

Washington Apple Health (Medicaid)

Family Planning Billing Guide

January 1, 2019

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

About this guide*

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

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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.

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
<u>Client Eligibility: BHO, Changes for January 1, 2019, IMC, and Integrated Apple Health Foster Care</u>	Effective January 1, 2019 , some existing integrated managed care regions have new counties and many new regions and counties will be implemented.	Apple Health managed care organizations (MCOs) in certain RSAs will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services.

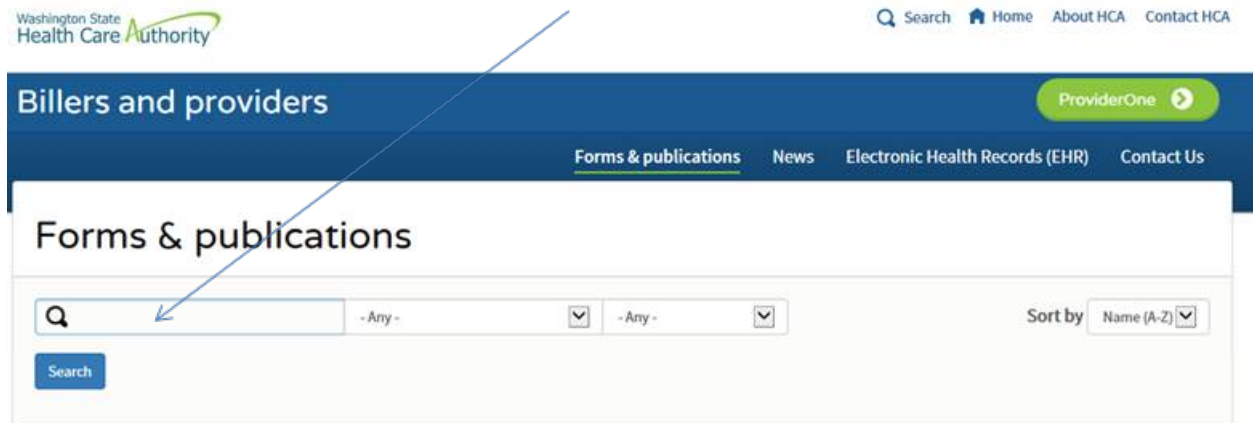
How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) web page.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) web page.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers web page, select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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Resources Available

Topic	Resource
Information about reproductive health services, the Family Planning Only program, and TAKE CHARGE, including becoming a TAKE CHARGE provider	<p>Contact the Billers and providers "contact us" web page.</p> <p>Contact the Family Planning Program:</p> <p>PO Box 45506 Olympia, WA 98504-5506 Phone: 360-725-1652 Fax: 360-725-1152 familyplanning@hca.wa.gov</p>
For additional billing guidance	<p>See the following billing guides:</p> <ul style="list-style-type: none"> • Outpatient Hospital Billing Guide • Physician-Related/Professional Services Billing Guide • Professional Administered Drugs Fee Schedule
TAKE CHARGE Application form, HCA 13-781 (for clients)	<p>Application for TAKE CHARGE (Family Planning) Services.</p>
Information about sterilization	<p>See the agency's Sterilization Supplement Billing Guide and WAC 182-531-1550.</p>
Pharmacy information	<p>See the agency's Pharmacy Information and the Prescription Drug Program Billing Guide.</p>
Additional agency resources	<p>See the agency's Billers and Providers web page.</p>

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](#)).

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

Comprehensive prevention visit for family planning – A comprehensive, preventive, contraceptive visit that includes evaluation and management of an individual, based on 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.

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

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

Client Eligibility - General

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

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

How do I verify a client's eligibility?

Check the client's services card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

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

Verifying eligibility is a two-step process:

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

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

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

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

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

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

Managed care enrollment

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

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

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

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

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **North Sound:** Includes Island, San Juan, Skagit, Snohomish, and Whatcom counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason:** Includes Thurston and Mason counties

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

See the agency's [Mental Health Services Billing Guide](#) for details.

Apple Health – Changes for January 1, 2019

Effective January 1, 2019, agency-contracted managed care organizations (MCOs) in certain Regional Services Areas (RSAs) will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the [Integrated Managed Care Regions](#) section.

