Department of Health

Office of Health Insurance Programs

NEW YORK STATE
MEDICAID FAMILY PLANNING
and
REPRODUCTIVE HEALTH SERVICES

Frequently Asked Questions

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Department of Health

I. Definitions, Acronyms, and Initials

340B Pricing: The 340B Drug Discount Program is a federal program created in 1992 that requires drug manufacturers to provide outpatient drugs to eligible healthcare organizations and covered entities at significantly reduced prices. Drugs purchased at 340B discount pricing cannot be used for inpatient services.

Abortion: An abortion is an induced termination of pregnancy, this being either medical, surgical, or both; the word "abortion" refers to either or both. The following medical procedures are not abortions: termination of ectopic pregnancy, the use of drugs or devices to prevent implantation of the fertilized ovum, and menstrual extraction.

Ambulatory Patient Groups (APG): APG is a payment methodology based on the 3M Health Information Systems Enhanced Ambulatory Patient Groups classification system utilized for the reimbursement of a facility's cost of outpatient care. APGs are designed to predict the average pattern of resources used for a group of patients in a given APG. The APG payment methodology pays differential amounts for ambulatory care services based on the resources required for each patient visit.

Common Benefit Identification Card (CBIC): The CBIC is a permanent plastic card that contains information needed for eligibility verification for a single Medicaid recipient. The photo or non-photo CBIC contains the following information for the recipient:

- Medicaid number
- First name
- Last name
- Middle initial
- Sex
- Date of birth
- An access number, a sequence number, an encoded magnetic strip, and a signature panel.

The issuance of an identification card does not constitute full authorization for the provision of medical services and supplies. The provider must verify recipient eligibility each time a service is provided to be assured that a recipient is eligible. A provider not verifying eligibility prior to the provision of services will risk the possibility of nonpayment for those services.

Current Procedural Terminology (CPT): The CPT code set is a medical code set maintained and copyrighted by the American Medical Association. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

eMedNY: eMedNY is the electronic Medicaid system of New York State which was developed and implemented to process HIPAA-compliant Medicaid claims.

Family Planning Benefit Program (FPBP): FPBP is a free, confidential program that provides Medicaid coverage of family planning services for individuals of child-bearing years who have an income under 223% of the Federal Poverty Level. FPBP services are available to persons who are not otherwise eligible for Medicaid or who have indicated that they only want to apply for the FPBP. For more information on the FPBP please see Question #5.

Family Planning Extension Program (FPEP): The FPEP provides up to 26 months of additional access to family planning services for individuals who were on Medicaid while they were pregnant, but subsequently were not eligible for comprehensive Medicaid coverage when the pregnancy ended. FPEP is 100% State funded. For more information on FPEP please see Question #5.

Federal Poverty Level (FPL): The FPL is a level of income published annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits, including Medicaid.

Fee-for-Service (FFS): FFS is an encounter-based billing methodology whereby the state pays providers directly for each covered service received by a Medicaid beneficiary. Recipients use their CBIC to access services from NYS Medicaid enrolled providers.

Free Access: Free Access is a NYS Medicaid policy required by Federal law. Free Access applies only to Medicaid Managed Care enrollees, and it allows enrollees to obtain family planning and reproductive health services from any qualified Medicaid participating provider (in or out of a managed care plan's network), without a referral or prior approval of the plan.

Healthcare Common Procedure Coding System (HCPCS): HCPCS was established in 1978 to provide a standardized coding system for describing the specific items and services provided in the delivery of health care.

Medicaid: Medicaid provides health coverage to eligible New Yorkers. It is a public health insurance program funded jointly by the state and federal governments.

Medicaid Managed Care: Medicaid managed care is a Medicaid program where members are enrolled in a health plan and use their health plan insurance card to access services from their health plan's participating providers.

