Clinical Policy: Family Planning Service

Reference Number: WNC.CP.102 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Family Planning Medicaid services are provided to an eligible Medicaid Beneficiary of childbearing age to temporarily or permanently prevent or delay pregnancy. Medicaid Family Planning is designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina.

NOTE: Family Planning Medicaid (Medicaid beneficiaries with MAFDP Plan Code) are carved out of Medicaid Managed Care. WellCare of North Carolina covers the same services as "Traditional Medicaid" as referenced in this Clinical Coverage Policy.

Definitions:

I. Traditional Medicaid family planning services consist of:
- **A.** Consultation;
- **B.** Examination;
- **C.** Treatment prescribed by a physician, nurse midwife, physician assistant, nurse practitioner, pharmacist per state protocol or furnished by or under the physician's supervision;
- **D.** Laboratory examinations and tests; and
- **E.** Food and Drug Administration(FDA) approved family planning supplies and devices to prevent conception.

II. Family Planning Medicaid (FP Medicaid)
- **A.** FP Medicaid provides only limited family planning and family planning related services to beneficiaries with MAFDN eligibility.
- **B.** Family Planning Medicaid Beneficiaries needing non-family planning services shall be referred to their primary care or a safety net provider.

POLICY/CRITERIA

I. Eligibility Requirements:
- **A.** A traditional Medicaid or a FP Medicaid Beneficiary **may be eligible** for family planning and family planning-related services when the Beneficiary meets **ALL** the following eligibility criteria:
  1. Is a North Carolina resident; is a U.S. citizen or qualified alien;
  2. Is Childbearing age;

3. Is not knowingly pregnant; and
4. Is not incarcerated.
5. FP Medicaid shall cover a beneficiary who meets the above criteria, and the income eligibility requirements defined in 42 CFR 435.214.

B. Special Provisions:

1. **Non-Citizens**
   Emergency care services shall be provided for the treatment of people in a population group for whom the state cannot provide family planning services. These people shall meet the description per 42 CFR 440.255 (c).
2. **Retroactive eligibility** applies to FP Medicaid.

II. Telehealth Services - Select services within this clinical coverage policy may be provided via Telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy WNC.CP.193 Telehealth, Virtual Communications, and Remote Patient Monitoring.

III. Medicaid shall cover family planning services when the Beneficiary meets the following specific criteria:

A. A beneficiary enrolled in Traditional or Family Planning Medicaid and is not sterilized or otherwise unable to conceive, upon prescription or provider order, shall be eligible for the following:

1. The "fitting" of diaphragms;
2. Oral Contraceptives and transdermal patches per the North Carolina State Health Director's Standing Order,;
3. Emergency contraception;
4. Insertion and removal of LARC devices:
5. Condoms, spermicides, and vaginal rings (refer to Attachment A Letter C**).
6. Contraceptive injections;
7. Emergency Contraception, Listed in Medicaid Clinical Coverage Policy 9 *Outpatient Pharmacy Program*, located at Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov);
8. Screening, early detection and education for Sexually Transmitted Infections (STIs), Hepatitis B and Hepatitis C;
9. Treatment for STIs (refer to Attachment C**)
10. Laboratory services: **(**for specific FP Medicaid coverage please refer to Attachment A**).
11. Ultrasounds when the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are not intended for the purpose of routine checking of placement after IUD insertion;
12. Human Papillomavirus (HPV) Gardasil 9 Vaccine. Agencies shall follow the current HPV vaccine recommendations from the Advisory Committee on Immunization Practice (ACIP);

13. Up to four (4) Depression screenings per 365 rolling calendar days when performed with a scientifically validated screening tool;
14. Covered Sterilization procedures,
15. Non-emergency medical transportation, as needed, to and from family planning appointments. **AND**
16. Family Planning Services must adhere to 42 CFR §441.20, "For beneficiaries eligible under the plan for family planning services, the plan must provide that each beneficiary is free from coercion or mental pressure and free to choose the method of family planning to be used."

Note: *The contraceptive methods named above in Criteria III, 3, 4,5,6,7, are not all inclusive for Traditional Medicaid Beneficiaries.*

**** Note:*** *Removal of IUD is reimbursable in an inpatient setting for beneficiaries with full coverage*

*****NOTE: For Attachment information in Criteria III.B.5, 9, 10, please refer to*** North Carolina Medicaid State Policy site for Clinical Coverage Policy No: 1E-7 Family Planning Services at: Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov)

IV. United States Preventive Services Task Force (USPSTF) Recommendations

NC Medicaid encourages family planning providers to offer screening for hypertension, sexually transmitted diseases and infections and cancer as part of current A and B USPSTF recommendations.

