

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Family Planning

Federal resources are available to support the Medi-Cal program in the area of family planning. For this reason, it is most important that family planning services provided to Medi-Cal recipients be identified by entering the appropriate family planning indicator on the claim form.

Participation and Services

Family planning services are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. They include the following:

- Medical and surgical services performed by or under the direct supervision of a licensed physician
- Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician

Participation

Participation must be voluntary and individuals must not be coerced to accept services. Family planning services shall not be required for receipt of any welfare benefits. Individuals must not be coerced to employ or not to employ any particular method of birth control including sterilization and abortion. Sterilization services are subject to special program requirements, including a minimum age, informed consent process, and waiting period. (Refer to the *Sterilization* section in the appropriate Part 2 manual for detailed information regarding consent for sterilization.)

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Services

Family planning services include, but are not limited to:

- Patient visits for the purpose of family planning
- Family planning counseling services provided during a regular patient visit (see “Non-Comprehensive Family Planning Visits” later in this section)
- IUD and IUCD insertions, or any other invasive contraceptive procedures/devices
- Tubal ligations
- Vasectomies
- Contraceptive drugs or devices
- Treatment for complications resulting from previous family planning procedures
- Laboratory procedures, radiology and drugs associated with family planning procedures

Some of these services can be easily recognized as family planning by the CPT-4 procedure code or drug type code (for example, intrauterine device (IUD) insertion, vasectomy, contraceptive drugs and devices). Other services such as visits, laboratory tests and X-rays are not so readily identifiable as family planning services.

Billing

Providers are to indicate “Family Planning” as a diagnosis when billing any of the services listed on a previous page that relate to family planning. Indicate this by entering the appropriate code in the *Conditions Codes* fields (Boxes 18 – 24) of the *UB-04* claim form or in the *EPSDT/Family Planning* field (Box 24H) on the *CMS-1500* claim. Complete the diagnosis code or the appropriate narrative, where applicable. (Refer to the billing instructions in the *CMS-1500 Completion* or *UB-04 Completion: Outpatient Services* section in this manual for family planning codes and descriptions.) In addition, providers should identify services related to the treatment of complications of family planning.

Examples:

- Surgical procedure such as I & D (Incision and Drainage) of pelvic abscess resulting from infection with IUD
- Office visit and laboratory tests needed because of uterine bleeding while on oral contraceptives

Occasionally other services (including hospital, radiology, pharmaceutical, blood and blood derivatives) may be related to family planning or to its complications, and should be properly identified.

**Physician-Administered Drugs:
Inclusion of NDC on Claim**

For physician-administered drugs, providers must include the National Drug Codes (NDCs) on the claim, according to the policy in the *Physician-Administered Drugs – NDC* section in this manual. This is in addition to the HCPCS code, which remains the basis of pricing. For claim form completion instructions, refer to the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions*, or *Physician-Administered Drugs – NDC: UB-04 Billing Instructions* sections in the appropriate Part 2 manual.

**Non-Comprehensive
Family Planning Visits**

Modifier FP should be used when billing for additional time spent discussing family planning needs with a recipient during routine, non-family planning office visits. Family planning counseling services include the following:

- Contraceptive counseling
- Instruction in pregnancy prevention
- Any other family planning counseling service

Modifier FP may be used with the following HCPCS and CPT-4 codes: Z1032 – Z1038, Z6200 – Z6500, 59400, 59510, 59610, 59618, 99201 – 99215, 99241 – 99245, 99281 – 99285, 99341 – 99353, 99384, 99394.

Reimbursement is limited to female recipients 15 – 44 years of age. Additional reimbursement is made for appropriate use of this modifier, but not more than once per recipient, for the same provider, in a 12-month period. Services billed by an assistant surgeon or anesthesiologist are not reimbursable.

Modifier FP must be billed on a separate claim line than the primary visit code. When billing for family planning counseling, list the primary procedure code and modifier, if applicable, on one claim line, and the same procedure code with modifier FP on the next claim line. A family planning diagnosis code is not required when billing with this modifier.

Note: Modifier FP should not be billed with comprehensive family planning visit as identified by the family planning diagnosis code.

See “Comprehensive Family Planning Visit” in this section, when billing for visits primarily related to family planning.

Services Not Included
in Family Planning

Reimbursement for family planning does not extend to the following services:

- Facilitating services such as transportation, parking, and child care while family planning care is being obtained
- Infertility studies or procedures provided for the purpose of diagnosing or treating infertility
- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only
- Therapeutic abortions and related services
- Spontaneous, missed or septic abortions and related services

**Comprehensive Family
Planning Visits**

The following ICD-9-CM diagnosis codes, when billed as a primary diagnosis code, indicate comprehensive family planning services. The use of these codes enables federal financial participation in funding these services.

