Washington Apple Health

FAMILY PLANNING PROVIDER GUIDE

April 1, 2016

Washington State Health Care Authority

About this guide*

This publication takes effect April 1, 2016, 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?

Subject	Change	Reason for Change
Important Changes to Apple Health Effective April 1, 2016	**Effective April 1, 2016,** important changes are taking place that **all providers** need to know. Information has been added regarding a new policy for early enrollment into managed care, the implementation of fully integrated managed care in the SW WA region, Apple Health Core Connections for foster children, Behavioral Health Organizations (formerly RSNs), and contact information for Southwest Washington.	Program changes

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's Provider Publications website.

* This publication is a billing instruction.

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Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available on the Washington Apple Health (Medicaid) providers webpage.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **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.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- 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 new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Provider guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who live outside Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Resource
Information about Reproductive Health Services, the Family Planning Only program, and TAKE CHARGE, including becoming a TAKE CHARGE provider	Visit the Family Planning website. Contact the Customer Service Center. Contact the Family Planning Program: Family Health Care Services Unit PO Box 45530 Olympia, WA 98504-5530 Phone: 360-725-1652 Fax: 360-725-1152
TAKE CHARGE Application form, HCA 13-781 (for clients)	Medicaid agency forms
Information about sterilization	See the agency's Sterilization Supplement Provider Guide and WAC 182-531-1550.
Pharmacy information	See the agency's Pharmacy Information and the Prescription Drug Program Medicaid Provider Guide.
Additional agency resources	See the agency's Resources Available web page.
Finding agency documents (e.g., provider guides and fee schedules)	See the Provider Publications website
ICD 10 Diagnosis Codes	See the agency's Program Policy Approved Diagnosis Codes for Family Planning.

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).

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 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 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

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 (see 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.

Reproductive Health

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 half 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, 40% of women who unintentionally become pregnant decide to have an abortion.[1]

The goal of the Medicaid reproductive health services is to improve the health of women, children and families in Washington by decreasing unintended pregnancies, lengthening intervals between births, and reducing 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 provider guide describes requirements for three programs: Reproductive Health Services, Family Planning Only, and TAKE CHARGE.

[1] http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html accessed on September 21, 2015.

Reproductive Health Services

What are reproductive health services?

(WAC 182-532-050)

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.

What are the requirements for providers?

(WAC 182-532-110)

To be paid by the 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 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 agency covers limited, medically necessary Reproductive Health Services for clients who are on a Benefit Package (BP) covering Reproductive Health Services.

Note: 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 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 organization (MCO) may self-refer to providers not contracted with their MCO 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

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, 182-532-123, and 182-532-125)

In addition to services listed in WAC 182-531-0100, the agency covers all reproductive services listed in this section.

Covered services for women

(WACs 182-532-120 and 182-532-123)

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.

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

- Z01.411 OR Z01.49 routine gynecological exam with Pap cervical smear;
- Z12.72 routine vaginal Pap smear; or
- Z12.4 cervical Pap smear without general gynecological exam.

Bill a diagnosis code in the Z30 series for the yearly comprehensive prevention visit for family planning.

Dx

-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.

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

Female Medicaid clients 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 Provider Guide for more information)
- Over-the-Counter (OTC) family planning drugs, devices, and drug-related supplies (as described in the agency's Prescription Drug Program Provider Guide)
- Emergency contraception, such as Plan B (as described in the agency's Prescription Drug Program 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 Z30.2.

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 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

- 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 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 Provider Guide)

- Abortion (see thePhysician-Related Services/Healthcare Professional Services 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 services listed in WAC 182-531-0100, the 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 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 Z30.2.

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 Supplement 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 agency does not cover the Reproductive Health Services listed as noncovered in the agency's Physician-Related Services/Healthcare Professional Services Provider Guide and WAC 182-531-0150. The 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 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 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 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 Society for Colposcopy and Cervical Pathology (ASCCP), 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 Z30.2.

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 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 agency to consider payment when complications occur, providers of Family Planning Only-related inpatient or outpatient services must submit to the 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.