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

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

Clients can change their plan at any time by:

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

Integrated managed care

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

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

American Indian/Alaska Native (AI/AN) clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on integrated managed care, see the agency's [Changes to Apple Health managed care webpage](#).

Integrated managed care regions

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

Existing integrated managed care regions – Expanding January 1, 2019

- **North Central** (Chelan, Douglas, Grant, and Okanogan counties)
The agency expanded this region to include Okanogan County
- **Southwest Washington** (Clark, Klickitat, and Skamania counties)
The agency expanded this region to include Klickitat County

New integrated managed care regions – Effective January 1, 2019

The following new regions are implemented for integrated managed care:

- **Greater Columbia** (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman counties)
- **King** (King County)
- **Pierce** (Pierce County)
- **Spokane** (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties)

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

These clients are identified in ProviderOne as
“Coordinated Care Healthy Options Foster Care.”

Fee-for-service Apple Health Foster Care

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

Reproductive Health Services

What are reproductive health services?

([WAC 182-532-050](#) and [WAC 182-501-0065](#))

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, providers, including licensed midwives, must:

- Meet the requirements in [Chapter 182-502 WAC](#) and the [Physician-Related/Professional Services Billing Guide](#).
- 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.

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

Who is eligible for reproductive health services?

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

The agency covers medically necessary reproductive health services for people enrolled in Washington Apple Health.

Managed care clients

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

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

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

Self-referral for managed care clients:

([WAC 182-532-100\(2\)](#))

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

Limited coverage

Family Planning Only and TAKE CHARGE programs:

[Family Planning Only](#) and [TAKE CHARGE](#) clients are eligible to receive limited reproductive health services which includes only family planning and specified family planning-related services. See the program guidelines in this guide.

Alien Emergency Medical:

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

Where can Washington Apple Health clients receive reproductive health services?

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

What reproductive health services are covered?

([WAC 182-531-0100](#) and [WAC 182-501-0065](#))

Covered services for women

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

The agency covers the following reproductive health services for women:

- One comprehensive family planning preventive visit per year (once every 12 months) based on nationally recognized clinical guidelines that include counseling, education, and initiation or management of contraceptive methods
 - ✓ This visit **may** include STI and cancer screening.
 - ✓ This visit may be billed as a preventive visit only when provided by a TAKE CHARGE provider. Other providers must use the appropriate office visit code. See the [TAKE CHARGE](#) section for information on how to bill a preventive visit.
 - ✓ A woman who is sterilized or otherwise not at risk for pregnancy does not qualify for a comprehensive family planning prevention visit. She does qualify for all other services.
- Cervical and breast cancer screening according to schedules established by nationally recognized clinical guidelines (see the [Physician-Related Services/Healthcare Professional Services Billing Guide](#))
- Sexually transmitted infection (STI) and disease (STD) screening according to nationally recognized clinical guidelines based on age
- STI and STD testing and treatment when medically indicated by symptoms or report of exposure
- HPV vaccination
- Follow-up visits for contraceptive management, STI/STD treatment, diagnostic testing for cervical and breast cancer
- Diagnosis and treatment of gynecological disorders and urological disorders (see the [Physician-Related Services/Healthcare Professional Services Billing Guide](#))
- Maternity-related services (see “Maternity Care and Services” in the [Physician-Related Services/Healthcare Professional Services Billing Guide](#))

Family Planning

- Abortion (see the [Physician-Related Services/Healthcare Professional Services Billing Guide](#))
- Sterilization procedures that meet the requirements of [WAC 182-531-1550](#) and the [Sterilization Supplemental Provider Guide](#)
- Contraception:
 - ✓ See [Coverage for Contraception](#)
 - ✓ Food and Drug Administration (FDA)-approved prescription and nonprescription contraception methods (see the [Prescription Drug Program Billing 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 Billing Guide](#))
 - ✓ Emergency contraception (as described in the agency's [Prescription Drug Program Billing Guide](#))
 - ✓ Education and supplies for FDA-approved contraceptives, natural family planning and abstinence
- Laboratory, imaging, diagnostic, and pharmacy services associated with the services in the [Covered services for women](#) section