V. Depression Screening

Providers performing depression screenings are required to bill CPT code 96127 (brief emotional or behavioral assessment with scoring and documentation per standardized instrument) in combination with either diagnosis code Z13.31 (Encounter for depression screening) or diagnosis code Z13.32 (Encounter for screening for maternal depression) and the FP modifier, in addition to a family planning diagnosis.

VI. Medicaid **shall not cover**:

- **A.** Infertility services and related procedures;
- **B.** Reversals of sterilizations;
- **C.** Diaphragms and cervical caps; and
- **D.** Ultrasounds to verify placement of an IUD at the time of insertion.

VII. In addition to the specific criteria not covered in **CRITERIA VI**, of this policy, Family Planning Medicaid (**MAFDN) shall not cover**:

A. Medical conditions unrelated to family planning or family planning-related services.
B. MAFDN eligible beneficiaries are ONLY eligible for services described in **CRITERIA IV**.
C. If a medical condition unrelated to family planning or family planning related services occurs, or the beneficiary has no need for family planning services, the provider shall refer the beneficiary to a primary care or safety net provider.
D. MAFDN beneficiaries may request services not described in **CRITERIA IV**, but they would be responsible for the cost of those services.

VIII. In addition to the specific criteria not covered in **CRITERIA VI**, of this policy, Family Planning Medicaid (MAFDN) **shall not cover** the following:

A. Abortions;
B. Ambulance Services;
C. Hospital Emergency room or emergency department services;
D. Inpatient hospital services;
E. Surgical procedures or hospital services requiring outpatient beneficiary registration other than medically necessary removal of contraceptive devices or sterilizations.
F. Treatment for acute or chronic conditions discovered during screening
G. Hysterectomy.
H. Services for beneficiaries who have been sterilized or no longer have a need for family planning services;

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

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

IX. LIMITATIONS OR REQUIREMENTS: FP Medicaid beneficiaries are subject to the following limitations and requirements:

A. FP Medicaid beneficiaries are limited to either one comprehensive preventive medicine evaluation or an annual assessment examination per 365 calendar days.
B. FP Medicaid beneficiaries are **required to receive an annual office** visit assessment to determine the beneficiary's need for services related to preventing or achieving pregnancy before rendering any other family planning or family planning-related services. This annual assessment is not required to be a comprehensive preventive medicine evaluation. If the beneficiary has had an annual assessment or a comprehensive preventive medicine evaluation or postpartum exam in the previous 365 days, the beneficiary is not required to have another comprehensive evaluation prior to receiving Family Planning services.

C. FP Medicaid beneficiaries are limited to a total of six inter-periodic visits per 365 calendar days in addition to the annual assessment or comprehensive preventive medicine exam.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Please refer to *North Carolina Medicaid State Policy site for Clinical Coverage Policy No: 1E-7 Family Planning Services* at: Program Specific Clinical Coverage Policies| NC Medicaid (ncdhhs.gov) for **all coding and billing guidance**.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/24	04/24
Criteria I.A.3. "added knowingly" to 'Is not knowingly pregnant; ' Criteria I.B.1. Changed Undocumented Aliens to-non-citizens to comply with current standard language. Criteria IV. Changed verbiage to "IV. Medicaid shall cover family planning services when the Beneficiary meets the following specific criteria" Criteria IV.A. added "Meets eligibility criteria for enrollment in Family Planning Medicaid." Criteria IV.B: Changed to "Medicaid for Family Planning Services" Criteria IV.B.2. changed 'oral contraceptives (Prescriptions of up to 12 consecutive months). B.3.Added 'covered under Medicaid' and deleted brand name IUDs. B.4.Clarified the removal of LARC's. B.5. Deleted "contraceptive injections" B.6. Deleted "Nexplanon" B.7. Changed to 'Contraceptive patches and vaginal rings; available from the pharmacy with a prescription;'B.8. Changed to 'Contraceptive injections;'B.9. Added Reference to CCP 9 Outpatient Pharmacy Program and included web link.B.10. deleted 'including HIV and… (AIDS).B.11. deleted 'most' B.14. Added "Agencies are to follow the most current HPV recommendations set forth by the ACIP" B.15. Added "4 depression screenings per 365 rolling calendar days as covered services" and removed verbiage 'male and female beneficiary…sterilization' B.16. Added 'Covered sterilization procedures' B.17. Added NEMT, as needed, to and from family planning appointments;" B.18. Added "Ultrasound to locate a	08/24	08/24