Medicaid Eligibility Verification System (MEVS): MEVS is a component of the eMedNY system that enables providers to verify member eligibility prior to the provision of services. A member must present an official CBIC. The verification process through eMedNY can be accessed using one of the following methods:

- Telephone verification process (Audio Response Unit or ARU);
- VeriFone POS device(s); and
- Other access methods: ePACES, CPU-CPU link, eMedNY eXchange, dial-up FTP, and File Transfer Service using SOAP.

National Drug Code (NDC): The NDC is a universal product identifier for human drugs. Drug products are identified and reported to the U.S. Food and Drug Administration using a unique, three-segment number, called the National Drug Code (NDC).

Procedure Code Modifiers: Procedure code modifiers help further describe a procedure code without changing the definition of the code. Modifiers can be found in the CPT and HCPCS.

UD Modifier: The UD modifier is a procedure code modifier nationally designated as applicable only to Medicaid billing. In NYS, the UD modifier is included on claims to designate a drug purchased at a discounted rate (340B pricing).

Welfare Management System (WMS): WMS is a system capable of receiving, maintaining, and processing information relating to persons who apply for benefits, or who are determined to be eligible for benefits under NYS Social Services Law. Section 21 of the New York State Social Services Law required the New York State to design and implement a Welfare Management System (WMS).

II. Family Planning Fundamentals

1. Q. What family planning services are covered by Medicaid?

A. Medicaid-covered family planning services include:

- Most FDA-approved birth control methods, devices, and supplies (e.g., birth control pills, injectables, patches, condoms, diaphragms, intrauterine devices (IUDs))
- Emergency contraception services and follow-up care
- Male and female sterilization
- Preconception counseling and preventive screening and family planning options **before** pregnancy
- Transportation to/from family planning visits (not covered under FPEP)

The following additional services are considered family planning only when provided within the context of a family planning visit **and** when the service provided is directly related to family planning:

- Pregnancy testing and counseling
- Comprehensive health history and physical examination, including breast exam and referrals to primary care providers as indicated
- Screening and treatment for sexually transmitted infections (STIs)
- Screening for cervical cancer and urinary tract or female-anatomy-related infections
- Screening and related diagnostic laboratory testing for medical conditions that affect the choice of birth control (e.g., a history of diabetes, high blood pressure, smoking, blood clots)
- HIV counseling and testing
- Counseling services related to pregnancy, informed consent, and STI/HIV risk counseling
- Bone density scan (only for patients who plan to use or are currently using Depo–Provera)
- Ultrasound (to assess the placement of an intrauterine device)

2. Q: How do patients access coverage for family planning services through Medicaid?

A. The type of program that a patient is covered by can be determined by checking their Medicaid coverage (i.e., verifying the type of Medicaid coverage using the client identification number found on the patient's Common Benefit Identification Card (CBIC)) online or by phone. In New York State, patients may access family planning services through any of the following government health insurance programs:

- **Medicaid** is a public health insurance program for low-income New Yorkers.
- **Fee-For-Service** members use their CBIC to access services from NYS Medicaid-enrolled providers.
- **Medicaid Managed Care** enrollees use their health plan insurance card to access services from their health plan's participating providers. Managed care enrollees may also use their CBIC card to access family planning services from any qualified NYS Medicaid-enrolled provider. The **Free Access** policy allows Managed care enrollees to obtain family planning and reproductive health services from any qualified Medicaid participating provider (in or out of a managed care plan's network). Refer to **Free Access** in the **Definitions, Acronyms, and Initials** section for more information.
- **Family Planning Benefit Program (FPBP) is a free, confidential program that provides** Medicaid coverage of family planning services for individuals who have an income under 223% of the Federal Poverty Level. FPBP services are available to persons who are not otherwise eligible

for Medicaid or who have indicated that they only want to apply for the FPBP. Refer to Question #5 for more information on FPBP.

- **Family Planning Extension Program (FPEP) provides** up to 26 months of additional access to family planning services for individuals who were on Medicaid while they were pregnant, but subsequently were not eligible for comprehensive Medicaid coverage when the pregnancy ended. Refer to Question #5 for more information on FPEP.

