medical services or treatments, including pharmaceutical and preventive care services or treatments, directly involved in the reproductive system and its processes, functions, and organs involved in reproduction, in all stages of life. Reproductive health care services do not include infertility treatment.

Reproductive system - Includes, but is not limited to: Genitals, gonads, the uterus, ovaries, fallopian tubes, and breasts.

Sexually Transmitted Infection (STI) –A disease or infection acquired as a result of sexual contact. (WAC 182-532-001)

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

General

How do I verify a client's eligibility?

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

Check the client's services card or follow the two-step process below to verify that a client has 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.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program benefit packages and scope of services webpage.

Note: Patients who are not 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.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

The Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for the following three Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see Changes coming to Washington Apple Health. You may also refer to the agency's Apple Health managed care webpage.

See the agency's Mental Health Services Billing Guide for details.

Apple Health – Changes for July 1, 2019

Effective July 1, 2019, the agency is continuing to shift to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and drug or alcohol treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

Agency-contracted managed care organizations (MCOs) in certain Regional Services Areas (RSAs) will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the Integrated managed care regions section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. HCA will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the ProviderOne Client Portal.
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change online through our secure Contact us – Apple Health (Medicaid) client web form. Select the topic "Enroll/Change Health Plans."
- Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

> **American Indian/Alaska Native (AI/AN)** clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.
>
> For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the Medicaid agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
North Sound **(new)**	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care.**"

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Administrative Services Organization (BH-ASO). For details, see the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

Provider Requirements

Confidentiality, consent, and release of information

When providing family planning services, providers must do all of the following:

- Follow federal Health Insurance Portability and Accountability Act (HIPAA) requirements in safeguarding the confidentiality of clients' records. These safeguards must do the following:

  ✓ Allow for timely sharing of information with appropriate professionals and agencies on the client's behalf

  ✓ Ensure that confidentiality of disseminated information is protected

  (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

  ✓ The federal Consent for Sterilization form HHS-687 must be attached to a sterilization claim. See the Sterilization Supplemental Billing Guide for requirements and instructions. See also Where can I download agency forms?

  ✓ Authorization from clients for release of information

- Ensure the proper release of client information:

  ✓ To transfer information to another 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

Nationally recognized clinical guidelines

Providers must follow nationally recognized clinical guidelines. Cervical cancer screening guidelines are produced by the American Society for Colposcopy and Cervical Pathology (ASCCP), the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), and the U.S. Preventive Services Task Force (USPSTF). Breast cancer screening guidelines are produced by the American College of Obstetrics and Gynecology (ACOG), the American Cancer Society (ACS), and the U.S. Preventive Services Task Force (USPSTF). Family planning guidelines are produced by the Centers for Disease Control and Prevention (CDC) and the U.S. Office of Population Affairs.

How do I bill claims electronically?

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers, providers, and partners webpage.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

How do providers bill for managed care services?

(WAC 182-532-140(4) - (7))

Family planning providers under contract with an agency-contracted managed care organization (MCO) must directly bill the MCO for family planning or sexually transmitted infection (STI) services received by clients enrolled in the MCO.

Family planning providers not under contract with an agency-contracted MCO 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 who are contracted with an agency-contracted managed care organization (MCO) must follow their contract regarding laboratory services for MCO clients.

Family planning providers or agency-contracted local health department STI clinics not under contract with an agency-contracted MCO must pay a laboratory directly for services provided to clients who self-refer outside of their MCO. Providers then must bill the agency for payment for laboratory services.

- Laboratories must be certified through the Clinical Laboratory Improvements Act (CLIA).

- Documentation of current CLIA certification must be kept on file.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment before providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

How do providers who participate in the 340B drug pricing program bill for drugs and dispensing fees?

- The provider NPI used for 340B drugs must be listed on the federal Office of Pharmacy Affairs Medicaid Exclusion File.

- Bill the agency the actual acquisition cost (AAC) for all drugs purchased under the 340B Drug Pricing Program.

- The agency pays family planning clinics a dispensing fee only for agency designated hormonal contraceptives that are purchased through the 340B program of the Public Health Service Act. (See chapter 182-530 WAC.)

- To receive the 340B dispensing fee the provider must be listed on the Medicaid Exclusion file as a family planning entity type (Title X funded).

Reproductive Health Services

What are reproductive health services?

The 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.

Who is eligible for reproductive health services?
(WAC 182-532-100(1))

The agency covers medically necessary reproductive health services, as described in this guide, for clients covered by one of the Washington Apple Health programs as listed in the table in WAC 182-501-0060.

Managed care clients

For clients enrolled in one of the agency-contracted managed care organizations (MCOs), managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

Clients enrolled in an agency-contracted MCO must obtain services through their MCO, unless otherwise noted.

