



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Family Planning Services

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Family Planning Services

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system.*

*For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging (PathWays) services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#) at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Bulletins](#) at in.gov/medicaid/providers.

Introduction

Family planning services are services, supplies or pharmaceuticals that are provided to temporarily or permanently prevent or delay pregnancy. Based on Centers for Medicare & Medicaid Services (CMS) policies, the Indiana Health Coverage Programs (IHCP) also considers the following services, provided during a family planning encounter, to be part of family planning services:

- Initial diagnosis and treatment of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs)
- Screening, testing, counseling and referral of members at risk for human immunodeficiency virus (HIV)

Note: Ongoing follow-up of STDs and STIs and visits for treatment of chronic STDs and STIs are not considered to be a part of family planning services. These services may be covered for members with benefit plans that are not restricted to family planning services only.

Family planning services include the following:

- Annual family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods
- Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, within the parameters described in the [Obstetrical and Gynecological Services](#) module
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Food and Drug Administration (FDA)-approved contraceptive drugs, devices and supplies, including emergency contraceptives
- Initial diagnosis and treatment of STDs and STIs, if medically indicated, including the provision of FDA-approved anti-infective agents
- Screening, testing, counseling and referral of members at risk for HIV, within the parameters described in the [Laboratory Services](#) module
- Tubal ligation
- Hysteroscopic sterilization with an implant device
- Vasectomy
- Pregnancy testing and counseling

Family planning services are covered under all IHCP programs that include full Indiana Medicaid State Plan benefits. Certain individuals who are not eligible for any other IHCP program may qualify for the IHCP Family Planning Eligibility Program, which provides limited coverage to qualifying individuals for family planning services **only**. Family Planning Eligibility Program coverage is restricted to specific procedure codes and diagnosis codes, as described in the [Family Planning Eligibility Program](#) module and listed in *Family Planning Eligibility Program Codes*, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers.

Billing for Family Planning Services

Medical providers bill family planning services and supplies on the professional claim (CMS-1500 claim form, IHCP Provider Healthcare Portal [IHCP Portal] professional claim or 837P electronic transaction), using the appropriate Current Procedural Terminology (CPT^{®1}) or Healthcare Common Procedure Coding System (HCPCS) codes for the services or supplies rendered and the appropriate International Classification of Diseases (ICD) diagnosis codes for the condition treated. If applicable, the claim must also include the National Drug Code (NDC), name, unit of measure and number of units of the product administered or dispensed. See *Procedure Codes That Require NDCs*, accessible from the [Code Sets](#) webpage at in.gov/medicaid/providers.

Note: Because no specific HCPCS code currently exists for the Depo-SubQ Provera, medroxyprogesterone acetate 104 mg/0.65 mL, suspension for injection, providers are advised to bill this injectable contraceptive using HCPCS code J3490 – Unclassified drugs. This single-source agent is not generically equivalent to multisource Depo-Provera 150 mg/1 mL, and therefore should not be billed with HCPCS code J1050 – Injection, medroxyprogesterone acetate, 1 mg.

See the [Claim Submission and Processing](#) module for general information about professional claim billing. See the [Pharmacy Services](#) module for information about pharmacy claim billing.

Providers must ensure that the member's chart contains documentation supporting all information on the claim.

Contraceptives

IHCP reimbursement is available for most FDA-approved contraceptive drugs, devices and supplies. Covered supplies, devices and drugs are as follows:

- Birth control pills
- Injectable contraceptive drugs
- Emergency contraception
- Male condoms
- Female condoms
- Spermicides
- Contraceptive vaginal rings
- Contraceptive patches
- Diaphragms
- Cervical caps

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- Intrauterine devices (IUDs)
- Contraceptive implants

Members must be given information and education about all methods of contraception available, including reversible methods (for example, oral, emergency, injectable, implant, IUD, diaphragm, cervical cap, contraceptive patch, vaginal ring, spermicide, condom and rhythm) and irreversible methods (for example, tubal ligation and vasectomy). Education regarding all contraceptive methods must include relative effectiveness, common side effects, risks, appropriate use and difficulty in usage. Basic information concerning STDs and STIs must also be discussed.

Prescriptions for a contraceptive method must reflect the member's choice, except where such choice is in conflict with sound medical practice.

Members are encouraged to follow up with their family planning provider when a specific problem related to a contraceptive method occurs, or when additional services and supplies are needed. All members, regardless of the contraceptive method chosen, must be encouraged to return for a physical examination, laboratory services and health history at least once per year.

Contraceptive drugs and supplies may be administered, dispensed, prescribed or ordered. Prescriptions for family planning drugs and supplies may be refilled as prescribed by the practitioner for up to one year. Emergency contraception may be dispensed or prescribed as needed.