Covered services for men

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 Billing Guide](#))
- Education and supplies for FDA-approved contraceptives, natural family planning, and abstinence
- Sterilization procedures that meet the requirements of [WAC 182-531-1550](#) and the [Sterilization Supplement Billing Guide](#)
- Screening and treatment for STI, including lab tests and procedures
- One prostate cancer screening per year (once every 12 months), when medically necessary (see the [Physician-Related Services/Healthcare Professional Services Billing Guide](#))
- Diagnostic mammograms when medically necessary (see the [Physician-Related Services/Healthcare Professional Services Billing Guide](#))

What reproductive health 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 Billing Guide](#) and WACs [182-531-0150](#), [182-531-0150](#), and [182-525-130](#). This includes, but is not limited to, treatment for infertility, hysterectomy for the purpose of sterilization, and marital counseling. The agency reviews requests for noncovered services under [WAC 182-501-0160](#).

Coverage for Contraception

Hormonal contraceptive prescribing

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

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

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

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

Hormonal contraceptives filled at the pharmacy

([WAC 182-530-2000](#))

The agency generally requires pharmacies to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply. For prescriptions written with a dispensing quantity less than a 12 month supply, the agency encourages pharmacies to contact the prescriber to request a change in the dispensing quantity. Pharmacies may dispense a lesser amount if either:

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

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

See the [Prescription Drug Program Billing Guide](#) for more details.

Hormonal contraceptives dispensed from a family planning clinic

12 month supply

The agency generally requires family planning clinics to dispense oral, transdermal, and intra-vaginal hormonal contraceptives as a one-time prescription of a 12-month supply. Clinics may dispense or write the prescription for a lesser amount if 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
- The clinic does not have enough supply to fill for 12 months

340B dispensing fee

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

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

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

Note:

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

Immediate postpartum Long-Acting Reversible Contraceptive (LARC) insertion

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

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

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

- Through the facility's pharmacy point of sale system;
- As a separate professional claim submitted by the facility when the facility supplies the device; 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.

Contraception Coverage Table

Prescription contraceptives

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

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.

HCPCS Code	Short Description	Comments
Pills, Ring, and Patch		
S4993	Contraceptive pills for birth control	1 unit = each 21 or 28-day pack (Seasonale should be billed as 3 units.) Participating 340B provider: may bill with S9430.
J7303	Contraceptive ring, each (Nuvaring)	Participating 340B provider may bill with S9430.
J7304	Contraceptive patch, each (Ortho-Evra)	Participating 340B provider may bill with S9430.

HCPCS Code	Short Description	Comments
S9430	Pharmacy compounding and dispensing services	<p>A dispensing fee for participating 340B providers.</p> <p>May bill only with S4993 (birth control pills, and emergency contraception pills), J7303 (contraceptive rings), J7304 (contraceptive patches).</p> <p>Units of dispensing fee must match units of contraceptive.</p>
Emergency Contraception		
S4993	<p>Unclassified drug Used for:</p> <p>Ulipristal acetate 30 mg</p>	<p>Ulipristal is prescription for all ages.</p> <p>Each 1 unit equals one course of treatment.</p> <p>Participating 340B provider may bill with S9430.</p>
Injectable		
J1050	Injection, Medroxyprogesterone acetate 1 mg (Depo-Provera)	<p>No 340B dispensing fee allowed.</p> <p>May be billed with injection administration code 96372 only when not in conjunction with an office visit.</p>
Intrauterine Devices (IUD)		
J7297	Levonorgestrel-releasing IUD (Liletta), 52 mg	No 340B dispensing fee allowed.
J7298	Levonorgestrel-releasing IUD (Mirena), 52 mg	No 340B dispensing fee allowed.
J7300	Intrauterine copper device (Paragard)	No 340B dispensing fee allowed.
J7301	Levonorgestrel-releasing IUD (Skyla), 13.5 mg	No 340B dispensing fee allowed.
J7296	Levonorgestrel 19.5 mg - releasing IUD (Kyleena)	No 340B dispensing fee allowed.