For IUD complications, use one of the following codes:

Diagnosis code	Short description
T83.31xA	Breakdown (mechanical) of intrauterine contraceptive device, initial encounter
T83.32xA	Displacement of intrauterine contraceptive device, initial encounter
T83.39xA	Other mechanical complication of intrauterine contraceptive device, initial encounter
T83.81xA	Embolism of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.82xA	Fibrosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.83xA	Hemorrhage of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.84xA	Pain from genitourinary prosthetic devices, implants and grafts, initial encounter
T83.85xA	Stenosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.86xA	Thrombosis of genitourinary prosthetic devices, implants and grafts, initial encounter Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.89xA	Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.9xxA	Unspecified complication of genitourinary prosthetic device, implant and graft, initial encounter
Z30.431	Routine Checking IUD

What drugs and supplies are covered?

For the Family Planning Only program, the 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 Emergency contraception 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 Nitrofuran Derivatives Oral contraceptives Quinolones Tetracyclines Vaginal antibiotics Vaginal antifungals Vaginal lubricant preparations Vaginal Sulfonamides

Note: For drugs related to sterilization procedures, see the Sterilization Supplemental Provider Guide.

Over-the-counter, nonprescribed contraceptive drugs and supplies (for example, emergency contraception, 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). When specifying the dispensing quantity for these contraceptives, prescribers **should** write a 12-month supply (13 cycles) unless there is a **clinical** reason not to do so. 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 requirement applies to 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.

This requirement applies to 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. For a list of family planning diagnosis codes, see the agency's Program Policy Approved Diagnosis Codes for Family Planning.

What services are not covered?

(WAC 182-532-540)

Medical services are not covered under the Family Planning Only program unless those services are both:

- Performed in relation to a primary focus and diagnosis of family planning; and
- 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 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 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 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, such as a physician, advanced registered nurse practitioner (ARNP), physician assistant (PA), 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 agency's TAKE CHARGE program guidelines.
- Comply with the required general agency policies and specific TAKE CHARGE provider policies, procedures, and administrative practices in this guide.
- Participate in the 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 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 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 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 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 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 agency providers are: pharmacies, labs, and surgeons performing sterilization procedures and sterilization-related services.) For details, see the Sterilization Supplemental 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 agency only for a clinic visits that are related to sterilization or complications from a birth control method. (WAC 182-532-780)

The agency pays for these services under the rules and fee schedules applicable to the specific services provided under the 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 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
  - ✓ Adult clients, 19 and over, who are at or below 150% of the FPL, must have applied for Apple Health (Medicaid) and been denied before they can be enrolled in TAKE CHARGE. Clients will not be enrolled in TAKE CHARGE unless they have already been denied Apple Health
  - ✓ 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 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 agency determines eligibility. Upon reapplication for TAKE CHARGE by the client, the 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: • Has been sterilized. • Is seeking pregnancy. • Does not plan to use birth control. • Is pregnant.	
Health insurance including Medicaid		A current client of the 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.	

Topic	Eligible	Not Eligible	Notes
Residency requirements	The applicant for TAKE CHARGE services must reside in the state of Washington (for example, not residing in Oregon or Idaho).		
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 TAKE CHARGE program. 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.	

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 TAKE CHARGE. Clients will not be enrolled in TAKE CHARGE unless they have already been denied Apple Health. • (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) 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. 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.
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 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 agency.

- Inform clients that they may give their permission for an authorized representative (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 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 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 agency's TAKE CHARGE eligibility unit determines client eligibility.

Processing the client's application

Every application that comes into the 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 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 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 TAKE CHARGE 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 TAKE CHARGE.

Denial or pending status

The client receives a letter from the TAKE CHARGE 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 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 Society for Colposcopy and Cervical Pathology (ASCCP), 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 Z30.2.

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

- Over-the-counter (OTC) contraceptive supplies (as described in the agency's Prescription Drug Program 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 Z30.2.

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 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. One example of a contraceptive complication in a female patient is an IUD that migrated out of the uterus and needed to be removed by laparoscopy. One example of a contraceptive complication in a male patient is a hematoma from a vasectomy.

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 agency to consider payment when complications occur, providers of TAKE CHARGE-related inpatient or outpatient services must submit to the 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.

