

FAMILY PLANNING

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

Billing guidelines for family planning services:

- Use the appropriate office visit code
- Use a DX code in the range of V25 through V25.9

Family planning includes one or more of the following services:

- Obtaining a medical history
- A pelvic examination
- The preparation of smears such as a Pap Smear
Note: Obtaining a specimen of a Pap Smear is included in the office visit. Screening and interpretation of a Pap Smear can be reimbursed only to a clinic or certified independent laboratory.
- A breast examination

Providers may bill the following family planning services in addition to the office visit:

- All laboratory and x-ray services provided as part of the family planning encounter.
- A pregnancy test if provided at the time at which family planning services are initiated.
- HIV blood screening testing performed as part of a package of screening testing and counseling in conjunction with family planning encounter.

PARAGARD

The IUD is defined as an “Intrauterine Copper Contraceptive”. Missouri Care sets reimbursement for this device. Payment is based on the usual and customary fee

- HCPCS Code J7300 - IUD
- CPT Code 58300 - Insertion of the IUD
- No invoice is required when submitting claims on a HCFA 1500 form

Note: The appropriate office visit procedure code may be billed for the removal of the IUD. CPT code 58301 is not a billable procedure as payment for this service is included in the office visit procedure code.

MIRENA

The IUD is defined as a “Levonorgestrel-releasing Intrauterine Contraceptive System”. Reimbursement for this device is set by the Health Plan. Payment is based on the usual and customary fee

- HCPCS Code J7302 - IUD
- CPT Code 58300 - Insertion of the IUD
- No invoice is required when submitting claims on a HCFA 1500 form

Note: The appropriate office visit procedure code may be billed for the removal of the IUD. CPT code 58301 is not a billable procedure as payment for this service is included in the office visit procedure code.

DIAPHRAGMS OR CERVICAL CAPS

The fitting for the diaphragm or cervical cap is included in the fee for an office visit procedure code.

- Procedure Code A4266 – Diaphragm for contraceptive use
- Procedure Code A4261 – Cervical cap for contraceptive use

Reimburse for each item is based on the Medicaid Fee Schedule pricing. No invoice is required for claims submission.

NORPLANT SYSTEM

The insertion and device are reimbursed separately. An office visit code may not be billed in addition to any of the Norplant procedure codes. The charge for the office visit is assumed to be covered in the reimbursement of the procedure.

- Procedure Code J7306 – Levonorgestrel (contraceptive) implant system, including implants and supplies.
- CPT Code 11975 – Insertion, implantable contraceptive capsules
- CPT Code 11976 – Removal, implantable contraceptive capsules
- CPT Code 11977 – Removal with reinsertion, implantable contraceptive capsules

Reimburse for each item is based on the Medicaid Fee Schedule pricing. No invoice is required for claims submission

DEPO-PROVERA

The appropriate office visit code may be billed in addition to this service.

- HCPCS Code J1051 – Injection, medroxyprogesterone acetate, 50mg
- HCPCS Code J1055 – Injection, medroxyprogesterone acetate for contraceptive use, 150 mg

Reimburse for each item is based on the Medicaid Fee Schedule pricing. No invoice is required for claims submission

ORAL CONTRACEPTIVES

A provider should refer to Missouri Care Health Plan's Preferred Drug List for approved contraceptives. www.missouricare.com

STERILIZATIONS

Sterilization is defined as any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

A Medicaid Recipient must be at least 21 years of age at the time the consent is obtained and be mentally competent. All sterilization procedures require a prior authorization.

Guidelines for consent form:

- The recipient must give an informed consent voluntarily in accordance with Federal and State requirements.
- Form must be completed and signed by the recipient at least 31 days, but not more than 180 days, prior to the date of the sterilization procedure.
- There must be 30 days between the date of signing and the surgery date.
- The day after the signing is considered the first day when counting the 30 days.
- The form must be completed and forwarded to Missouri Care Health Plan when requesting authorization prior to services rendered.
- The completed consent form is reviewed to ensure compliance with State and Federal guidelines prior to issuing an authorization number.

EXCEPTIONS

The only exceptions to the time requirements are for situations involving premature delivery or emergency abdominal surgery

- **Premature delivery:** The Sterilization Consent Form must be completed and signed by the recipient at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery. Expected date of delivery is required on the Sterilization Consent Form. (This also applies to consent forms used in lieu of the Missouri- approved Sterilization Consent Form for services provided in non-bordering states.)
- **Emergency abdominal surgery:** The Sterilization Consent Form must be completed and signed by the recipient at least 72 hours prior to sterilization. The nature of the emergency abdominal surgery must be documented on the Sterilization Consent Form. (This also applies to consent forms used in lieu of the Missouri- approved Sterilization Consent Form for services provided in non-bordering states.)

Billing: Claims should be billed with the appropriate procedure code. The sterilization form is not a required attachment when submitting claims.

CPT Code – 58600 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

CPT Code – 58605 Ligation of transection of fallopian tubes(s), abdominal or vaginal Approach, postpartum, unilateral or bilateral, during same hospitalization

CPT Code – 58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery

CPT Code – 58615 Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) Vaginal or suprapubic approach

CPT Code – 58671 Occlusion of fallopian tube(s) by laparoscopic approach

HYSTERECTOMY

A hysterectomy is not a covered benefit if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

Hysterectomy's are a covered service if the following guidelines are met:

- The individual or her representative, if any, has signed a written Acknowledgment of Receipt of Hysterectomy Information form
- The person who secured authorization to perform the hysterectomy has informed the individual orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing

SERVICES NOT COVERED UNDER FAMILY PLANNING

- Condoms and devices or supplies available as non-prescribed, over-the-counter products
- Reversal of sterilization procedure
- Abortions performed as family planning
- Hysterectomies for the purpose of family planning