- V25.01 Prescription of oral contraceptives
- V25.02 Initiation of other contraceptive measures
- V25.03 Encounter for emergency contraceptive counseling and prescription
- V25.04 Counseling and instruction in natural family planning to avoid pregnancy
- V25.09 Other contraceptive management
- V25.2 Sterilization
- V25.11 Encounter for insertion of intrauterine contraceptive device**
- V25.12 Encounter for removal of intrauterine contraceptive device**
- V25.13 Encounter for removal and reinsertion of intrauterine contraceptive device**

- V25.40 Contraceptive surveillance, unspecified
- V25.41 Contraceptive pill
- V25.42 Intrauterine contraceptive device
- V25.43 Implantable subdermal contraceptive
- V25.49 Other contraceptive method
- V25.5 Insertion of implantable subdermal contraceptive
- V25.8 Other specified contraceptive management
- V25.9 Unspecified contraceptive management
- V26.31 Testing of female for genetic disease carrier status
- V26.32 Other genetic testing of female
- V26.33 Genetic counseling
- V26.34 Testing of male for genetic disease carrier status
- V26.35 Encounter for testing of male partner of habitual aborter
- V26.51 Tubal ligation status**
- V26.52 Vasectomy status**
- V45.51 Intrauterine contraceptive device**
- V45.52 Subdermal contraceptive implants**

Contraceptives

Contraceptive medication and supplies for family planning services billed by providers such as family planning centers include the following:

HCPCS

<u>Code</u>	<u>Description</u>
J7300	Intrauterine copper
J7301	Skyla
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
S4993	Contraceptive pills for birth control

A quantity of "1" is entered in the *Service Units/Days or Units* field (Box 24G) of the claim when billing for codes J7300 – J7302. When billing birth control medication with code S4993, the number of cycles covered (up to 12) is entered in the *Service Units/Days or Units* field (Box 24G) of the claim. Code S4993 covers oral medication only and may be dispensed by a registered nurse (RN) who has completed the required training pursuant to California Business and Professions Code (B&P Code), Section 2725.2, when Evaluation and Management (E&M) procedure 99201, 99211 or 99212 (office or other outpatient visit for the evaluation and management of a new or established patient, presenting problem minimal, minor or self-limiting) is performed. If performed by an RN, the E&M procedures must be billed with modifier TD.

**Contraceptives:
Public Health Service
Covered Entities**

Providers participating as covered entities, and purchasing drugs through the Public Health Service (PHS) 340B program, must not bill more than the actual acquisition cost, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. Community clinics, free clinics, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) pursuant to Section 14132.01 of California *Welfare and Institutions Code* (W&I Code) may also submit for a dispensing fee of \$12 per unit. The unit for ParaGard, Mirena and Skyla is a calendar month, with a maximum allowable of 36 units per device.

Eligible entities will be reimbursed the lesser of the acquisition cost of the drug plus the maximum dispensing fee or the Medi-Cal maximum rate on file.

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Emergency Contraceptive: Ella	Ella (ulipristal acetate, 30 mg) is billed with HCPCS code J3490U5 (modifier U5 must be used with code J3490). Ella contains one pill per package. This contraceptive is for females only and is a single course of treatment to be taken within five days (120 hours) of unprotected sex and can reduce the risk of pregnancy by 85 percent after unprotected sex or a contraceptive accident, such as a condom breaking. Ella is recommended for women with a body mass index (BMI) over 25.
Emergency Contraceptive: Next Choice	Next Choice (levonorgestrel, two tablets of 0.75 or one tablet of 1.5 mg) is billed with HCPCS code J3490U6 (modifier U6 must be used with code J3490). Next Choice contains two progestin-only pills containing levonorgestrel 1.5 mg. This contraceptive is for females only and is a single course of treatment to be taken within three days (72 hours) of unprotected sex and can reduce the risk of pregnancy by 89 percent after unprotected sex or a contraceptive accident, such as a condom breaking.
Combined Maximum Dispensing	<p>Codes J3490U5 and J3490U6 have a combined maximum dispensing.</p> <p>They may be reimbursed up to a maximum of one pack per recipient, per month, any provider and a maximum of six packs per recipient, per year, any provider.</p> <p>Codes J3490U5 and J3490U6 may be dispensed by an RN who has completed the required training pursuant to California B&P Code, Section 2725.2, when E&M procedure 99201, 99211 or 99212 (office or other outpatient visit for the evaluation and management of a new or established patient, presenting problem minimal, minor or self-limiting) is performed. If performed by an RN, the E&M procedures must be billed with modifier TD.</p>

Implantable Contraceptives:
Etonogestrel

Etonogestrel, 68 mg contraceptive implant (Implanon, Nexplanon) is billed with code J7307. Implanon must be FDA approved, labeled for use in the United States, and obtained from the single-source distributor. Only providers who have completed a company-sponsored training course and have been assigned a unique "Training Identification Number" may purchase Implanon. The certificate of training for each provider who inserts the implant must be retained by the provider and is subject to post-audit review.

Implanon may be reimbursed when service is performed by non-medical practitioners (NMPs) who have completed the required training. Implanon is not reimbursable to Pharmacy providers.