For IUD complications, use one of the following codes:

Diagnosis code	Short description
T83.31xA	Breakdown (mechanical) of intrauterine contraceptive device, initial encounter
T83.32xA	Displacement of intrauterine contraceptive device, initial encounter
T83.39xA	Other mechanical complication of intrauterine contraceptive device, initial encounter

Diagnosis code	Short description
T83.81xA	Embolism of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.82xA	Fibrosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.83xA	Hemorrhage of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.84xA	Pain from genitourinary prosthetic devices, implants and grafts, initial encounter
T83.85xA	Stenosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.86xA	Thrombosis of genitourinary prosthetic devices, implants and grafts, initial encounter Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.89xA	Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.9xxA	Unspecified complication of genitourinary prosthetic device, implant and graft, initial encounter
Z30.431	Routine Checking IUD

What drugs and supplies are covered?

The 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 *may* be dispensed from a pharmacy**
Azithromycin Condoms Contraceptives, implantable, systemic Contraceptives, injectables Contraceptives, intravaginal Contraceptives, transdermal Emergency contraception 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 Nitrofuran Derivatives Quinolones Tetracyclines Vaginal Antibiotics Vaginal antifungals Vaginal Sulfonamides

Note: For drugs related to sterilization procedures, see the Sterilization Supplemental Provider Guide.

Over-the-counter, nonprescribed contraceptive drugs and supplies (for example, emergency contraception, 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). When specifying the dispensing quantity for these contraceptives, prescribers **should** write a 12-month supply (13 cycles) unless there is a **clinical** reason not to do so. 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 requirement applies to 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.

This requirement applies to 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. All services related to sterilization must be billed with the sterilization diagnosis code. See the agency's Program Policy Approved Diagnosis Codes for Family Planning.

What services are not covered?

(WAC 182-532-750)

The 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 www.wahealthplanfinder.org to enroll for coverage. Clients may also wish to contact www.withinreachwa.org for further assistance.

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 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 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.

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. For clients at high risk of contraceptive failure and unintended pregnancy, bill using the modifier SK to enable the 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 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
• 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	• 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
• 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	• 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
• Multiple partners • Lack of communication • Abusive partner • Drug-using partner • Controlling partner • Unsupportive/uninvolved partner • Apathetic • Partner unwilling to help with cost	• 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
• 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	• 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
• 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	• 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 Provider Guide.

Note: For billable codes and fees for nonfamily planning Reproductive Health Services, refer to the Physician-Related Services/Healthcare Professional Services 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 agency-contracted managed care organization 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.

See the agency's Program Policy Approved Diagnosis Codes for Family Planning.

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.

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.

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.

Prescription birth control methods

Note:

- 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 (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		
J1050	Injection, Medroxyprogesterone acetate1 mg (Depo-Provera)	150 mg is the therapeutic dose for contraception. Allowed once every 67 days and only with Z30.013, Z30.014, Z30.018, Z30.019, Z30.42, Z30.49, Z30.8, Z30.9
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	Short Description	Comments
J7307	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	For the insertion of the device	
11982	For removal of the device.	
11983	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

Unlisted contraceptive drugs and supplies

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

Emergency contraceptive pills

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

HCPCS 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 (1 unit of **J3490** should be billed with 1 unit S9430).

Nondrug contraceptive supplies

Providers must bill the 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

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 *Depo-Provera.*
77081		Radius, wrist-heel	Covered only for clients according to standard of care for clients using or considering *Depo-Provera.*
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 *Depo-Provera.*

Lab services

Note: See reimbursement for information more details about payment for lab services.

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	
81002		Urinalysis nonauto w/o scope	
81003		Urinalysis, auto, w/o scope	

CPT Code	Modifier	Short Description	Comments
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	
87624		Hpv high-risk types	
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	

CPT Code	Modifier	Short Description	Comments
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 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 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 acetate1 mg (Depo-Provera)	150 mg is the therapeutic dose for contraception. Allowed once every 67 days and only with Z30.013, Z30.014, Z30.018, Z30.019, Z30.42, Z30.49, Z30.8, Z30.9
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		Spectinomycn 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

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 Family Planning Fee Schedule.