> **Note:** A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Self-referral for managed care clients
(WAC 182-532-100(2)(3))

A client enrolled in an agency-contracted MCO may self-refer outside their MCO for reproductive health care services including, but not limited to:

- Family planning
- Abortion
- Sexually transmitted infection (STI) services

A client may seek services from any agency-approved provider. A client who is age 21 or older may not self-refer outside their MCO for sterilization.

Limited coverage

Family Planning Only programs
Family Planning Only – Pregnancy Related and Family Planning Only clients are eligible to receive limited reproductive health services which includes only family planning and specified family planning-related services. See the program guidelines in this guide.

Alien Emergency Medical
Under WAC 182-507-0115, the agency covers reproductive health services under Alien Emergency Medical programs only when the services are directly related to an emergency medical condition.

Where can Washington Apple Health clients receive reproductive health services?

Reproductive health services can be provided by any licensed, agency-contracted provider whose scope of practice includes reproductive health or the ancillary services associated with a reproductive health procedure or treatment (e.g., pathology, anesthesia, facility, etc.). See Chapter 182-502 WAC for requirements of agency contracted providers.

What are the requirements for providers?
(WAC 182-532-110)

To be paid by the agency for reproductive health services provided to eligible clients, providers, including licensed midwives, must:

- Meet the requirements in Chapters 182-501, 182-502, and 182-532 WAC.
- Provide only those services that are within the scope of their licenses.
- Bill the agency according to this guide and other applicable agency billing guides.
- Educate clients on Food and Drug Administration (FDA)-approved contraceptive methods and over-the-counter (OTC) contraceptive drugs, devices, and products, as well as related medical services.
- Provide medical services related to FDA-approved contraceptive methods and OTC contraceptive drugs, devices, and products upon request.
- Supply or prescribe FDA-approved contraceptive methods and OTC contraceptive drugs, devices, and products upon request.

What reproductive health services are covered?
(WAC 182-532-120)

In addition to the services listed in WAC 182-531-0100, the agency covers all of the following reproductive health services:

- For a client capable of reproducing, a comprehensive preventive family planning visit every 12 months, based on nationally recognized clinical guidelines, including all of the following:
  - ✓ Sexually transmitted infection (STI) and cancer screenings
  - ✓ Comprehensive and client-centered counseling, education, risk reduction, and initiation or management of contraceptive methods

Note: Clients who are sterilized or otherwise not at risk for pregnancy do not qualify for a comprehensive family planning prevention visit. They do qualify for all other services.

- Contraception, including all of the following:
  - ✓ Food and Drug Administration (FDA)-approved contraceptive methods (see the Prescription Drug Program Billing Guide)
  - ✓ Education and supplies for FDA-approved contraceptives, natural family planning, and abstinence
  - ✓ Sterilization procedures, as described in WAC 182-531-1550 and the Sterilization Supplemental Provider Guide
- Cervical, breast, and prostate cancer screenings, according to nationally recognized clinical guidelines (see the Physician-Related Services/Healthcare Professional Services Billing Guide)
- STI screening, testing, and treatment, according to nationally recognized clinical guidelines
- Human papillomavirus (HPV) immunization, administered according to the recommended schedule published by the Centers for Disease Control and Prevention (CDC)
- Diagnostic services, follow-up visits, imaging, and laboratory services related to the services listed in this section
- Pregnancy-related services including:
  - ✓ Maternity-related services, as described under "Maternity Care and Services" in the Physician-Related Services/Healthcare Professional Services Billing Guide
  - ✓ Abortion (see Physician-Related Services/Healthcare Professional Services Billing Guide)

What contraceptives does the agency cover?

Hormonal contraceptive prescribing

The agency generally requires prescriptions for oral, transdermal, and intra-vaginal hormonal contraceptives to be dispensed as a one-time prescription for a 12-month supply. When specifying the dispensing quantity for these contraceptives, prescribers **should** write for a 12-month supply according to the chart below, unless there is an acceptable reason not to do so.

For prescriptions written with a dispensing quantity less than a 12-month supply, providers will receive requests from pharmacies to change the dispensing quantity. Providers may write the prescription for a lesser amount if any of the following are true:

- 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.

This requirement applies to clients in both fee-for-service and managed care clients.

Quantity required for 12 months to be dispensed		
Contraceptive type	**Quantity**	**Cycles/Packs**
Oral contraceptives, e.g. pills	364 tablets	13
Continuous oral contraceptives	504 tablets when dispensed as 28-day packs	18
	378 tablets when dispensed as 21-day packs	
Transdermal contraceptives, e.g. patch	39 transdermal patches	13
	52 transdermal patches	18
Intra-vaginal contraceptives, e.g. ring	13 intra-vaginal rings	13
	18 intra-vaginal rings	18

Hormonal contraceptives filled at the pharmacy
(WAC 182-530-2000)

The agency generally requires pharmacies to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply. 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. Pharmacies may dispense a lesser amount if any of the following are true:

- The client does not want a 12-month supply all at once.
- There is a clinical reason, documented on the prescription, for the client to receive a smaller supply.
- The pharmacy does not have enough supply to fill for 12 months.