Contraceptive Drugs

Generic medications must be dispensed when available; however, if generic drugs are not available, brand-name drugs may be dispensed. Generic and preferred drugs must be used when available, unless the physician indicates a medical reason for using a different drug. Brand name drugs may be dispensed, even if generic drugs are available, if the IHCP determines that the brand name drugs are less costly to the IHCP.

Contraceptive Supplies

For a pharmacy provider to be reimbursed for over-the-counter external contraceptive supplies, a licensed IHCP-enrolled practitioner with prescriptive authority must prescribe them. The member may receive up to a three-month supply at one time. Reimbursement for condoms is available for both male and female members.

Cervical caps and diaphragms for contraceptive use may be reimbursed separately, in addition to the service of fitting and providing instructions for using the device.

Long-Acting Reversible Contraception Products

Long-acting reversible contraception (LARC) products are defined as implantable products that remain effective for several years to prevent pregnancies. LARC products include IUDs and contraceptive implants:

- **Intrauterine Devices** – The IHCP reimburses for intrauterine devices (IUDs) and the insertion of IUDs, including insertions on the same date of service as a dilation and curettage. The IHCP also covers the removal of an IUD; however, a provider will not be reimbursed for both an office visit and an IUD removal when billed on the same date of service.
- **Contraceptive Implants** – The IHCP reimburses for contraceptive implants. The IHCP also reimburses for the insertion and removal of contraceptive implants.

*Note: Norplant systems are no longer available in the United States; however, the IHCP reimburses the **removal** of the implanted contraceptive capsule (procedure code 11976 – Removal, implantable contraceptive capsules) when billed with ICD-10 diagnosis code Z30.49 – Encounter for surveillance of other contraceptives.*

Transferring LARC Products

In accordance with *Indiana Code IC-12-15-47*, LARC intrauterine devices and birth control implants obtained for a Medicaid member may be transferred to another Medicaid member if the LARC was not delivered to, implanted in or used on the original Medicaid member to whom the LARC was prescribed, if the LARC product meets the following conditions:

- Is in the original, unopened package.
- Has been in the possession of the provider for at least 12 weeks. (However, this requirement may be waived by the written consent of the original Medicaid recipient to whom the LARC was prescribed.)
- Has not left the possession of the provider that originally prescribed the LARC.
- Is medically appropriate and not contraindicated for the Medicaid member to whom the LARC is being transferred.

Claims for transferred LARC products will need to be reversed for the original Medicaid member and resubmitted for the Medicaid member to whom the product is being transferred.

Pharmacy Reimbursement for LARC Products

The IHCP reimburses LARC claims through the pharmacy benefit only for IHCP-enrolled pharmacies that meet the resell, reuse or redistribute requirements set forth in *IC 25-26-13-25*. Pharmacy providers that do not meet *IC 25-26-13-25* requirements for dispensing returned products will not be reimbursed for LARC claims.

Medical Provider Reimbursement for LARC Products

The IHCP reimburses IHCP-enrolled medical providers for covered LARC products provided to eligible members and billed on a professional claim.

The following special reimbursement policies apply for designated LARC products provided in the settings indicated:

- **Inpatient hospitals and birthing centers** – When the LARC product is implanted during an inpatient hospital or birthing center stay for a delivery, the IHCP allows separate reimbursement, in addition to the inpatient hospital diagnosis-related group (DRG) or the birthing center all-inclusive reimbursement amount. The appropriate HCPCS code for the LARC product must be submitted on a professional claim (*CMS-1500* claim form or electronic equivalent).
- **Outpatient hospitals and ambulatory surgical centers (ASCs)** – When provided in an outpatient hospital or ASC setting, the LARC product is reimbursable when billed separately on a professional claim. Outpatient hospitals and ASCs bill for the device under the professional or durable medical equipment (DME) provider number.
- **Federally qualified health centers (FQHCs) and rural health clinics (RHCs)** – When provided in an FQHC or RHC, the LARC product may be reimbursed separately from the prospective payment system (PPS) rate. FQHC and RHC providers should bill the appropriate HCPCS code for the LARC product, with place of service (POS) code 71 and **without** the HCPCS code T1015. Providers can bill for a LARC product provided on the same day as an encounter that has a T1015 – but it must be billed on a separate claim.

For applicable HCPCS codes, see *Family Planning Services Codes*, accessible from the [Code Sets](#) webpage at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Sterilization

Note: The IHCP does not cover a hysterectomy performed solely to render a member permanently incapable of bearing children, whether performed as a primary or secondary procedure. For information about IHCP coverage for medically necessary hysterectomies performed to treat an illness or injury, see the [Obstetrical and Gynecological Services](#) module.