III. Confidentiality

3. Q: If a patient is concerned about confidentiality, what can I tell them will happen when Fee-for-Service (FFS) Medicaid is billed for family planning services?

A: All communications, information, and documents received in the course of accepting the Medicaid and FPBP application and assisting the applicant are confidential and may not be disclosed to unauthorized personnel or used for any purpose other than determining eligibility for Medicaid and the FPBP. When FFS Medicaid is billed for family planning services, an explanation of benefits is not sent to the member.

4. Q: Does a provider have to bill a patient's private (non-Medicaid) insurance before billing Medicaid, if the patient says doing so would jeopardize their emotional or physical health, safety, and/or confidentiality?

A: It depends. "Good cause" may be granted when, during the application process, an applicant/recipient states that billing their third-party health insurance (TPHI) could jeopardize their emotional or physical health, safety, and/or confidentiality and privacy. The provider is required to call the **New York Health Options Statewide Call Center (1-800-541-2831)** to request a "good cause waiver authorization." This good cause waiver can be authorized for a period of up to one year. During that time, the TPHI will not be billed. The New York Health Options Statewide Call Center will enter the necessary information into eMedNY. If a good cause waiver is not obtained, then TPHI billing rules apply.

IV. Family Planning Programs

- Family Planning Benefit Program (FPBP)
- Family Planning Extension Program (FPEP)

5. Q: What are the differences between FPBP and FPEP?

	FPBP	FPEP
Medicaid Eligibility Verification (MEVS) Response	• "Eligible Only Family Planning Services"	• "Eligible Only Family Planning Services No Transportation"
Eligibility Criteria	• New York State resident, U.S. citizen, National, Native American, or have satisfactory immigration status, and • Income at/below 223% Federal Poverty Level (FPL).	• Must have been pregnant while in receipt of Medicaid (regardless of how that pregnancy ended, immigration status, or household income) but is no longer eligible for Medicaid after 12-month postpartum period.
Additional Information	• Presumptive eligibility provides an individual immediate access to FPBP-covered services (see question 1) and assures that the provider will receive Medicaid reimbursement for covered family planning services, supplies, and treatment provided during the presumptive period.	• Claiming is now done through eMedNY. • Eligibility can be checked using the Common Benefit Identification Card (CBIC).
Coverage	• Retroactive coverage up to 3 months may be available, if eligible. • Coverage must be renewed every 12 months. • FPBP enrollees have coverage of transportation to/from family planning services.	• Coverage is automatically generated on WMS based on the ineligibility of the individual at the end of the postpartum period. • FPEP enrollees do NOT have Medicaid coverage of transportation services.

NOTE: Eligibility should be checked using the CBIC through MEVS for both FPBP and FPEP at every visit, just as is done for FFS Medicaid enrollees.

V. Sterilization

6. Q: Are there instructions for completing Sterilization Consent Forms for Medicaid? Where are the forms and instructions located?

A: A Sterilization Consent Form (LDSS-3134 [or LDSS-3134(S)]) must be completed for each sterilization procedure. For the procedure to be covered by Medicaid, the LDSS-3134 (or LDSS-3134(S)) must be completed at least 30 days, but not more than 180 days prior to the procedure. The practitioner claims for sterilization procedures must be submitted on paper, and a copy of the completed and signed LDSS-3134 (or LDSS-3134(S)) must be attached to the claim.
When completing the LDSS-3134 (or LDSS-3134(S)), please follow these guidelines to ensure payment:

- Do not alter the form. An illegible or altered form will not be accepted.
- Complete each required field.
- If a patient is not Medicaid eligible at the time he/she signs the LDSS-3134 (or LDSS-3134(S)) form but becomes eligible prior to the procedure and is 21 years of age when the form was signed, the 30-day waiting period starts from the date the LDSS form was signed regardless of the date the patient becomes Medicaid eligible.

Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed LDSS-3134 (or LDSS-3134(S)) in their files.