This requirement applies to both fee-for-service and managed care.

See the Prescription Drug Program Billing Guide for more details.

Hormonal contraceptives dispensed from a family planning clinic

12-month supply
The agency generally requires family planning clinics to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply. Clinics may dispense or write the prescription for a lesser amount if any of the following are true:

- 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.
- The clinic does not have enough supply to fill for 12 months.

340B dispensing fee
A 340B dispensing fee may be billed only for designated hormonal contraceptives which must be purchased and dispensed by a family planning clinic participating with Medicaid in the 340B drug program under the Public Health Service (PHS) Act. The clinic is listed on the Medicaid Exclusion File as a family planning entity type (Title X funded). The 340B drugs must be billed at actual acquisition cost. See WAC 182-530-7900.

The 340B dispensing fee may be billed on a unit-by-unit basis only with HCPCS codes S4993, J7303, and J7304. The number of billed units for S9430 must always equal the number of units dispensed by the provider for codes S4993, J7303, and/or J7304 and be billed on the same day of service and on the same claim.

These requirements apply to clients in both fee-for-service and managed care.

Note:

- The agency does not reimburse for any drug provided free of charge (for example, samples obtained through special manufacturer agreements). A dispensing fee in these cases is not reimbursable.
- The agency requires providers to list the 11-digit National Drug Code (NDC) number in the appropriate field of the claim when billing for all drugs administered in or dispensed from their office or clinic.

Immediate postpartum Long-Acting Reversible Contraceptive (LARC) insertion

The agency reimburses professional services for immediate postpartum IUD or contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure.

The agency does not reimburse facility services for the immediate postpartum IUD or contraceptive implant insertion procedure. These inpatient services may not be unbundled on the hospital's facility claim.

The agency reimburses for the IUD or contraceptive implant device in one of the following ways:

- Through the facility's pharmacy point of sale system
- As a separate professional claim submitted by the facility when the facility supplies the device
- As part of the professional claim when the device is supplied by the provider performing the insertion

Note: When billing for an IUD or contraceptive implant device, the provider must use the appropriate HCPCS code and NDC.

Contraceptives coverage table

Prescription contraceptives

Note: For sterilization procedure codes, see the Sterilization Supplemental Billing Guide. For instructions on billing for office, professionally administered drugs, imaging, and laboratory codes, see the Physician-Related Services/Health Care Professional Services Billing Guide. For additional information on billing for drugs, see the Prescription Drug Program Billing Guide.

HCPCS Code	Short Description	Comments
Pills, Ring, and Patch		
S4993	Contraceptive pills for birth control	1 unit = each 21 or 28-day pack (Seasonale should be billed as 3 units.) Participating 340B provider: may bill with S9430.
J7303	Contraceptive ring, each (Nuvaring)	Participating 340B provider may bill with S9430.
J7304	Contraceptive patch, each (Ortho-Evra)	Participating 340B provider may bill with S9430.
S9430	Pharmacy compounding and dispensing services	A dispensing fee for participating 340B providers. May bill only with S4993 (birth control pills, and emergency contraception pills), J7303 (contraceptive rings), J7304 (contraceptive patches). Units of dispensing fee must match units of contraceptive.
Emergency Contraception		
S4993	Unclassified drug Used for: Ulipristal acetate 30 mg	Ulipristal is prescription for all ages. Each 1 unit equals one course of treatment. Participating 340B provider may bill with S9430.
Injectable		
J1050	Injection, Medroxyprogesterone acetate 1 mg (Depo-Provera)	No 340B dispensing fee allowed. May be billed with injection administration code 96372 only when not in conjunction with an office visit.

Intrauterine Devices (IUD)		
J7297	Levonorgestrel-releasing IUD (Liletta), 52 mg	No 340B dispensing fee allowed.
J7298	Levonorgestrel-releasing IUD (Mirena), 52 mg	No 340B dispensing fee allowed.
J7300	Intrauterine copper device (Paragard)	No 340B dispensing fee allowed.
J7301	Levonorgestrel-releasing IUD (Skyla), 13.5 mg	No 340B dispensing fee allowed.
J7296	Levonorgestrel 19.5 mg - releasing IUD (Kyleena)	No 340B dispensing fee allowed.
58300	Insertion of intrauterine device (IUD)	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate.
58301	Removal of intrauterine device (IUD)	
Implant		
J7307	Etonogestrel (contraceptive) implant system (Nexplanon)	No 340B dispensing fee allowed.
11981	For the insertion of the device	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate. Must be billed with FP modifier.
11982	For removal of the device.	Must be billed with FP modifier.
11983	For removal of the device with reinsertion on the same day	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate. Must be billed with FP modifier.
11976	Removal of contraceptive capsule	Norplant only
Cervical Cap/Diaphragm		
A4261	Cervical cap for contraceptive use	No 340B dispensing fee allowed.
A4266	Diaphragm	No 340B dispensing fee allowed.
57170	Fitting of diaphragm/cap	

Nonprescription over-the-counter (OTC) contraceptives

Nonprescription OTC contraceptives may be obtained with a Services Card through a pharmacy or agency-designated family planning clinic.

