



FAMILY PLANNING CLINICS

Chapter Thirty-Three of the Medicaid Services Manual

Issued April 1, 2011

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

The Social Security Amendments of 1972 amended sections 1903 (a) (5) and 1905 (a) (4) of the Act in order to give impetus to the availability and provision of family planning services in the states. The law makes family planning services a mandatory Medicaid service for Categorically Needy individuals of childbearing age (including minors who can be considered to be sexually active) who desire such services, and permits States to extend those services to the Medically Needy. Federal Regulations found at 42 Code of Federal Regulations (CFR) 440.40 and 42 CFR 440.210 describe the required services including family planning services and supplies for individuals of child-bearing age.

Family planning services and related health services provided under the Medicaid Family Planning Clinic (FPC) Program are provided to assist individuals in determining the number and spacing of their children.

In order for a Medicaid beneficiary to utilize a Medicaid enrolled FPC, one must meet all of the following criteria:

1. Female;
2. Age 10 through 59 years;
3. Desire services to prevent or to otherwise control family size; and
4. Services must be medically necessary.

The FPC Program is distinguished from family planning services provided by a physician or a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) in that the FPC Program enrolls providers under a specific provider type and permits certain designated procedure codes to be billed.

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SECTION 33.1: COVERED SERVICES

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COVERED SERVICES

Services which are covered and reimbursable for payment by Medicaid-enrolled family planning clinics (FPCs) are defined in this section. The fees that are associated with these services are published in the FPC fee schedule on www.lamedicaid.com. ClaimCheck® claims editing policy applies. For additional information on ClaimCheck® please refer to the Louisiana Medicaid website.

FPC services are as follows:

1. Evaluation and management;
2. Diagnostic services; and
3. Contraceptive services.

Evaluation and Management

Louisiana Medicaid will pay no more than **one** “new patient” evaluation and management code per 3-year period, except when identifying the initial pre-natal visit of each new pregnancy. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.

Providers are to use the appropriate Preventive Medicine Services “New Patient” or “Established Patient” Current Procedure Terminology (CPT) code.

Office Visits - Initial/Annual Examinations

Family planning initial visit is the beneficiary’s first visit to the FPC (**new patient**). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.

Family planning annual visit is the beneficiary’s yearly visit to assess the beneficiary’s physical status and contraceptive practices (**established patient**). An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years.

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The FPC initial/ annual visit must include the following when applicable:

1. Initiation of a medical record, collecting medical history, reproductive history, and some social history;
2. Beneficiary education in a group setting, including reproductive physiology, benefits of family planning, contraceptive methodology, and an explanation of services provided at the clinic;
3. Routine laboratory tests as indicated including hematocrit/hemoglobin, urinalysis, sickle cell prep, Papanicolaou (PAP) smear, pregnancy test, and gonorrhea/chlamydia culture. (**Note:** The laboratory must bill for services performed by the laboratory);
4. Physical examination, including at least height, weight, blood pressure recording, and breast, abdominal, and pelvic examination; and
5. Prescription and referral services - the issuance of prescriptions for drugs for conditions such as vaginal infection and anemia. Referrals are made for other medical problems when indicated (severe infection, persistent abdominal cervical cytology, positive urine culture, pregnancy, anemia, etc.).

Rescheduled Physician Visit

The appropriate procedure code must be used for the billing of a **rescheduled** visit when the provider was unable to be present for a beneficiary's initial/reopen/annual visit which requires the presence of a physician.

Intermediate Physician Visit

The intermediate physician visit must include all of the appropriate physician services that are included in the Initial/Reopen/Annual Examination. Refer to the section entitled "Office Visits – Initial /Annual Examinations" for detailed information regarding these services."

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Nurse Visit

This service must be used for the billing of a nursing assessment/evaluation when the physician is unable to be present for the scheduled initial/annual visit and the beneficiary is rescheduled to return for the physician services.

The nursing assessment/evaluation must include all of the appropriate nursing services that are included in the initial/annual examination. Refer to the section entitled “Office Visits – Initial/Annual Examinations” for detailed information regarding these services.

This service must be reported for beneficiaries receiving services through the National Family Planning Program (Title X) who are using foam, condoms or diaphragm for every second year exam since the Title X Program allows a physician exam only once every other year rather than annually. Title X of the Public Health Service Act supports a network of clinics providing comprehensive family planning services.

NOTE: When a beneficiary returns to the office at a later date for the physician to complete the initial/annual visit, the rescheduled physician visit must be reported with the corresponding procedure code.

Routine Return Visit

This service must be used for the billing of a routine return visit to the clinic requiring non-physician services. This is a service that is provided by the registered nurse (RN). Services may include the following:

1. Intrauterine device (IUD) string check if indicated;
2. Height/weight;
3. Blood pressure check;
4. Medical history program counseling;
5. Family planning counseling;
6. Contraceptive method counseling;

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7. Pregnancy counseling;
8. Patient education;
9. Hematocrit/hemoglobin;
10. Pap-smear; and
11. Other services provided by the RN under the scope of the routine return visit.