A sample consent form and field-by-field instructions can be found in Appendix B of the NYS Medicaid General Professional Billing Guidelines (Version 2013-1) Manual that may be accessed online at:
https://www.emedny.org/ProviderManuals/AllProviders/General_Billing_Guidelines_Professional.pdf

Sterilization Consent Forms, available in English [LDSS-3134] and Spanish [LDSS- 3134(S)], can be obtained from the NYS DOH website at:
http://www.health.ny.gov/health_care/medicaid/publications/ldssforms.htm

VI. Reproductive Health/Abortion Services

7. Q: Are abortion services covered under Medicaid?

A: Yes, Medicaid covers abortion services that have been determined to be medically necessary by the attending physician.

8. Q: How do patients access abortion services covered by Medicaid?

A: Access to abortion services is available to all New Yorkers, including New Yorkers with Medicaid. To find an abortion provider, visit the *Safe Abortion Access for All* website online at https://www.ny.gov/abortion-new-york-state-know-your-rights/safe-abortion-access-all or call the National Abortion Federation referral hotline at 877-257-0012 and contact the provider to find out if they participate with New York Medicaid Managed Care or Fee-for-Service Medicaid.

NEW YORK STATE OF OPPORTUNITY. Department of Health

9. **Q: If a patient is concerned about confidentiality, what can I tell them will happen when Fee-for-Service (FFS) Medicaid is billed for an abortion service?**

A: Abortion services in New York must be completely confidential. Abortion service providers and other healthcare professionals are not allowed to disclose any information to anyone other than the patient without permission. The confidential information includes medical records, as well as any information about the appointment or procedure. Information may not be disclosed to the other biological parent of the fetus, parents (where the patient is a minor), or anyone else not identified as having the patient's express permission to receive information about the abortion (https://www.ny.gov/abortion-new-york-state-know-your-rights/safe-abortion-access-all#abortion_providers).

When FFS Medicaid is billed for abortion services, an explanation of benefits is not sent to the member.

10. **Q: Does a provider have to bill a patient's private (non-Medicaid) insurance before billing Medicaid for abortion services, if the patient says doing so would jeopardize their emotional or physical health, safety, and/or confidentiality?**

A: It depends. "Good cause" may be granted when, during the application process, an applicant/recipient states that billing their third-party health insurance (TPHI) could jeopardize their emotional or physical health, safety, and/or confidentiality and privacy. The provider is required to call the New York Health Options Statewide Call Center (1-800-541-2831) to request a "good cause waiver authorization." This good cause waiver can be authorized for a period of up to one year. During that time, the TPHI will not be billed. The New York Health Options Statewide Call Center will enter the necessary information into eMedNY. If a good cause waiver is not obtained, then TPHI billing rules apply.

11. **Q: How do patients access coverage for abortion services through Medicaid?**

A. The type of program that a patient is covered by can be determined by checking their Medicaid coverage (i.e., verifying the type of Medicaid coverage using the client identification number found on the patient's Common Benefit Identification Card (CBIC)) online or by phone. In New York State, patients may access family planning services through any of the following government health insurance programs:

- **Medicaid** is a public health insurance program for low-income New Yorkers.
- **Fee-For-Service** members use their CBIC to access services from NYS Medicaid enrolled providers.
- **Medicaid Managed Care** enrollees use their health plan insurance card to access services from their health plan's participating providers. Managed Care enrollees may also use their CBIC card to access family planning services from any qualified NYS Medicaid-enrolled provider. The **Free Access** policy allows Managed care enrollees to obtain family planning and reproductive health services from any qualified Medicaid participating provider (in or out of a managed care plan's network). Refer to **Free Access** in the **Definitions, Acronyms, and Initials** section for more information.

An individual may qualify for Medicaid depending on age, financial circumstances, family situation, or

living arrangement. Visit the New York State of Health, the Official Health Plan Marketplace to see available health insurance options. Individuals (those seeking FPBP or Medicaid coverage for pregnancy) may also apply at many clinics, hospitals, and provider offices.

There may be financial assistance for patients who do not live in New York State. For more Information, please visit https://www.ny.gov/abortion-new-york-state-know-your-rights/safe-abortion-access-all.