HCPCS Code	Short Description	Comments
58300	Insertion of intrauterine device (IUD)	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate.
58301	Removal of intrauterine device (IUD)	
Implant		
J7307	Etonogestrel (contraceptive) implant system (Nexplanon)	No 340B dispensing fee allowed.
11981	For the insertion of the device	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate. Must be billed with FP modifier.
11982	For removal of the device.	Must be billed with FP modifier.
11983	For removal of the device with reinsertion on the same day	Enhanced fee applies. See Physician-Related Services Fee Schedule for current rate. Must be billed with FP modifier.
11976	Removal of contraceptive capsule	Norplant only
Cervical Cap/Diaphragm		
A4261	Cervical cap for contraceptive use	No 340B dispensing fee allowed.
A4266	Diaphragm	No 340B dispensing fee allowed.
57170	Fitting of diaphragm/cap	

Nonprescription over-the-counter (OTC) contraceptives

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

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

Nondrug contraceptive supplies (natural family planning)

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

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

Family Planning Only Program

What is the purpose of the Family Planning Only 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 Family Planning Only providers?

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

To be paid by the agency for services provided to people eligible for the Family Planning Only program, providers must meet the [requirements for Reproductive Health providers](#).

Who is eligible for Family Planning Only 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 in the Family Planning Only program?

The purpose of the Family Planning Only program is to prevent unintended pregnancies. Services provided under Family Planning Only must be related to the prevention of unintended pregnancies.

Family Planning Only services include:

- One comprehensive family planning preventive visit per year (once every 12 months) based on nationally recognized clinical guidelines which **must** have a primary focus and diagnosis of family planning. This includes:
 - ✓ Counseling, education, and initiation or management of contraceptive methods
 - ✓ This visit may be billed as a preventive visit only when provided by a TAKE CHARGE provider. Other providers must use the appropriate office visit code. See the TAKE CHARGE section for information on how to bill a preventive visit.

- The following services if they occur during a visit focused on family planning:
 - ✓ Cervical cancer screening according to schedules established by nationally recognized clinical guidelines
 - ✓ Gonorrhea and chlamydia screening according to nationally recognized clinical guidelines based on age (only covered for women 13-25)
 - ✓ Assessment and management of medically necessary family planning or contraceptive problems
 - ✓ STI and STD testing and treatment when medically indicated by symptoms or report of exposure **and** medically necessary for the client's safe and effective use of the chosen contraceptive method
- 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:
 - ✓ Oral hormonal contraceptives (pills)
 - ✓ Transdermal hormonal contraceptives (patch)
 - ✓ Intra-vaginal contraceptive (ring)
 - ✓ Injectable hormonal contraceptives
 - ✓ Implantable hormonal contraceptives
 - ✓ Intrauterine devices (IUDs)
 - ✓ Diaphragm, cervical cap, and cervical sponge
 - ✓ Male and female condoms
 - ✓ Spermicides (foam, gel, suppositories, and cream)
 - ✓ Emergency contraception
- Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies, as described in [Chapter 182-530 WAC](#) and the [Prescription Drug Program Billing Guide](#).
- Sterilization procedures that meet the requirements of WAC 182-531-1550 and the [Sterilization Supplemental Provider Guide](#).
- Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

Complications from contraceptive methods

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

- An example of a minor contraceptive complication is when a client is unable to find the IUD string and it is not visualized on speculum exam, and an ultrasound is needed to determine location.
- An example of a serious contraceptive complication is an IUD that migrates out of the uterus and needs to be removed by laparoscopy.

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

A complete report includes:

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

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

What drugs and supplies are covered in the Family Planning Only program?

See the guidelines regarding contraceptive prescribing and dispensing in the [Reproductive Health Services](#) section of this guide.

See the [Contraceptive Coverage Table](#) section in this guide for contraceptive products and procedures covered for the Family Planning Only Program.

See the [Family Planning Only and Take Charge Coverage Table](#) section in this guide for additional procedures, drugs, and tests covered for the Family Planning Only Program.

See the [Sterilization Supplemental Billing Guide](#) for drugs related to sterilization procedures.

The following categories of drugs are covered:

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

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

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

What services are not covered in the Family Planning Only program?

(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.

The following reproductive health services are not included in the agency's Family Planning Only program:

- HIV counseling and testing
- Follow-up for abnormal cervical cancer screening
- Testing and treatment for vaginal infections
- Prostate cancer screening
- Breast cancer screening
- HPV vaccination
- Gynecological and urological services and procedures

Clients may be eligible for these services if they are eligible for Apple Health.