Sterilization Counseling

This service is the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. The appropriate procedure code must be used when sterilization counseling is provided by the provider to explain the actual sterilization procedure, allay beneficiary fears and respond to concerns of the beneficiary. Consent forms are initiated. Referrals are made and followed up with the appropriate provider.

Social Services Counseling – Social Worker

This service must be reported with **modifier AJ** (Clinical Social Worker) for counseling provided by a social worker with a Masters of Social Work (MSW) regarding the medical/family planning needs of the beneficiary.

Outreach or Follow-up Phone Call

These services are to be used for the billing of an outreach phone or follow-up phone call to a beneficiary by or under the direction of a physician. Choose according to criteria outlined in the CPT. Only one of these procedures is reimbursable per day, per beneficiary when provided by the same billing provider.

Nutritional Counseling

The appropriate code must be used for the billing of counseling services provided by a licensed dietician/nutritionist regarding the nutritional needs and diet habits of the beneficiary. Monitoring and goal setting is also provided by the dietician/nutritionist.

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Diagnostic Services

Specimens forwarded to an outside laboratory may not bill for performance of the test. Only the laboratory must bill for services performed by the laboratory. The appropriate procedure code must be used for the billing of the following procedures:

1. Venipuncture;
2. Urine Testing;
3. Hematocrit Testing;
4. Hemoglobin Testing;
5. Gonorrhea Culture;
6. Chlamydia Culture; and
7. PAP Smear.

Contraceptive Services

The appropriate procedure codes must be used for the billing of the insertion, removal, fitting, and/or delivery of contraceptives devices to prevent pregnancy as described below.

Implantable Contraceptive Capsules

Contraceptive capsule implants are inserted subdermally, under local anaesthesia usually in the inner aspect of the non-dominant arm. Services include contraceptive management, insertion, removal and reinsertion of implantable contraceptives, including implant and supplies.

Diaphragm

Diaphragms are supplied and sized by a health care professional.

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Intrauterine Contraceptives

Copper and hormonally-based devices placed in the uterus to prevent conception. Intrauterine device services include the insertion and removal of the device.

Contraceptive Supplies

Contraceptive supplies include female and male condoms, as well as spermicides.

Injectable Contraceptive

A deep intra-muscular injectable medicine used as a temporary method of contraception.

Oral Contraceptive

Oral contraception is medication taken by mouth for the purpose of birth control given in a one-month supply.

Other Services – Referrals

Medicaid will reimburse a Medicaid-enrolled FPC for routine family planning services administered for family planning purposes only. A referral must be made for the treatment of other medical conditions as indicated. If the beneficiary has been assigned a Medicaid primary care physician (PCP), the beneficiary must be referred to the PCP for treatment of other medical conditions. Pregnant women must also be referred to a PCP as the FPC Program does not include services for pregnant women.

For Take Charge Plus beneficiaries receiving services at a FPC, refer to the Take Charge Plus manual chapter and the Take Charge Plus fee schedule on the Louisiana Medicaid website.

NOTE: Refer to Chapter 1, *General Administration and Information*, of the Medicaid Services Manual for general record keeping criteria.

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SECTION 33.2: BENEFICIARY REQUIREMENTS**PAGE(S) 1**

BENEFICIARY REQUIREMENTS

In order for a Medicaid beneficiary to utilize a Medicaid enrolled Family Planning Clinic (FPC), one must meet all of the following criteria:

1. Female;
2. Age 10 through 59 years; and
3. Desire services to prevent or to otherwise control family size.

The procedure codes/services listed in the FPC fee schedule are the only procedure codes/services that are reimbursable by Medicaid to FPCs and are the only codes to be billed to Louisiana Medicaid. The FPC fee schedule is available online at www.lamedicaid.com.

Freedom of Choice

Family planning clients are guaranteed the right to choose family planning providers and methods without coercion or intimidation. Acceptance of family planning services must not be a prerequisite to eligibility for or receipt of any other service or assistance.

Medicaid beneficiaries have freedom of choice (FOC) to obtain FPC services from any participating FPC provider.

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PROVIDER REQUIREMENTS

Providers must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately for their job position.

Personnel policies and procedures must include job descriptions, a written orientation plan for new staff to include competencies appropriate for the position, and performance evaluation process for all staff. Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

All medical care must be provided under the supervision, direction, and responsibility of a licensed Medical Director.

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CLAIMS RELATED INFORMATION

All claim submissions for dates of service must contain Healthcare Common Procedure Coding System (HCPCS) codes. Refer to the **Louisiana Family Planning Clinics (FPCs) Fee Schedule** published online at www.lamedicaid.com for a list of procedure codes/services reimbursable by Louisiana Medicaid.

The fiscal intermediary (FI) accepts standardized professional 837P electronic transactions if the Vender Billing Agent and Clearinghouse (VBC) used by the provider has been tested and approved by the FI. Providers billing hard copy claims will continue to bill on the CMS-1500. All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.