HCPCS/ CPT Code	Short Description	Comments
A4267	Male Condom, each	No 340B dispensing fee allowed.
A4268	Female Condom, each	No 340B dispensing fee allowed.
A4269	Spermicide (for example, foam, sponge), each	Includes gel, cream, foam, vaginal film, and contraceptive sponge. No 340B dispensing fee allowed.
Emergency Contraception		
S4993	Unclassified drug Used for: Levonorgestrel 1.5 mg	Levonorgestrel is over the counter for clients of all ages per FDA. Each 1 unit equals one course of treatment. Participating 340B provider may bill with S9430.

Nondrug contraceptive supplies (natural family planning)

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.

Note: For fees for family planning and nonfamily planning reproductive health services, refer to the Physician-Related Services/Health Care Professional Services fee schedules. See also the Professional Administered Drug Fee Schedule.

What reproductive health services are not covered?

(WAC 182-532-130)

Noncovered reproductive health services are described in the agency's Physician-Related Services/Healthcare Professional Services Billing Guide and WACs 182-501-0070 and 182-531-0150.

> **Note:** The agency reviews requests for noncovered services under WAC 182-501-0160.

What fee does the agency pay?

(WAC 182-532-140 (1)(3)(8))

- The agency pays:
  - ✓ Providers for covered reproductive health services using the agency's Family Planning Fee Schedule.
  - ✓ For family planning pharmacy services, family planning laboratory services, and sterilization services using the agency's published fee schedules.
  - ✓ A dispensing fee only for contraceptive drugs purchased through the 340B program of the Public Health Service Act.
- The agency requires providers to seek timely reimbursement from a third party when a client has available third-party resources, as described under WAC 182-501-0200. See Billing for third-party liability and "good cause" for exceptions.

Family Planning Only Programs

What is the purpose of the Family Planning Only programs?

(WAC 182-532-500)

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

- Improve access to family planning and family planning-related services.
- Reduce unintended pregnancies.
- Promote healthy intervals between pregnancies and births.

Who is eligible?

(WAC 182-532-510)

To be eligible for one of the Family Planning Only programs listed in this section, a client must meet the qualifications for that program.

Family Planning Only – Pregnancy Related program

To be eligible for Family Planning Only – Pregnancy Related services, a client must be determined eligible for Washington Apple Health for pregnant clients during the pregnancy, or determined eligible for a retroactive period covering the end of a pregnancy.

A client is automatically eligible for the Family Planning Only – Pregnancy Related program when the client's pregnancy ends.

> **Note:** A client may apply for the Family Planning Only program up to 60 days before the expiration of the Family Planning Only – Pregnancy Related program.

> **Note:** Clients will continue to use the same Services Card they received when they applied for pregnancy-related medical services.

Family Planning Only program (formerly referred to as TAKE CHARGE)

To be eligible for the Family Planning Only program, a client must meet all of the following:

- Be a United States citizen, U.S. National, or "qualified alien" as described in WAC 182-503-0535
- Provide a valid Social Security number (SSN) or meet good cause criteria listed in WAC 182-503-0515(2)
- Be a Washington state resident, as described in WAC 182-503-0520
- Have an income at or below 260% of the federal poverty level, as described in WAC 182-505-0100
- Need family planning services
- Have been denied Apple Health coverage-within the last 30 days, unless the applicant meets any of the following:
  - ✓ Is age 18 and younger and seeking services in confidence
  - ✓ Is a domestic violence victim who is seeking services in confidence
  - ✓ Has an income of 150% to 260% of the federal poverty level, as described in WAC 182-505-0100.

A client is not eligible for Family Planning Only medical if the client is any of the following:

- Pregnant
- Sterilized
- Covered under another Apple Health program that includes family planning services

- Covered by concurrent creditable coverage, as defined in RCW 48.66.020, unless the client meets any of the following:

  ✓ Is age 18 and younger and seeking services in confidence

  ✓ Is a domestic violence victim who is seeking services in confidence

  ✓ Has an income of 150% to 260% of the federal poverty level, as described in WAC 182-505-0100.

A client may reapply for coverage under the Family Planning Only program up to 60 days before the expiration of the 12-month coverage period. The agency does not limit the number of times a client may reapply for coverage.