Providers must maintain a written log or electronic record of all Implanon implant systems, including the recipient's name, medical record or Medi-Cal BIC number, date of surgery, and lot number of the product, for at least three years from the date of insertion. Records are subject to post-audit reviews.

Implantable Contraceptives:
Billing Guidelines

When billing for HCPCS code J7307, providers must attach a copy of the invoice to the claim or document the invoice number and price in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim.

Etonogestrel (code J7307)

Covered for females

Reimbursement limited to one per recipient, any provider, per 34 months *

Bill in conjunction with ICD-9-CM diagnosis code V25.43 (implantable subdermal contraceptive) or V25.5 (insertion of implantable subdermal contraceptive)

* While the duration of action of Implanon is 36 months, the 34-month limit will permit early removal and insertion of a new implant.

Providers billing code J7307 more than once in 34 months must document the necessity for the repeat implant in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim.

**Implantable Contraceptives:
Public Health Service Covered
Entities**

Providers participating as covered entities, and purchasing drugs through the PHS 340B program, must not bill more than the actual acquisition cost, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. Community clinics, free clinics, FQHCs and RHCs pursuant to Section 14132.01 of California *Welfare and Institutions Code* may also bill for a dispensing fee of \$12 per unit. The unit for the etonogestrel contraceptive implant is a calendar month, with a maximum allowable billing of 36 units per device.

Implantable Contraceptives:
Surgical Insertion

The following CPT-4 codes are used for billing and reimbursement of the surgical procedure to insert or remove the contraceptive:

CPT-4

<u>Code</u>	<u>Description</u>
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11976	Removal, implantable contraceptive capsules
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11981	Insertion, non-biodegradable drug delivery implant
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When multiple surgery procedures are performed at the same operative session, see the *Surgery: Billing with Modifiers* section of the provider manual.

These are common office procedures that require “By Report” documentation and can be reimbursed as a physician, NMP or nurse midwife service.

Anesthetic Injection Codes	Anesthetic injection codes are reimbursable when anesthesia is necessary during insertion or removal of implantable contraceptive capsules.
Injectable Contraceptives	<p>HCPCS code J3490U8 (unclassified drugs) is limited to contraceptive injections and is reimbursable not more frequently than once every 80 days if billed by the same provider, for the same recipient.</p> <p>Note: Modifier U8 <u>must</u> be used with code J3490.</p> <p>The usual dose is medroxyprogesterone acetate 150 mg administered by intramuscular injection every three months. Code J3490U8 may be administered by an RN who has completed the required training pursuant to California B&P Code, Section 2725.2, when E&M procedure 99201, 99211 or 99212 (office or other outpatient visit for the evaluation and management of a new or established patient, presenting problem minimal, minor or self-limiting) is performed. If performed by an RN, the E&M procedures must be billed with modifier TD.</p>
Public Health Service Covered Entities	<p>Providers participating as covered entities, and purchasing drugs through the PHS 340B program, must not bill more than the actual acquisition cost, as charged by the manufacturer at a price consistent with the PHS program for covered outpatient drugs. In addition to the administration fee, community clinics, free clinics, FQHCs and RHCs pursuant to Section 14132.01 of California W&I Code may also bill for a dispensing fee of \$12 per unit.</p>

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Other Contraceptive
Supplies/Medication

Male condoms are billed with HCPCS code A4267 and female condoms are billed with code A4268. Other contraceptive supplies or medications, including foams, gels and creams are billed with code A4269 and the appropriate modifier, or code S5199, as indicated below. The modifier indicates the type of spermicide.

<u>HCPCS Code/Modifier</u>	<u>Description</u>
A4269U1	Gel/jelly/foam/cream
A4269U2	Suppository
A4269U3	Vaginal film
A4269U4	Contraceptive sponge
S5199	Lubricant

On the claim, providers enter a “1” in the *Service Units/Days or Units* field (Box 24G) and document the following in the *Remarks* field (Box 80) or *Additional Claim Information* field (Box 19):

- Description of items
- Actual quantity
- “At cost” expense

Providers enter the appropriate code in the *Condition Codes* fields (Boxes 18 – 24) on the *UB-04* claim form or in the *EPSDT/Family Planning* field (Box 24H) on the *CMS-1500* claim form. Providers also include the appropriate diagnosis when billing these codes. Medi-Cal policy requires that charges for supplies be “at cost.”

Note: Neither HCPCS code Z7610 nor CPT-4 code 99070 is used to bill for contraceptive supplies or medications.

Evaluation and
Management Codes

E&M CPT-4 codes, for example 99203 or 99213, may be billed when the patient is counseled regarding contraception or is examined to determine the suitability of contraceptive modalities.

Modifiers UA and UB

Modifier UA (supplies and drugs for surgical procedures without general anesthesia) or UB (supplies and drugs for surgical procedures with general anesthesia) is reimbursable with CPT-4 code 11976 (removal of implantable contraceptive capsules), code 58300 (insertion of an IUD) and code 58301 (removal of an IUD) when surgical supplies are necessary.

Elective Sterilization

Please refer to the *Sterilization* section in the appropriate Part 2 manual for billing instructions.