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 www.wahealthplanfinder.org to enroll for coverage. People may also wish to contact www.withinreachwa.org/ for further assistance.

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 the TAKE CHARGE program?

(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 increases access to family planning (birth control) services for people 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 providers performing sterilizations, pharmacies, and imaging and lab services related to the safe and effective use of the client's chosen contraceptive method. See [when other providers give services to TAKE CHARGE clients](#) for further information. For detailed information about sterilization, see the [Sterilization Supplemental Billing Guide](#).

What are the requirements for TAKE CHARGE providers?

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

Qualifications of approved TAKE CHARGE providers

A TAKE CHARGE provider must:

- Be a 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.

Note: The agency reimburses only enrolled and approved TAKE CHARGE providers for services provided to TAKE CHARGE clients. Take Charge providers must bill using taxonomy 261QA0005X for all services provided to Take Charge clients.

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.
- If the client requests confidentiality regarding the use of family planning services, the provider must have a way of reaching the client in a confidential manner.
- 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
 - ✓ The federal Consent for Sterilization form [HHS-687](#) must be attached to a sterilization claim. See the [Sterilization Supplemental Billing Guide](#) for requirements and instructions. See also [Where can I download agency forms?](#)
 - ✓ Authorization from clients for release of information
- Ensure the proper release of client information:
 - ✓ To transfer information to another 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 of counseling on the use of the client's chosen contraceptive method and risk reduction interventions
- Documentation of referrals to or from other providers
- A form signed by the client authorizing release of information for referral purposes, as necessary

- The federal Consent for Sterilization form [HHS-687](#) must be attached to a sterilization claim. See the [Sterilization Supplemental Billing Guide](#) for requirements and instructions. See also [Where can I download agency forms?](#)
- 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.
- Document when the client's alternative address is that of a TAKE CHARGE provider. Notify the client within 5 business days that the client has important, time-sensitive correspondence that is available for them to pick up.

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, lab and imaging services provided in relation to the safe and effective use of the client's chosen contraceptive method, and surgeons performing sterilization procedures and sterilization-related services.) For details, see the [Sterilization Supplemental Billing Guide](#).

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

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 according to 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 TAKE CHARGE provider's partnership with pharmacists is especially critical since pharmacists provide immediate access to methods not received at the TAKE CHARGE clinic.

Who is eligible for TAKE CHARGE 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 [182-503-0535](#), 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 182-503-0520](#)
 - ✓ Have income at or below 260 percent of the federal poverty level (FPL) as described in [WAC182-505-0100](#)

Family Planning

- ✓ 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 for Apple Health coverage
 - ✓ Need family planning services and not be currently covered by or eligible for another medical assistance program for family planning
- Clients who are currently pregnant, sterilized, or incarcerated are 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.

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.

Specific eligibility criteria for the TAKE CHARGE program

Topic	Eligible	Not Eligible	Notes
Need for family planning	The applicant must state that they need family planning	<p>The applicant is not in need of family planning and not eligible for TAKE CHARGE if the applicant:</p> <ul style="list-style-type: none"> • Has been sterilized. • Is seeking pregnancy. • Does not plan to use birth control. • Is pregnant. 	
Health insurance including Medicaid		<p>A current client of the agency with family planning coverage, such as categorically needy coverage (CNP), is not eligible for TAKE CHARGE.</p> <p>Clients with health insurance may not apply for TAKE CHARGE.</p>	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
<p>Residency requirements</p>	<p>The applicant for TAKE CHARGE services must reside in the state of Washington (for example, not residing in Oregon or Idaho).</p>		
<p>College students</p>	<p>Washington residents attending school out-of-state meet residency requirements if they:</p> <ul style="list-style-type: none"> • Are attending college out-of-state. • Primarily reside in Washington. • Intend to remain in Washington after college. 	<p>Out-of-state college students attending school in Washington State are not considered permanent Washington residents if they do not plan to remain in Washington when their schooling is complete. They do not qualify for the TAKE CHARGE program.</p> <p>Foreign students or visiting foreign nationals are not considered legal permanent residents; they are temporarily in Washington State and are not eligible for TAKE CHARGE.</p>	