12. Q: What is the difference between a medically necessary abortion and an elective abortion?

A: A physician may determine that an abortion is medically necessary in accordance with Social Services Law 365-a when the abortion is *"...necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his/her capacity for normal activity or threaten some significant handicap and which are furnished to an eligible person in accordance with this title and the regulations of the Department."*

Medicaid also relies on the language from the federal Supreme Court decision Doe V. Bolton to further refine the definition of medically necessary abortions.

This decision held that the determination that an abortion is medically necessary "is a professional judgment that may be exercised in the light of all factors - physical, emotional, psychological, familial, and the woman's age - relevant to the well-being of the patient. All these factors may relate to health."

An elective abortion service is a service the pregnant individual chooses (elects) to end the pregnancy and does not meet the criteria outlined above.

13. Q: Are there co-payments for Medicaid-covered abortion services?

A: No. Medicaid-covered reproductive health services are exempt from all co-payment requirements. Additional information can be accessed online at: https://www.health.ny.gov/health_care/medicaid/members/faqs_benefits.htm

14. Q: Can Medicaid be billed for both an abortion service and a contraceptive service on the same day?

A: Yes. Providers can bill for contraceptive services provided on the same day as an abortion service. Providers may bill Medicaid for the cost of contraceptive rings, birth control patches, etonogestrel implants, Intrauterine Devices (IUDs), and an initial supply of oral contraceptives (including emergency contraceptives) provided to the patient during a covered visit. The Medicaid payment to a clinic is subject to the APG logic.

15. Q: Can Medicaid be billed for abortion services provided to a patient during a covered clinic visit?

A: Yes, Medicaid may be billed for an abortion service provided to a patient during a covered clinic/hospital outpatient department (HOPD) visit. Clinics and HOPDs should include HCPCS

codes for abortion services on their APG claim.

16. Q: Can an abortion service be provided to a patient and be billed to Medicaid as a stand-alone service?

A: Yes, Medicaid may be billed for an abortion service provided to a patient when it is the only service the patient receives at the clinic/HOPD that day.

17. Q: What needs to be included on the Medicaid claim to identify an abortion service?

A: The FFS Medicaid claim must contain a sterilization/abortion condition code, an appropriate procedure and dx code (Z33.2 is the only ICD-10 code). The FFS Medicaid claim must not include a family planning indicator. Managed care claims must be submitted in accordance with plan requirements.

18. Q: What procedure codes/HCPCS codes are used to bill FFS Medicaid for abortions provided on-site?

A: The following procedure codes can be billed to FFS Medicaid for abortions provided in a hospital, hospital outpatient department, or physician's office:

59840: Induced abortion, by dilation and curettage
59841: Induced abortion, by dilation and evacuation
59850: Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;
59851: with dilation and curettage and/or evacuation
59852: with hysterotomy (failed intra-amniotic injection)
59855: Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856: with dilation and curettage and/or evacuation
59857: with hysterotomy (failed medical evaluation)
S0190: Mifepristone, oral, 200 mg
S0191: Misoprostol, oral, 200 mcg

19. Q: Can the provider bill Medicaid for an abortion service provided during a covered family planning visit?

A: Yes. However, members with only coverage for family planning (i.e., FPBP/FPEP) would need to have their Medicaid eligibility redetermined as a pregnant person. (The FPBP/FPEP does not include coverage for pregnancy and abortion services).

VII. Billing and Claiming

20. Q: Are there co-payments for Medicaid-covered family planning services?

A: No. Medicaid-covered family planning services are exempt from all co-payment requirements. Additional information can be accessed online at: https://www.health.ny.gov/health_care/medicaid/members/faqs_benefits.htm

21. Q: **Can Medicaid be billed for the long-active reversible contraceptive (LARC) when provided on the same day as a delivery?**