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
malpositioned or otherwise missing IUD." Beneath Criteria IV – Added Notes regarding "FP Services & Coercion" AND added "above in Criteria IV.4,5,6,7,8" in "Note: The contraceptive methods named above in Criteria IV, 4,5,6,7,8, are not all inclusive for Traditional Medicaid Beneficiaries." AND Added * Note: Removal of IUD is also reimbursable in an inpatient setting for full Medicaid enrolled beneficiaries with full coverage." Criteria V. Clarified Medicaid for Family Planning Medicaid and added cervical caps to "C," and added "to verify placement of IUD" and removed 'MAFDN beneficiary verbiage' to E. Criteria VII. E. Added "medically necessary removal of contraceptive devices or" and added F. 'Treatment for acute or chronic conditions not specifically listed in Attachment B, conditions discovered during screening,' Removed "Treatment for HIV or Aids/Hepatitis C/Cancer/Services to Manage or treat medical conditions/any specialty health care…" Criteria VIII. A. Clarified that FP beneficiaries are allowed one Comprehensive Preventive Assessment and one Annual Assessment per 365 calendar days." Background I. Added "NC Medicaid encourages family planning providers to offer screening for hypertension, sexually transmitted diseases and infections and cancer as part of current A and B USPSTF recommendations." And Deleted specific screenings.		
Annual Review. Definitions I.C. added "pharmacist, per state protocol" Definitions II.A. removed "Serves eligible beneficiaries regardless of age or gender." Criteria I.A.5. changed 'individual' to 'beneficiary.' Criteria IV.A. added "A beneficiary enrolled in Traditional or Family Planning Medicaid and is not sterilized or otherwise unable to conceive, upon prescription or provider order, shall be eligible for the following:" Criteria IV.A.2. changed text to **"**Oral Contraceptives and transdermal patches per the North Carolina State Health Director's Standing Order, (Prescriptions of up to 12 consecutive months) covered by Medicaid, including a one-month supply of birth control or emergency contraception prior to an initial visit if requested." Criteria IV.A.3. deleted "IUD covered by Medicaid." Criteria IV.A.5. text changed to "Condoms, spermicides, and vaginal rings (refer to Attachment A Letter C), from "Contraceptive patches & vaginal rings available from the pharmacy with a prescription." Criteria IV.A.7. deleted 'available from the pharmacist with a prescription." Criteria IV.A.5.,9., 10, added Attachment information and link, deleted 17 "Ultrasound to locate a malpositioned or otherwise missing IUD." Deleted Criteria IV.C. regarding sterilization and NEMT. Added Criteria V. Depression Screening. Then Criteria V became VI. Etc. Criteria VI.D. Deleted and E became D. and added text, "at the time of insertion." Criteria VIII.F. added 'discovered during screening.' And	02/2025	02/2025

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
deleted "not specifically listed in Attachment B…" Under Note beneath Criteria VIII, added text, "an ultrasound for an IUD complication or removal of an IUD." Criteria IX.A. added text, 'either' and 'evaluation.' Criteria IX.B. added text, "If the beneficiary has had a comprehensive preventive medicine evaluation or postpartum exam in the previous 365 days, the beneficiary is not required to have another comprehensive evaluation prior to receiving Family Planning services."		
Definitions II.A. text updated with no effect on criteria and II.C. deleted. Criteria I.A. added 'or a.' Criteria III. Family planning services bullet deleted d/t duplication below. Criteria III.A. 2. Deleted "prescriptions up to 12 mos….to an initial visit if requested." Added Criteria III.3. emergency contraception, Deleted Criteria III.4. Implantable contraceptive device, Deleted Criteria III.11. text "ultrasounds are also covered to located stringless/IUD's." Criteria III.13. changed "365 consecutive to 365 rolling." Background I. became Criteria IV. For USPSTF. Criteria IX.B. changed "exam to evaluation' and added 'an annual assessment or a." Under NC Guidance/Claims related information, updated state web address.		

1. State of North Carolina Medicaid Clinical Coverage Policy No:1E-7 Family Planning Service. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 15, 2025. Accessed February 24, 2025.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

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

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

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

condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

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

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

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

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

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

EPSDT and Prior Approval Requirements

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

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

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

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

A. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

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

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  Unlisted Procedure or Service
  CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
  HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
- Modifiers - Providers shall follow applicable modifier guidelines.

- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

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

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.