Topic	Eligible	Not Eligible	Notes
<p>Income requirements and family size</p>	<p>Applicant meets the eligibility requirement of 260 percent of Federal Poverty Level (FPL) or below</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Married clients—Use both the client’s and spouse’s incomes to determine potential financial eligibility, entering both income separately. • Single clients—Use gross income to determine potential financial eligibility. • To check the current Federal Poverty Level (FPL) program standards, see the Program standard for income and resources web page. • If the client reports “0” income, the client must explain on the application how they meet their basic needs, such as food, clothing, shelter, and other necessities. <p>Examples of explanations for “0” income:</p> <p>“Parents support me.”</p> <p>“My boyfriend/girlfriend supports me.”</p> <p>Alert! Remind all clients that their reported gross income will be verified.</p>
<p>Adolescents</p>	<p>Applicant meets the eligibility requirement of 260 percent of FPL or below</p>		<p>For adolescents 17 years of age or younger, use the client’s income to determine income eligibility regardless of the parents’ income.</p>

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

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

How can clients apply for the TAKE CHARGE program?

Applicants must apply in person for TAKE CHARGE at an 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 (known as an AREP) to talk with the agency about the client’s application and benefits.
 - ✓ This representative may be a specific person or the client’s 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 TAKE CHARGE application

Providers should review the client’s TAKE CHARGE application for completeness and accuracy before the client signs the application and leaves the office.

- If it appears the client does not meet eligibility requirements, for instance, if a client is not a U.S. citizen:
 - ✓ Do not have the client sign the application.
 - ✓ Inform the client they do not meet the eligibility requirements.

- ✓ Inform them about other agency programs that may fit the client's needs and eligibility.
- ✓ Shred the application.
- If it is likely that the client meets the eligibility requirements:
 - ✓ Make a copy of the client's U.S. Citizenship and Immigration Services (USCIS) paperwork and photo ID if the client is a U.S. national or qualified alien. Retain a copy of these documents with the client's application.
 - ✓ Have the client sign the application.
 - ✓ Within 5 business days of the client's signature, mail or fax the application and any other required documents to the 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 TAKE CHARGE 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.

Notifying the client about TAKE CHARGE eligibility status

Approval

If the agency approves TAKE CHARGE 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 TAKE CHARGE 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 under the TAKE CHARGE program?

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

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

Covered services for women in the TAKE CHARGE program

- One comprehensive family planning preventive visit per year (once every 12 months) based on nationally recognized clinical guidelines which **must** have a primary focus and diagnosis of family planning. This includes:
 - ✓ Counseling, education, and initiation or management of contraceptive methods
 - ✓ This visit must be provided by an approved TAKE CHARGE provider. This visit may be billed as a preventive visit.
- The following services if they occur during a visit focused on family planning:
 - ✓ Cervical cancer screening according to schedules established by nationally recognized clinical guidelines

Family Planning

- ✓ Gonorrhea and chlamydia screening according to nationally recognized clinical guidelines based on age (only covered for women 13-25)
- ✓ Assessment and management of family planning or contraceptive problems, when medically necessary.
- ✓ STI and STD testing and treatment when medically indicated by symptoms or report of exposure **and** medically necessary for the client's safe and effective use of the client's chosen contraceptive method.
- 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:
 - ✓ Oral hormonal contraceptives (pills)
 - ✓ Transdermal hormonal contraceptives (patch)
 - ✓ Intra-vaginal hormonal contraceptives (ring)
 - ✓ Injectable hormonal contraceptives
 - ✓ Implantable hormonal contraceptives
 - ✓ Intrauterine devices (IUDs)
 - ✓ Diaphragm, cervical cap, and cervical sponge
 - ✓ Male and female condoms
 - ✓ Spermicides (foam, gel, suppositories, and cream)
 - ✓ Emergency contraception
- Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies, as described in [Chapter 182-530 WAC](#) and the [Prescription Drug Program Billing Guide](#).
- Sterilization procedures that meet the requirements of WAC 182-531-1550 and the [Sterilization Supplemental Provider Guide](#).
- Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

Covered services for men in the TAKE CHARGE program

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:

- Over-the-counter (OTC) contraceptive supplies (as described in the agency's [Prescription Drug Program Billing Guide](#)).
- Sterilization procedures that meet the requirements of WAC 182-531-1550 and the [Sterilization Supplemental Provider Guide](#). These additional services are covered in conjunction with a sterilization:
 - ✓ Office visits or physical exams only when related to and necessary for sterilization.
 - ✓ STI/STD screening or treatment only when related to and medically necessary for a sterilization procedure.
- One preventive office visit every 12 months for those male clients whose female partners are at moderate to high risk for unintended pregnancy. Men are not eligible for a preventive office visit if their partners have had a sterilization or are using an IUD, Depo-Provera, or contraceptive implant. The visit must:
 - ✓ Be provided by an approved TAKE CHARGE provider.
 - ✓ Include education and counseling for risk reduction to prevent unintended pregnancy and support safe and effective use of a contraceptive method, including abstinence. This may include providing supplies for FDA-approved contraceptives and natural family planning.
 - ✓ Documented in the client's chart with detailed information that allows for a well-informed follow-up visit.
 - ✓ Not be used to cover the cost of providing other reproductive health services for men. This includes STI/STD counseling, testing and treatment, which are not covered by TAKE CHARGE except in conjunction with a sterilization.

The agency will closely monitor the provision of this service to men.

Complications from contraceptive methods

The agency covers inpatient, outpatient, and professional costs when they result from a complication arising from covered TAKE CHARGE services.

- An example of a minor contraceptive complication is when a client is unable to find the IUD string and it is not visualized on speculum exam, and an ultrasound is needed to determine location.
- An example of a serious contraceptive complication is an IUD that migrates out of the uterus and needs to be removed by laparoscopy.

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

A complete report includes:

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

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

What drugs and supplies are covered under the TAKE CHARGE program?

See the guidelines regarding contraceptive prescribing and dispensing in the [Reproductive Health Services](#) section of this guide.

See the [Contraceptive Coverage Table](#) section in this guide for contraceptive products and procedures covered for the TAKE CHARGE Program.

See the [Family Planning Only and Take Charge Coverage Table](#) section in this guide for additional procedures, drugs, and tests covered for the TAKE CHARGE Program.

See the [Sterilization Supplemental Billing Guide](#) for drugs related to sterilization procedures.

The following categories of drugs are covered:

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

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

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

What services are not covered under the TAKE CHARGE program?

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

Medical services are not covered under the TAKE CHARGE 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.

The following reproductive health services are not included in the agency's TAKE CHARGE program:

- HIV counseling and testing
- Follow-up for abnormal cervical cancer screening
- Testing and treatment for vaginal infections
- Prostate cancer screening
- Breast cancer screening
- HPV vaccination
- Gynecological and urological services and procedures

Clients may be eligible for these services if they are eligible for Apple Health.

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. People may also wish to contact www.withinreachwa.org/ for further assistance.

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](#).)

Family Planning Only and TAKE CHARGE Coverage Table

This coverage table is limited to the codes that are covered for clients enrolled in the Family Planning Only or TAKE CHARGE programs. Procedures and visits are covered only if they are medically necessary for the person's safe and effective use of a chosen contraceptive method. See the [Family Planning Only and TAKE CHARGE Fee Schedule](#) for fees related to covered procedures and visits.

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

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

Office visits for family planning surveillance and follow-up visits

HCPCS/ CPT Code	Short Description	Comments
99201	Office/outpatient visit, new	
99202	Office/outpatient visit, new	
99203	Office/outpatient visit, new	
99204	Office/outpatient visit, new	
99211	Office/outpatient visit, est	
99212	Office/outpatient visit, est	
99213	Office/outpatient visit, est	
99214	Office/outpatient visit, est	
G0101	CA screen; pelvic/breast exam	As indicated by nationally recognized clinical guidelines. Covered only when occurs at a family planning visit.

Comprehensive prevention family planning visit

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

CPT Code	Modifier	Short Description	Comments
99395	FP	Established (female) patient. 18-39 years	Once every 11-12 months. Only TAKE CHARGE providers can bill.
99396	FP	Established (female) patient. 40-64 years	Once every 11-12 months. Only TAKE CHARGE providers can bill.
99401	FP	New or established male patient. Preventive medicine counseling, individ	Use for male contraceptive counseling Once every 12 months. Only TAKE CHARGE providers can bill.