A: Yes. The hospital may bill Medicaid when a patient receives a LARC during the inpatient stay following a delivery. Since 340B drugs are limited to hospital outpatient services only, 340B hospitals should submit the LARC charges at non-340B price, with no UD modifier. It is expected that there would be a corresponding claim for an inpatient post-partum stay. Additional information is available in the provider communications available online at:
https://www.emedny.org/listserv/Inpatient/Inpatient_Reimbursement_for_LARC_Provided_as_an_Inpatient_Post-Partum_Service_05-28-14.pdf

https://www.emedny.org/listserv/Inpatient/Inpatient_Clarification_on_Reimbursement_for_LARC_Provided_as_an_Inpatient_Post-Partum_Svc_4-9-15.pdf

22. Q: **Can Medicaid be billed for contraceptives provided to a patient during a covered clinic visit?**

A: Yes. Medicaid can be billed when the following contraceptive methods/devices are provided during a covered clinic visit: the patient's initial supply of oral contraceptives (including emergency contraceptives), the vaginal ring, patch, birth control injection, implant, and IUD.

This applies to patients with Medicaid (which includes coverage of family planning services) as well as those only eligible for the Family Planning Benefit Program (FPBP) or the Family Planning Extension Program (FPEP). In addition, this policy applies when Medicaid members in a Medicaid Managed Care plan access contraception services via "Free Access."

NOTE: The provision of oral contraceptives may not be billed as a stand-alone service. The provision of oral contraceptives must be billed in conjunction with another service, for example, an evaluation and management visit. Please see the February 2013 Medicaid Update that explains the change in Medicaid billing policy to allow clinics to bill Medicaid for oral contraceptives (including emergency contraception), available online at:
http://www.health.ny.gov/health_care/medicaid/program/update/2013/feb_update.pdf

23. Q: **Can Federally Qualified Health Centers (FQHCs) bill Medicaid for oral contraceptives provided to patients during covered clinic visits?**

A: FQHCs that have "opted in" to APGs can bill for contraceptives provided on-site. Refer to the **NOTE within Q/A #22 for more information.** FQHCs may not bill their all-inclusive threshold rate when the only service provided is dispensing of oral contraceptives. FQHCs may bill their all-inclusive threshold rate when the patient receives an evaluation and management visit and receives a supply of oral contraceptives during the visit.

24. Q: **Can contraceptives provided to patients be billed to Medicaid as a stand-alone service?**

A: Most contraceptive methods provided to patients in a doctor's office, or a clinic cannot be billed to Medicaid as a stand-alone service. The only contraceptive that can be billed as a stand-alone clinic service is Depo-Provera when administered by a Registered Professional Nurse (RN) or Licensed

Practical Nurse (LPN) within their scope of practice with a patient-specific order from a physician, physician assistant, nurse practitioner, or licensed midwife in a clinic. In this situation, Depo- Provera (J1050) may be billed to Medicaid on an Ordered Ambulatory claim with the injection (96372) when an APG claim is **not** billed for the clinic patient on the same date of service.

25. Q: Can a provider bill Medicaid for an FPBP or an FPEP enrollee when the primary reason for the patient's visit is a sexually transmitted infection (STI)?

A: Yes. In April 2014 the Centers for Medicare and Medicaid Services (CMS) determined visits for the diagnosis and treatment of an STI are covered services under FBPB/FPEP because the services are always provided "pursuant to" a family planning service. To be reimbursed, the claim must include a diagnosis in the V25 series (Z30 for ICD-10) and a family planning indicator. For more information, access the CMS State Medicaid Director's Letter #14-003 at: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf and an article in the August 2014 NYS Medicaid Update at http://www.health.ny.gov/health_care/medicaid/program/update/2014/sept14_mu.pdf

26. Q: How much does Medicaid pay for the contraceptive methods provided to patients during covered clinic visits?

A: For clinic reimbursement policy and rates please see the Ambulatory Patient Groups (APGs) information online at: http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm.

For practitioner reimbursement policy and rates, please refer to the provider-specific manuals and fee schedules online at: https://www.emedny.org/ProviderManuals/index.aspx.

27. Q: How do providers bill Medicaid for contraceptive methods/devices provided to clinic patients during covered clinic visits?