Reimbursement

General reimbursement

(WAC 182-502-0100)

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

Long-acting reversible contraceptives

For dates of service on or after September 1, 2015, the agency pays an enhanced rate for procedure codes directly related to insertion or implant of long-acting reversible contraceptives (LARCs). See the agency's Family Planning Fee Schedule for rate changes on CPT codes 11981, 11983, and 58300.

Immediate postpartum 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 codes and the facility (including hospital inpatient) delivery claim. The agency does not pay separately for unbundled services billed by a hospital.

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; or
- 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.

Reproductive Health Services

(WAC 182-532-140)

- The agency pays providers for covered Reproductive Health Services using the agency's Family Planning Fee Schedule.

- Family planning pharmacy services, family planning lab services, and sterilization services are reimbursed by the agency under the rules and fee schedules applicable to these specific programs.

- The 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 who contract with an agency-contracted managed care organization (MCO) must directly bill the MCO for family planning or STI services received by clients enrolled with the MCO.

- Family planning providers not under contract with an agency-contracted MCO must bill using fee-for-service when providing services to MCO clients who self-refer outside their MCO.

- Family planning providers or agency-contracted local health department STI clinics under contract with agency-contracted MCOs must abide by their contract regarding lab services needed by clients from that MCO.

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

- The agency reimburses for immediate postpartum IUD and implant insertion separate from the global obstetric fee.

Family Planning Only and TAKE CHARGE

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

- The 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.

  - ✓ Are medically necessary for the client to safely and effectively use, or continue to use, their chosen contraceptive method.

- The agency pays providers for covered Family Planning Only and TAKE CHARGE services using the agency's Family Planning Fee Schedule.

- Providers without signed TAKE CHARGE agreements are reimbursed by the 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 agency under the rules and fee schedules applicable to these specific programs.

- The 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 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 agency for TAKE CHARGE services without regard to either:

  - ✓ Their special rates and fee schedules
  - ✓ The encounter rate structure

- The agency requires TAKE CHARGE providers to meet the billing requirements of WAC 182-502-0150.

- Under WAC 182-501-0200, the 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."

- The agency reimburses for immediate postpartum IUD and implant insertion separate from the global obstetric fee.

Contraceptive devices and drugs

(WACs 182-530-7250 and 182-530-7900)

If the 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 agency the actual acquisition cost (AAC) for all drugs purchased under the 340B Drug Pricing Program. Reimbursement is the AAC plus a 340B dispensing fee set by the agency.

Nonparticipating providers under 340B drug pricing program

Bill the agency the usual and customary fee. Reimbursement is the usual and customary fee or the 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 agency limits reimbursement to only enrolled and approved TAKE CHARGE providers.

Billing and Claim Forms

How do I complete the CMS-1500 claim form?

Instructions on how to bill professional claims and crossover claims electronically can be found on the Medicaid Providers Training page under Medicaid 101. Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing 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))

Family planning providers under contract with an agency-contracted managed care organization (MCO) must directly bill the MCO for family planning or 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 MCO.

Billing for third-party liability and "good cause"

(WAC 182-532-790)

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.

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 applies, 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 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