Contraceptives

See the reproductive health Section for the [Contraceptive Coverage Table](#).

Radiology services

Radiology services are covered only when medically necessary due to a family planning complication. See the complications section for how to bill when a family planning complication occurs for a [Family Planning Only](#) or [TAKE CHARGE](#) client. See the [Physician-Related Professional Services Fee Schedule](#) for payment rates for procedures related to a complication.

Laboratory services

Laboratory services are covered when they are directly related to the client's safe and effective use of a chosen contraceptive method. This includes pregnancy testing, gonorrhea and chlamydia screening and testing. Cervical cancer screening may also be covered. Specimens must be collected at a family planning visit to be covered by the Family Planning Only or Take Charge programs. Laboratory testing in conjunction with a sterilization procedure or family planning complication are covered. See the [Physician-Related Professional Services Fee Schedule](#) for payment rates for laboratory services related to a sterilization or family planning complication.

CPT Code	Short Description	Comments
36415	Drawing blood venous	Payment limited to one draw per day.
36416	Drawing blood capillary	
81025	Urine pregnancy test	
84703	Chorionic gonadotropin assay	
86631	Chlamydia antibody	
86632	Chlamydia igm antibody	
87110	Chlamydia culture	
87270	Infectious agent antigen detection by immuno-fluorescent technique; chlamydia trachomatis	
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative; chlamydia trachomatis	
87490	Chylmd trach, dna, dir probe	
87491	Chylmd trach, dna, amp probe	
87590	N.gonorrhoeae, dna, dir prob	
87591	N.gonorrhoeae, dna, amp prob	
87624	HPV high-risk types	
87625	HPV types 16, 18, and 45	
87800	Detect agnt mult, dna, direc	
87810	Chylmd trach assay w/optic	
88141	Cytopath, c/v, interpret	
88142	Cytopath, c/v, thin layer	
88143	Cytopath, c/v, thin lyr redo	
88147	Cytopath, c/v, automated	
88148	Cytopath, c/v, auto rescreen	
88150	Cytopath, c/v, manual	
88152	Cytopath, c/v, auto redo	
88153	Cytopath, c/v, redo	
88154	Cytopath, c/v, select	
88164	Cytopath tbs, c/v, manual	
88165	Cytopath tbs, c/v, redo	
88166	Cytopath tbs, c/v, auto redo	
88167	Cytopath tbs, c/v, select	
88174	Cytopath, c/v auto, in fluid	
88175	Cytopath, c/v auto fluid redo	

STD/STI treatment

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

HCPCS/ CPT Code	Short Description	Comments
96372	Ther/proph/diag inj, sc/im (Specify substance or drug)	May not be billed with an office visit.
J0456	Azithromycin inj, 500 mg	
J0696	Ceftriaxone sodium inj, 250 mg	
J1580	Gentamicin 80 mg IM	Per CDC guidelines for allergy
Q0144	Azithromycin dihydrate, oral, 1 g	
By prescription only	Doxycycline 100 mg PO 2/day x 7 days	Per CDC guidelines for allergy
By prescription only	Cefixime 400 mg PO	Per CDC guidelines for allergy
By prescription only	Gemifloxacin 320 mg PO	Per CDC guidelines for allergy

Billing

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

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's [Billers and Providers](#) web page, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange \(EDI\)](#) web page.

How do providers bill for Family Planning Only and TAKE CHARGE services?

(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 Only and Take Charge 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, family planning imaging services, and sterilization services are reimbursed by the agency under the rules and fee schedules applicable to these specific programs.

- 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](#).

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

- 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.”](#)

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.

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

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

- The provider NPI used for 340B drugs must be listed on the federal Office of Pharmacy Affairs Medicaid Exclusion File.
- Bill the agency the actual acquisition cost (AAC) for all drugs purchased under the 340B Drug Pricing Program.
- The agency pays family planning clinics a dispensing fee only for agency designated hormonal contraceptives that are purchased through the 340B program of the Public Health Service Act. (See chapter 182-530 WAC.)
- To receive the 340B dispensing fee the provider must be listed on the Medicaid Exclusion file as a family planning entity type (Title X funded).

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.

Family Planning

“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 that the client has other insurance.

Appendix A

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 B

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](#).) 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.