Clinical Policy: Family Planning Service

Reference Number: WNC.CP.102 Coding Implications
Last Review Date: 04/24 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-] Medicaid Family Planning 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:

A. **Traditional Medicaid family planning services** consist of:
   a. Consultation;
   b. Examination;
   c. Treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, 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.

B. **Family Planning Medicaid (FP Medicaid)**
   a. Serves eligible Beneficiaries regardless of age or gender.
   b. FP Medicaid provides limited coverage to Beneficiaries with MAFDN eligibility. These Beneficiaries are only eligible for family planning and family planning related services, as described in this policy.
   c. Family Planning Medicaid Beneficiaries needing non-family planning services shall be referred to their primary care or a safety net provider.
   d. Beneficiaries with MAFDN eligibility are not eligible for any other Medicaid program or categories of service.

POLICY/CRITERIA

I. Eligibility Requirements:

A. A traditional Medicaid, FP Medicaid Member **may be eligible** for family planning and family planning-related services when the Member 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 pregnant; and
4. Is not incarcerated.
5. FP Medicaid shall cover an individual who meets the above criteria and the income eligibility requirements defined in 42 CFR 435.214.

B. Special Provisions:

1. **Undocumented Aliens** are eligible for emergency medical services as found in 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. 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."

IV. Medicaid shall cover family planning services for a Member consisting of consultation, examination, laboratory tests, FDA approved contraceptive methods, supplies, and devices to prevent conception, as documented in this policy.

A. Traditional Medicaid, FP Medicaid shall cover the following when the eligibility criteria in Policy/Criteria I. are met:

1. The "fitting" of diaphragms;
2. Birth control pills (up to a 12-month supply);
3. Insertion of Intrauterine Devices (IUD's) (Mirena, Paragard, Liletta, Kyleena and Skyla);
4. Removal of IUD's outside of the office, i.e., Local Health Department (LHD), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) setting;
5. Contraceptive injections (Depo-Provera);
6. Implantable contraceptive devices (Nexplanon);
7. Contraceptive patch (norelgestromin and ethinyl estradiol transdermal system); available from the pharmacy with a prescription;
8. Contraceptive vaginal rings available from the pharmacy with a prescription;
9. Emergency Contraception (Plan B, One Step and Ella) available from the pharmacist with a prescription;
10. Screening, early detection and education for Sexually Transmitted Infections (STIs), including HIV and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis B and Hepatitis C;

11. Treatment for most STIs (for specific FP Medicaid coverage 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)
12. Lab services: for specific FP Medicaid coverage 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)
13. Ultrasounds when the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are also covered to locate stringless IUDs. Ultrasounds are not intended for the purpose of routine checking of placement after IUD insertion; **AND**
14. Human Papillomavirus (HPV) Gardasil 9 Vaccine.

Note: The contraceptive methods named above are not all inclusive for Traditional Medicaid Beneficiaries.

B. In addition to the above covered criteria, traditional Medicaid and FP Medicaid shall cover the following Family Planning Services:
1. Sterilization procedures for male and female Beneficiaries. Refer to Clinical Policy WNC.CP.226 Sterilization Procedures on the NC Medicaid website at https://www.wellcare.com/North-Carolina/Providers/Clinical-Guidelines/CCG-List for requirements related to sterilization procedures **AND**
2. Non-emergency medical transportation, as needed, to and from family planning appointments.

V. Traditional Medicaid, and FP Medicaid **shall not cover** the following:
A. Infertility services and related procedures;
B. Reversals of sterilizations;
C. Diaphragms;
D. Contraceptives that can be purchased without a prescription or do not require the services of a physician for fitting or insertion; **AND**
E. Ultrasounds for MAFDN Beneficiaries; unless performed to verify that the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are not covered for the purpose of routine checking of placement after IUD insertion.

VI. In addition to the specific criteria not covered in **CRITERIA V**, of this policy, FP 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 Member has no need for family planning services, the provider shall refer the Member 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.

VII. In addition to the specific criteria not covered in **CRITERIA V**, of this policy, FP 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 Member registration other than sterilizations.
F. Treatment for HIV or AIDS;
G. Treatment for Hepatitis B;
H. Treatment for Hepatitis C;
I. Treatment for cancer;
J. Services provided to manage or treat medical conditions (not including STIs):
1. Discovered during the screening;
2. Caused by or following a family planning procedure (including urinary tract infections, diabetes, hypertension, breast lumps);
3. Complications of women's health care problems, including heavy bleeding or infertility; **AND**
4. Hysterectomy.

K. Services for Beneficiaries who have been sterilized or no longer have a need for family planning services; **AND**
L. Any specialty health care services not related to family planning services (including dental, mammography, cardiology, physical therapy, neurology, radiology, behavior health services).

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

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.

VIII. LIMITATIONS OR REQUIREMENTS: FP Medicaid Beneficiaries are subject to the following limitations and requirements:
A. FP Medicaid Beneficiaries are limited to one comprehensive preventive medicine examination per 365 calendar days.

B. FP Medicaid Beneficiaries are **required to receive an annual office** visit assessment to determine the Member'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 exam.

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.

Background[1]

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

NC Medicaid encourages screening for the following United States Preventative Services Task Force (USPSTF) recommendations in all Family Planning Medicaid Beneficiaries:

A. Increased blood pressure in adults aged 18 years or older and obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment. Beneficiaries with elevated blood pressure should be referred for follow up.

B. BRCA risk assessment: clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should be referred for genetic counseling and, if indicated after counseling, genetic testing. Women with Family Planning Medicaid should be referred to their primary care or a safety net provider.

C. Cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing). Women with Family Planning Medicaid should be referred to their primary care or a safety net provider for non-family planning services.

D. Chlamydia and Gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.

E. HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened.

F. Screening and referral for preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

G. Hepatitis B Virus (HBV) screening among high-risk populations, which include persons from countries with a high prevalence of HBV infection, HIV-positive persons, injection drug users, household contact of persons with HBV infection, and men who have sex with men.

H. Hepatitis C Virus (HCV) screening in all asymptomatic adults (including pregnant Beneficiaries) aged 18 to 79 years without known liver disease. Most adults need to be screened only once. A Member with continued risk for HCV infection should be screened periodically.
I. Intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services.
J. Obesity: Offer and refer adults and adolescents with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions through their primary care or a safety net provider.
K. Postpartum depression: referring persons who are at increased risk of postpartum depression for counseling interventions through their primary care or a safety net provider.
L. Sexually transmitted infections: education and referral for intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
M. Syphilis infection in persons who are at increased risk for infection

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 2024, 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

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No:1E-7 Family Planning Service. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 15, 2023. Accessed April 4, 2024.

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/get-involved/nc-health-choice-state-plan

- 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.