Alert! Always check ProviderOne to make sure that a client's one-year eligibility for the Family Planning Only program is still valid, or that the client is not on another agency program that covers family planning services.

Specific eligibility criteria for the Family Planning Only program (formerly referred to as 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 the Family Planning Only program if the applicant: • Has been sterilized. • Is seeking pregnancy. • Does not plan to use birth control. • Is pregnant.	

Topic	Eligible	Not Eligible	Notes
Health insurance including Medicaid		A current client of the agency with family planning coverage, such as categorically needy coverage (CNP), is not eligible for the Family Planning Only program. Clients with health insurance may not apply for the Family Planning Only program.	Clients with health insurance coverage are not eligible to apply for the Family Planning Only program. All services covered under the Family Planning Only program are covered by insurance with no co-pays or deductibles.
Incarcerated clients		Incarcerated clients, including those in Work Release programs, are not eligible for the Family Planning Only program 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 the Family Planning Only program services must reside in the state of Washington (for example, not residing in Oregon or Idaho).		

Topic	Eligible	Not Eligible	Notes
College students	Washington residents attending school out-of-state meet residency requirements if they: • Are attending college out-of-state. • Primarily reside in Washington. • Intend to remain in Washington after college.	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 Family Planning Only program. Foreign students or visiting foreign nationals are not considered legal permanent residents; they are temporarily in Washington State and are not eligible for the Family Planning Only program.	

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	• Adult clients, 19 and over, who are at or below 150% of the FPL, must apply for Apple Health (Medicaid) and be denied before they can be enrolled in the Family Planning Only program. Clients will not be enrolled in the Family Planning Only program unless they have already been denied Apple Health. **Note:** It is advantageous to both providers and clients for a client to have expanded Medicaid coverage.	• 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) program standards, see the Program standard for income and resources webpage. • 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. Examples of explanations for "0" income: "Parents support me." "My boyfriend/girlfriend supports me." **Alert!** Remind all clients that their reported **gross** income will be verified.

Topic	Eligible	Not Eligible	Notes
Adolescents	Applicant meets the eligibility requirement of 260% 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.
Domestic violence victims	Applicant meets the eligibility requirement of 260% of FPL or below		For domestic violence victims, use only the client's income to determine income eligibility regardless if they are covered by someone else's insurance.

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 the Family Planning Only program (formerly referred to as TAKE CHARGE)?

Applicants may apply in the following ways:

- In person at a provider's office.
- By phone at 800-562-3022
- By fax at 866-841-2267
- By email
- By mail. Send completed applications to:

  Family Planning Only Program Eligibility Unit
  Medical Eligibility Determination Services
  PO Box 45531
  Olympia, WA 98504

The agency determines final client eligibility. Only applicants seeking and needing family planning services and supplies should be given a Family Planning Only program application. Some clients may apply at a Family Planning Only program provider and intend to see their usual physician and will use the Family Planning Only program to cover their contraceptives at the pharmacy. This is a legitimate use of the Family Planning Only program.

Sometimes the client applies for the Family Planning Only program after seeing a clinician, who determines that enrolling in the Family Planning Only program is appropriate for the client. It is to the provider's benefit to:

- Help the client (applicant) accurately complete the required Family Planning Only program application on a question-by-question basis, if needed.
- Help clients age 19 and older to apply for Washington Apple Health (Medicaid) before applying for the Family Planning Only program 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 agency.
- Inform clients that they may give their permission for an authorized representative (known as an AREP) to talk with the agency about the client's application and benefits.
    - ✓ This representative may be a specific person or the client's Family Planning Only program provider.
    - ✓ If a client chooses an AREP, they may still receive Family Planning Only program 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 Family Planning Only program information, which can be written on the Family Planning Only program application. Clients may:
    - ✓ Have the information come directly to their home or mailing address.
    - ✓ Have the information sent to the Family Planning Only program 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 Services Card and any related information to the client's preferred address within 5 working days of receipt. 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 Family Planning Only program (formerly referred to as TAKE CHARGE) application

Providers should review the client's Family Planning Only program application for completeness and accuracy before the client signs the application and leaves the office.

- 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 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 Family Planning Only program eligibility unit at:

    Family Planning Only program Eligibility Unit
    Medical Eligibility Determination Services
    PO Box 45531
    Olympia, Washington 98504
    Fax: 866-841-2267

The agency's Family Planning Only program eligibility unit determines client eligibility.

Processing the client's Family Planning Only program (formerly referred to as TAKE CHARGE) application

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

- The Family Planning Only program eligibility unit processes 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.

Notifying the client about Family Planning Only program (formerly referred to as TAKE CHARGE) eligibility status

Approval

If the agency approves Family Planning Only program 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 agency. If, on the application, the client has elected to use an alternative address, the 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 Family Planning Only program ends or the client is no longer eligible. If a client enrolls in another agency program that covers family planning services, the client is no longer eligible for the Family Planning Only program.