Sterilization renders a person unable to reproduce. The IHCP reimburses for sterilizations for men and women only when a valid consent form accompanies all claims connected with the service, according to *Indiana Administrative Code 405 IAC 5-28-8*. The IHCP may reimburse for the sterilization of an individual only if that individual meets the following requirements:

- Has voluntarily given informed consent (*Code of Federal Regulations 42 CFR 441.257* through *441.258*)
- Is 21 years old or over at the time the informed consent is given (*42 CFR 441.253*)
- Is neither mentally incompetent nor institutionalized (*42 CFR 441.251*)

Informed Consent for Sterilization

The IHCP reimburses for sterilizations only when a valid *Consent for Sterilization* form accompanies all claims connected with the service. For instructions on completing this form, see the [Consent for Sterilization Form Instructions](#) section.

The person who obtains informed consent must verbally communicate all information about a sterilization procedure to the member to be sterilized. Providers must furnish an interpreter if a language or hearing barrier exists. For a full description of the informed-consent process, *42 CFR 441.257* provides additional information.

Providers cannot obtain informed consent while the member to be sterilized is in one of the following situations:

- In labor or childbirth
- Seeking or obtaining an abortion (see the [Obstetrical and Gynecological Services](#) module for information regarding abortion and related services)
- Under the influence of alcohol or other substances that affect the member's state of awareness

Providers must allow at least 30 days, but not more than 180 days, to pass between the date when the member gives the informed consent and the date when the provider performs the sterilization procedure. For sterilizations planned concurrent with a delivery, the patient must give the informed consent at least 30 days before the expected date of delivery. The following exceptions apply to premature delivery (defined by the IHCP as labor before 37 weeks' gestation) or emergency abdominal surgery:

- The member must sign the *Consent for Sterilization* form 72 hours before the sterilization, when done at the time of a premature delivery.
- The physician must indicate the reason for the surgery being performed early and the individual's expected date of delivery. The reason for the surgery must be only premature delivery or emergency abdominal surgery.

If the provider does not obtain informed consent on the required *Consent for Sterilization* form within the required time frame because of a retroactive eligibility situation or because the patient failed to inform the provider of IHCP eligibility, the IHCP does not cover the service. The IHCP cannot pay for sterilizations performed if the member did not sign the *Consent for Sterilization* form before the procedure. In these situations, the provider may collect the balance due for the procedure from the patient. To prevent this situation and to ensure IHCP coverage, providers may use the *Consent for Sterilization* form for *all* patients in their practice.

Note: If unrelated services are provided at the same time as a sterilization for an IHCP member, the provider can be reimbursed for medically necessary services unrelated to the sterilization even when the sterilization is not covered due to consent not being obtained. Medically necessary services are subject to the IHCP established policy on retroactive services, as outlined in the [Member Eligibility and Benefit Coverage](#) module.

Services That Require a Sterilization Consent Form

See *Family Planning Services Codes* (accessible from the [Code Sets](#) webpage at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers)) for lists of CPT, HCPCS and ICD sterilization procedure codes that, when submitted to the IHCP, cause a claim to suspend for an analyst to review the consent form.

In addition to the codes listed in these tables, if any *other* service is performed specifically to sterilize a member, the provider is obligated to obtain informed consent and submit the sterilization consent form with the claim, as described in this module.

When a Sterilization Consent Form Is Not Required

A sterilization consent form is not required in these situations:

- The sterilization is performed due to illness or injury, when prior acknowledgement was not possible.
- The patient was already sterile prior to the procedure.
- The patient is not rendered sterile by the procedure (for example, because the procedure was performed unilaterally rather than bilaterally).

In these situations, to prevent the claim from denying when billing codes that would otherwise require a *Consent for Sterilization* form, the provider must attach either an operative report or a physician's statement attesting that one of the preceding exceptions applies. The following items should be included in the documentation:

- Patient name
- Explanation of the exception
- Physician signature

Consent for Sterilization Form Instructions

All providers (attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services) must attach a copy of a properly completed *Consent for Sterilization* form to each claim for voluntary sterilization and related services.

Providers may download the current version of the *Consent for Sterilization* form (HHS-687), and its Spanish-language equivalent (HHS-687-1), from the [Forms](#) webpage at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers). An expiration date appears in the upper-right corner of the form. Completed consent forms that are not the current version available will cause full claim denial.

When providers properly complete the *Consent for Sterilization* form, the IHCP receives all the necessary information regarding consent, interpreter's statement, statement of person obtaining consent and physician's statement.