A: Billing Medicaid for contraceptives provided during a covered clinic visit requires the clinic to file an APG claim for the evaluation and management (E & M) visit or other covered service. The APG claim must include the applicable CPT code for the medical service(s) in addition to the CPT/HCPCS code for the specific contraceptive provided (e.g., oral contraceptive, patch). The only exception is when Depo-Provera is administered as a stand-alone service. Refer to **Q/A #24** for more information. For contraceptive rings, IUDs, and implants, providers must submit two separate claims - an APG claim for the medical visit/service(s) and an Ordered Ambulatory claim for the acquisition cost of the device.

The acquisition cost by invoice of the contraceptive must be included on the APG or Ordered Ambulatory claim in the "charges" field. Report the actual acquisition cost as well as either **the NDC or the UD modifier**. If contraceptives are purchased under 340B (federal discount) pricing, append only the UD modifier. If contraceptives are not purchased under 340B pricing, report only the NDC. If the claim has neither the NDC nor the UD modifier, it will be denied.

Refer to the chart on the last page of this document: ***CLINIC BILLING FOR CONTRACEPTIVES.***

A LARC Quick Coding Guide: Coding for Contraceptive Implants and IUDs, developed by the American Congress of Obstetricians and Gynecologists is available online at: https://www.acog.org/education-and-events/publications/larc-quick-coding-guide

28. Q: For those Medicaid programs that only cover family planning services (Family Planning Benefit Program (FPBP) and Family Planning Extension Program (FPEP)), what needs to be included on the Medicaid claim to identify the service(s) as family planning?

A: When the primary reason for the visit is family planning, the primary diagnosis on the Medicaid claim must represent contraceptive management services (Z30 series ICD-10 diagnosis codes) and there must be a "Y" in the family planning box/indicator.

When the primary reason for the initial or follow-up visit is for STI testing and/or counseling, the primary diagnosis on the claim must represent the medical complaint/issue responsible for the visit and the claim must contain a secondary diagnosis for contraceptive management services (Z30 series ICD-10 diagnosis codes). When the primary reason for the visit is follow-up treatment of a limited medical condition that was diagnosed during a previous family planning visit, the secondary diagnosis code on the Medicaid claim must represent contraceptive management services (Z30 series ICD-10 diagnosis codes).

29. Q: What procedure codes/HCPCS are used to bill FFS Medicaid for contraceptives provided on-site?

A: Refer to the attached chart, ***CLINIC BILLING FOR CONTRACEPTIVES***. The procedure codes for contraceptive methods that should be included on the APG claim (with procedure codes for all other rendered services, e.g., 99215 for evaluation/management service) are:

- **Oral Contraceptives: S4993**
- **Emergency Contraceptives: S4993**
- **Contraceptive Patch: J7304**
- **Depo-Provera Injection: J1050** (If administered as a stand-alone service, see **Q/A # 24**.)

The procedure codes for contraceptive methods carved out of APGs that should be included on an Ordered Ambulatory claim (separate from the APG claim for all other rendered services) are:

- **Contraceptive Ring**
  - Yearly (Annovera) (J7294)
  - Monthly (Nuvaring, EluRyng, etc.) (J7295)
- **IUD**
  - Kyleena: J7296
  - Liletta: J7297
  - Mirena: J7298
  - ParaGard: J7300
  - Skyla: J7301

  Note: Additional codes for IUD insertion and removal reported on the APG claim:
  - Insertion: 58300
  - Removal: 58301

  Removal with reinsertion: There is no code that represents an IUD removal and insertion performed on the same date of service. When a qualified healthcare provider performs both of these procedures on the same day, both codes (58300 and 58301) must be reported
- **Etonogestrel Implant** (including insertion supplies): **J7307**

  Note: Additional codes for implant insertion and removal reported on the APG claim:

- Insertion: 11981
- Removal: 11982
- Removal with reinsertion: 11983

These ordered ambulatory claims must include:

- the acquisition cost by invoice and
- the NDC if not purchased at 340B price; or
- the UD modifier if purchased at the 340B price

Note: Claims denied due to exceeding service limits may be resubmitted on paper with supporting documentation of medical necessity for payment consideration.