Denial or pending Family Planning Only program status

The client receives a letter from the Family Planning Only program eligibility unit if the 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 are the requirements for Family Planning Only programs providers?

(WAC 182-532-520)

To be paid by the agency for services provided to clients eligible for Family Planning Only programs, providers must:

- Meet the requirements in Chapters 182-501, 182-502, and 182-532 WAC.
- Provide only those services that are within the scope of their licenses.
- Bill the agency according to this guide and other applicable agency billing guides.
- Educate clients on Food and Drug Administration (FDA)-approved contraceptive methods and over-the-counter (OTC) contraceptive drugs, devices, and products, as well as related medical services.
- Provide medical services related to FDA-approved contraceptive methods and OTC contraceptive drugs, devices, and products upon request.
- Supply or prescribe FDA-approved contraceptive methods and OTC contraceptive drugs, devices, and products upon request.
- Refer the client to available and affordable nonfamily planning primary care services, as needed.

Documentation requirements

(WAC 182-532-560)

In addition to the requirements in WAC 182-502-0020, providers must document the following in the client's medical record:

- Primary focus and diagnosis of the visit is family planning-related
- Contraceptive methods discussed
- Plan for use of a contraceptive method, or the reason and plan for no contraceptive method
- Education, counseling, and risk reduction with sufficient detail that allows for follow-up
- Referrals to, or from, other providers
- Copy of the completed Consent Form for Sterilization, if applicable. (See WAC 182-531-1550)

Provider requirements specific to the Family Planning Only program (formerly referred to as TAKE CHARGE)

When serving clients covered under the Family Planning Only program, providers must do all of the following:

- Participate in the research and evaluation component of the Family Planning Only program if requested by the agency. Some services related to research and evaluation may be contracted and billed separately.
- Provide Family Planning Only program client files, billing, and medical records when requested by agency staff
- Forward the client’s Services Card and any related information to the client’s preferred address within 5 working days of receipt if requested by the client
- Ensure they have a way of reaching the client in a confidential manner if the client requests confidentiality regarding the use of family planning services

- Inform the client of his or her right to seek services from any Family Planning Only program provider within the state.

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

What services are covered under the Family Planning Only programs?

(WAC 182-532-530)

The agency covers all of the following services:

- A comprehensive preventive family planning visit every 12 months, based on nationally recognized clinical guidelines. This visit must have a primary focus and diagnosis of family planning and include the following:

  - ✓ Counseling
  - ✓ Education
  - ✓ Risk reduction
  - ✓ Initiation or management of contraceptive methods

> **Note:** This visit may be billed as a preventive visit only when provided by a Family Planning Only programs provider. Other providers must use the appropriate office visit code.

- Assessment and management of family planning or contraceptive problems, when medically necessary

- Contraception, including all of the following:

  - ✓ FDA-approved contraceptive methods, as described under WAC 182-530-2000, including, but not limited to, the following items:

    - ➢ Oral hormonal contraceptives (pills)
    - ➢ Transdermal hormonal contraceptives (patch)
    - ➢ Intra-vaginal contraceptive (ring)
    - ➢ Injectable hormonal contraceptives
    - ➢ Implantable hormonal contraceptives
    - ➢ Intrauterine devices (IUDs)
    - ➢ Diaphragm, cervical cap, and cervical sponge
    - ➢ Male and female condoms
    - ➢ Spermicides (foam, gel, suppositories, and cream)
    - ➢ Emergency contraception

  - ✓ Education and supplies for FDA-approved contraceptives, natural family planning, and abstinence

  - ✓ Sterilization procedures, as described under WAC 182-531-1550.

  For more details on contraceptives the agency covers, see What contraceptives does the agency cover? and the Contraceptives Coverage Table.

- The following services, when appropriate, during a visit focused on family planning:

  - ✓ Pregnancy testing

  - ✓ Cervical cancer screening, according to nationally recognized clinical guidelines

  - ✓ Gonorrhea and chlamydia screening and treatment for clients age 13-25, according to nationally recognized clinical guidelines

  - ✓ Syphilis screening and treatment for clients who have an increased risk for syphilis, according to nationally recognized guidelines

  - ✓ Sexually transmitted infection (STI) screening, testing, and treatment, when medically indicated by symptoms or report of exposure, and medically necessary for the client's safe and effective use of their chosen contraceptive method.

Note: Pregnancy-related services, including abortions, are not covered under the Family Planning Only programs. Refer clients who become pregnant while on one of the Family Planning Only programs to www.wahealthplanfinder.org to enroll for coverage. People may also wish to contact www.withinreachwa.org/ for further assistance.