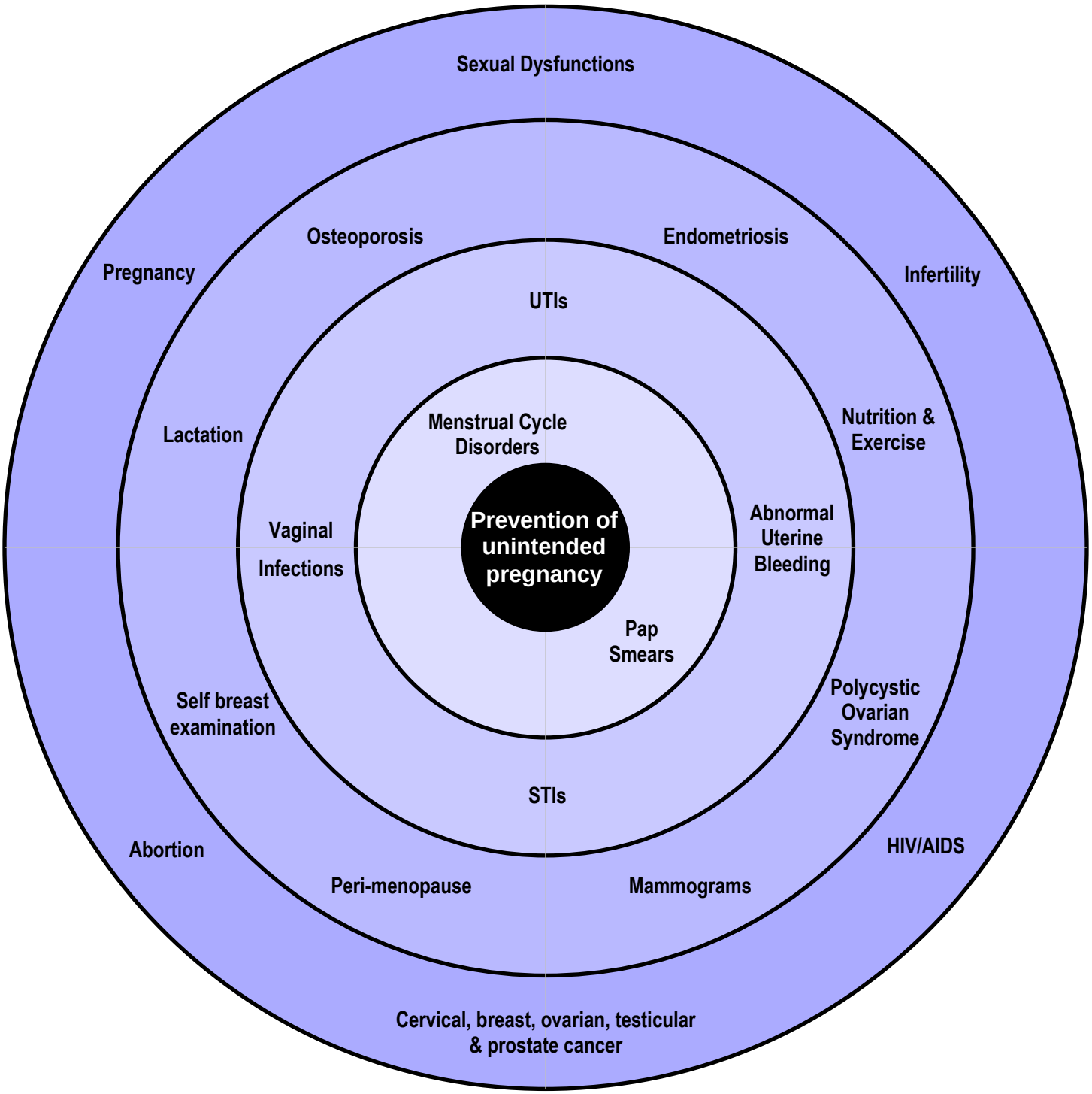
Aiming for the bull's eye: preventing unintended pregnancy

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.)


Sexual Dysfunctions
Pregnancy
Infertility
Abortion
HIV/AIDS
Cervical, breast, ovarian, testicular & prostate cancer
Osteoporosis
Endometriosis
Lactation
Nutrition & Exercise
Self breast examination
Polycystic Ovarian Syndrome
Peri-menopause
Mammograms
UTIs
Vaginal Infections
Abnormal Uterine Bleeding
STIs
Menstrual Cycle Disorders
Pap Smears
Prevention of unintended pregnancy

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.

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 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 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 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 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.

See the agency's Program Policy Approved Diagnosis Codes for Family Planning.

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
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
87624	87591	87800	87810	88141	88142	88143	88147	88148	88150
88153	88154	88164	88165	88166	88167	88174	88175	88300	88302
88152	96372	96374	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	J0561
J0690	J0694	J0696	J0697	J0698	J0710	J1890	J2460	J2510	J2540
J3320	J3490	J7300	J7302	J7303	J7304	J7307	Q0144	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
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
87624	87591	87800	87810	88141	88142	88143	88147	88148	88150
88153	88154	88164	88165	88166	88167	88174	88175	88300	88302
88152	96372	96374	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 non-TAKE-CHARGE providers

CPT codes

00840	00851	55250	55450	58600	58615	58670	58671		

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