30. Q: When billing Medicaid FFS for contraceptives provided during a covered family planning visit, does the number of units need to be reported on the claim?

A: Yes, the number of units must be reported on the Medicaid claims. For contraceptives that can be included on the APG claim, the units that may be billed with one visit are as follows:

- **Oral Contraceptives (including emergency contraceptives):** 3 units (1 unit = 1 month supply)
- **Patch:** 1 unit
- **Depo-Provera Injection:** 150 units (1 unit = 1 mg)

31. Q: What contraceptives are available to Medicaid beneficiaries on an over-the-counter basis at a pharmacy, and does the patient access them with their Medicaid card?

A: The following over-the-counter contraceptives can be obtained at participating pharmacies with the patient's Medicaid card (CBIC): Emergency contraceptives, male condoms, and female condoms. See the chart for more information.

OVER-THE-COUNTER CONTRACEPTIVE

Emergency Contraceptives	Male Condoms	Female Condoms
No Fiscal Order Required	Fiscal Order Required	Fiscal Order Required
Females only	Males and Females	Males and Females

VIII. Resources

32. Q: Who do I ask if I have other questions about Medicaid claims or coverage policy?

Billing & Claiming Questions
eMedNY Call Center
1-800-343-9000

Medicaid Policy Questions
Office of Health Insurance Programs
1-518-473-2160
maternalandchild.healthpolicy@health.ny.gov

Managed Care Questions
Contact the enrollee's health plan

Provider Enrollment/Revalidation
1-800-343-9000
https://www.emedny.org/info/ProviderEnrollment/

Medicaid Home Page
http://www.health.ny.gov/health_care/medicaid/

January 2016 Medicaid Update article, *Billing New York State Medicaid for Family Planning Services*
https://www.health.ny.gov/health_care/medicaid/program/update/2016/jan16_mu.pdf

NEW YORK STATE OF OPPORTUNITY. Department of Health

Department of Health | Office of Health Insurance Programs

CLINIC BILLING FOR CONTRACEPTIVES

ORAL CONTRACEPTIVE (0C)
1 CLAIM

APG CLAIM
Use **S4993** for OC (includes Emergency Contraceptives Plan B & Ella)

Not covered as a "stand-alone" Must be accompanied by another service, e.g., evaluation and management visit

OTHER CONTRACEPTIVE METHODS
1 CLAIM

APG CLAIM
Vaginal Ring - **J7303**
Patch - **J7304**
Depo-Provera Injection* **J1050**

IMPLANT
2 CLAIMS

APG CLAIM
Insertion - **11981**
Removal - **11982**
Removal with reinsertion **11983**

ORDERED AMBULATORY CLAIM
Device - use **J7307**
Report acquisition cost by invoice on the claim

IUD
2 CLAIMS

APG CLAIM
Insertion - **58300**
Removal - **58301**

ORDERED AMBULATORY CLAIM
Device - use **J7296 (KYLEENA), J7297 (LILETTA), or J7298 (MIRENA), J7300 (PARAGARD), J7301 (SKYLA)**
Report acquisition cost by invoice on the claim

Contraceptive Ring
2 CLAIMS

APG CLAIM
Applicable medical visit code

ORDERED AMBULATORY CLAIM
Device - use **J7294 or J7295**
Report acquisition cost by invoice on the claim

* When a Depo-Provera injection is administered by an RN or LPN within their scope of practice with a patient-specific order from a licensed and currently registered physician, physician assistant, nurse practitioner, or midwife, J1050 and 96372 (therapeutic injection) may be billed to Medicaid as an ordered ambulatory service when an APG claim is **not** billed for that patient on the same date of service.

Reminder: When the primary reason for the visit is family planning, a primary diagnosis of contraceptive management should be submitted on the claim. The claim should also include a family planning indicator.