Complications from contraceptive methods

The agency covers inpatient, outpatient, and professional costs when they result from a complication arising from covered Family Planning Only programs services.

Example of a minor contraceptive complication

A client is unable to find the intrauterine device (IUD) string, it is not visualized on the speculum exam, and an ultrasound is needed to determine its location.

Example of a serious contraceptive complication

An IUD has migrated out of the uterus and needs to be removed by laparoscopy.

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

A complete report includes all of the following:

- Letter of explanation (a short description of the clinical situation and medical necessity for the visit, procedure, testing, or surgery)
- Inpatient discharge summary or outpatient chart notes
- Operative report (if applicable)

Note: 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 the *Claim Note* section of the electronic claim. Claims are subject to post-payment review.

What drugs and supplies are covered under the Family Planning Only programs?

See the guidelines regarding contraceptive prescribing and dispensing in What contraceptives does the agency cover?

See the Contraceptive coverage table section in this guide for contraceptive products and procedures covered under the Family Planning Only programs.

See the Coverage table in this guide for additional procedures, drugs, and tests covered under the Family Planning Only programs.

See the Sterilization Supplemental Billing Guide for drugs related to sterilization procedures.

The following categories of drugs are covered:

- Prescription contraceptives
- Antibiotics for the treatment of chlamydia and gonorrhea
- Adjunctive to a sterilization procedure

Over-the-counter, nonprescribed contraceptive drugs and supplies (for example: emergency contraception, condoms, spermicidal foam, cream, and gel) may be obtained through a pharmacy or a family planning clinic using a Services Card.

The agency does not pay for noncontraceptive take-home drugs dispensed at a family planning clinic.

Coverage table

This coverage table is limited to the codes that are covered for clients enrolled in the Family Planning Only programs. Procedures and visits are covered only if they are medically necessary for the person's safe and effective use of a chosen contraceptive method. See the appropriate family planning fee schedule for fees related to covered procedures and visits.

Note: For sterilization procedure codes, see the Sterilization Supplemental Billing Guide. For instructions on billing for office, professionally administered drugs, imaging, and laboratory codes listed below, see the Physician-Related Services/Health Care Professional Services Billing Guide.

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 for family planning surveillance and follow-up 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	As indicated by nationally recognized clinical guidelines. Covered only when occurs at a family planning visit.

Comprehensive prevention family planning visit

CPT Code	Modifier	Short Description	Comments
99384	FP	New (female) patient. Adolescent (age 12 through 17)	Once every 11-12 months. Only covered for Family Planning Only program clients.
99385	FP	New (female) patient. 18-39 years	Once every 11-12 months. Only covered for Family Planning Only program clients.
99386	FP	New (female) patient. 40-64 years	Once every 11-12 months. Only covered for Family Planning Only program clients.
99394	FP	Adolescent (age 12 through 17)	Established (female) patient. Once every 11-12 months. Only covered for Family Planning Only program clients.
99395	FP	Established (female) patient. 18-39 years	Once every 11-12 months. Only covered for Family Planning Only program clients.
99396	FP	Established (female) patient. 40-64 years	Once every 11-12 months. Only covered for Family Planning Only program clients.
99401	FP	New or established male patient. Preventive medicine counseling, individ	Use for male contraceptive counseling Once every 12 months. Only covered for Family Planning Only program clients.

Contraceptives

See the Contraceptives Coverage Table.

Radiology services

Radiology services are covered only when medically necessary due to a family planning complication. See Complications from contraceptive methods for how to bill when a family planning complication occurs. See the Physician-Related Professional Services Fee Schedule for payment rates for procedures related to a complication.

Laboratory services

Laboratory services are covered when they are directly related to the client's safe and effective use of a chosen contraceptive method. This includes pregnancy testing, gonorrhea and chlamydia screening and testing. Cervical cancer screening may also be covered. Specimens must be collected at a family planning visit to be covered by the Family Planning Only programs.

Laboratory testing in conjunction with a sterilization procedure or family planning complication are covered. See the Physician-Related Professional Services Fee Schedule for payment rates for laboratory services related to a sterilization or family planning complication.

CPT Code	Short Description	Comments
36415	Drawing blood venous	Payment limited to one draw per day.
36416	Drawing blood capillary	
81025	Urine pregnancy test	
84703	Chorionic gonadotropin assay	
86592	Syphilis test non-trep qual	
86593	Syphilis test non-trep quant	
86631	Chlamydia antibody	
86632	Chlamydia igm antibody	
87110	Chlamydia culture	
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	
87490	Chylmd trach, dna, dir probe	
87491	Chylmd trach, dna, amp probe	
87590	N.gonorrhoeae, dna, dir prob	
87591	N.gonorrhoeae, dna, amp prob	
87624	HPV high-risk types	
87625	HPV types 16, 18, and 45	
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	
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	

CPT Code	Short Description	Comments
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	

STD/STI treatment

The Family Planning Only programs cover limited treatment for sexually transmitted diseases and sexually transmitted infections (STD/STI). Treatments for gonorrhea and chlamydia only are covered. Providers must follow CDC guidelines for treatment of STD/STIs. Single dose drugs that are recommended to be directly observed are covered when administered in an office or clinic. All other covered drugs, must be prescribed by and then obtained from and billed by a pharmacy.

HCPCS/ CPT Code	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	Peng benzathine/procaine inj	
J0561	Penicillin g benzathine inj	
J0696	Ceftriaxone sodium inj, 250 mg	
J1580	Gentamicin 80 mg IM	Per CDC guidelines for allergy
Q0144	Azithromycin dihydrate, oral, 1 g	
By prescription only	Doxycycline 100 mg PO 2/day x 7 days	Per CDC guidelines for allergy
By prescription only	Cefixime 400 capsules mg PO	Per CDC guidelines for allergy
By prescription only	Gemifloxacin 320 mg PO	Per CDC guidelines for allergy. **PA required.**

What does the agency pay for?

(WACs 182-532-550 (1))

- The agency limits payment under the Family Planning programs to services that:
  - ✓ Have a primary focus and diagnosis of family planning as determined by a qualified, licensed medical practitioner.
  - ✓ Are medically necessary for the client to safely and effectively use, or continue to use, the client's chosen contraceptive method.

What fee does the agency pay?

(WAC 182-532-550 (2)(4)(5))

- The agency pays:
  - ✓ Providers for covered family planning services using the agency's Family Planning Fee Schedule.
  - ✓ For family planning pharmacy services, family planning laboratory services, and sterilization services using the agency's published fee schedules.
  - ✓ A dispensing fee only for contraceptive drugs purchased through the 340B program of the Public Health Service Act.
- Family planning services provided to family planning clients by federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health care providers (IHCP) do not qualify for encounter or enhanced rates.
- The agency requires providers to do the following:
  - ✓ Meet the timely billing requirements of WAC 182-502-0150
  - ✓ Seek timely reimbursement from a third party when a client has available third-party resources, as described under WAC 182-501-0200. See Billing for third-party liability and "good cause" for exceptions.

What does the agency not pay for?

(WAC 182-532-550 (3))

The agency does not pay for inpatient services under the Family Planning Only programs, except for complications arising from covered family planning services.

> **Note:** Billing adjustments related to the Family Planning Only program must be completed no later than two years after the date of service in which Family Planning Only services occurred.

Billing for third-party liability and "good cause"

(WAC 182-532-570)

The 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.

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

- Routinely sends written, verbal, or electronic communications, as defined in RCW 48.43.505, 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 the subscriber.

Clients eligible for Family Planning Only programs may request an exemption from the requirement to bill third-party insurance due to "good cause" if they are either of the following:

- 18 years of age or younger and seeking services in confidence
- Domestic violence victims and seeking services in confidence

> **Note:** Clients must make the self-declaration on the Family Planning Only program client application to qualify for this exception.

If either of these conditions applies, the applicant is considered for Family Planning Only program 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 that the client has other insurance.

Appendix A

Clinic visit scenarios for Family Planning Only programs

The purpose of the Family Planning Only programs 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.

Example A

Amanda has chosen to use an intrauterine device (IUD). It is the standard of practice to screen for chlamydia/gonorrhea prior to IUD insertion. This sexually transmitted infection (STI) screening (and treatment if necessary) **would** be covered under the Family Planning Only program 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 6 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 contraceptive 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 contraceptive method. She just wants to be screened for STIs. This visit would not be covered under the Family Planning Only programs.

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 laboratory work to determine that her liver function has returned to normal before restarting her on pills. This visit and laboratory tests would be covered under the Family Planning Only programs. Again, your thorough charting of this client’s history and current presenting issues is your justification for requesting payment from the agency for these services.

Example E

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

Appendix B

Frequently asked questions

If a client changes from Family Planning Only program coverage to full scope Medicaid coverage, are they covered under the Family Planning Only 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 and the Family Planning Only programs?

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 Z12.5 (encounter for screening for malignant neoplasm of the 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 programs.

Are mammograms covered under reproductive health services and the Family Planning Only programs?

Mammograms are covered for clients under Reproductive Health Services for women age 40 and 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 programs.

Are abortions covered under reproductive health services and the Family Planning Only programs?

Abortions are covered for clients under Reproductive Health Services. Bill the agency for these services with a medical taxonomy, not a family planning taxonomy.

Abortions *are not* covered under the Family Planning Only programs.

> **Note**: If a Family Planning Only programs client becomes pregnant, refer the client to www.wahealthplanfinder.org or call 1-855-923-4633 to determine if the client qualifies for medical services under another program.