Federal regulations require that certain elements of the consent form be handwritten. If providers or members make an error on the form, they must complete a new form rather than submitting the form with a strikethrough.

The IHCP contractor must receive a properly completed *Consent for Sterilization* form before making payment. To ensure timely payment to related service providers, the primary service provider should forward **exact** copies of the properly completed consent form to the related service providers.

Table 1 provides instructions for each item on the *Consent for Sterilization* form. Fields marked with an asterisk must be completed with exactly the same wording and must match the procedure billed on the claim.

Table 1 – Instructions for the *Consent for Sterilization Form* (HHS-687)

Consent to Sterilization	
Field	Description
Doctor or Clinic	Enter the name of the doctor or clinic providing information to the patient. If the provider is a physician group, the professional group name can be listed (such as "Westside Medical Group") or all individual names can be listed (such as "Drs. Miller and Smith" or "Dr. Miller and/or Dr. Smith"). Alternatively, one or more names can be listed followed by the phrase <i>and/or associates</i> .
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, an abbreviation can be used, followed by an asterisk; the full name of the operation must then be written at the bottom of the form.
Date	Enter the patient's birth date in month, day and year format. The IHCP requires this information, and it must match the birth date on the claim.
[Name of Individual]	Enter the patient's name in this blank field. The name must be identical to the patient name appearing on the claim form.
Doctor or Clinic	Enter the name of the doctor that will be performing the procedure or the clinic where the procedure will be performed. If the provider is a group, the professional group name can be entered, or all individual names can be listed, or one or more individual names can be entered, followed by the phrase <i>and/or associates</i> .
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, an abbreviation can be used, followed by an asterisk; the full name of the operation must then be written at the bottom of the form.
Signature	The patients must sign their full name here. If the patient is illiterate, the IHCP permits X as the signature with a witness to countersign. The signature must match the name on the claim and consent form.
Date	Enter the date the form is signed, using month, day and year format. This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs." The IHCP calculates the waiting period from this date.
Ethnicity and Race Designation	Ethnicity and race information is voluntary and should be completed only by the patient.

Interpreter's Statement	
Field	Description
[Language]	If an interpreter was used, use this field to indicate the language in which the patient was counseled.
Interpreter's Signature	If an in-person interpreter was used, the interpreter's handwritten signature must be entered in this field. If an interpreter was used via teleconference (phone or video), the person obtaining the consent must write the interpreter's name and ID number (if applicable). The person obtaining the consent must initial, date and provide the method used (phone or video).
Date	Enter the date the interpreter translated the consent form to the patient, using month, day and year format. The date must be on or before the patient's signature date.

Statement of Person Obtaining Consent	
Field	Description
Name of Individual	Enter the patient's name here. The name must be identical to the name listed on the consent form and on the claim.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation at the bottom of the form.
Signature of Person Obtaining Consent	The handwritten signature of the person obtaining consent must be entered in this field. The person providing sterilization counseling can be a physician or the physician's designee, such as an office nurse.
Date	Enter the date consent was taken, using month, day and year format. The signature date of the person obtaining the consent must be the same as the patient's signature date.
Facility	Enter the name of the physician's office or clinic where the patient signed the sterilization consent form. This location may not necessarily be the facility where the operation is performed.
Address	Enter the address of the facility where the patient signed the sterilization consent form. After the <i>Statement of Person Obtaining Consent</i> section is completed, the provider gives the patient a copy of the form.

Physician's Statement	
Field	Description
Name of Individual	Enter the patient's full name. The name must be identical to the names listed on the consent form and the claim.
Date of Sterilization	Enter the specific date of the sterilization procedure, using month, day and year format. This date must be at least 30 days, and not more than 180 days, following the patient's signing the consent form (with previously noted exceptions for premature delivery or emergency abdominal surgery). The date on the claim must match the date entered here.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, an abbreviation with an asterisk can be used; the full name of the operation must then be written at the bottom of the form.
Instructions for use of alternative final paragraphs	The form provides two options: paragraph (1) or (2). Cross out the paragraph not used.

Physician's Statement	
Field	Description
Premature delivery	Check this item if alternative paragraph 2 was selected due to premature delivery. If providers check this item, they must also enter a date of expected delivery (see the next item).
Individual's expected date of delivery	If <i>Premature delivery</i> was selected, enter the patient's expected date of delivery, using month, day and year format. The patient's physician estimates this date based on the patient's history and physical exam.
Emergency abdominal surgery	Check this item if alternative paragraph 2 was selected due to emergency abdominal surgery. If providers check this box, they must indicate the operation performed (see the next item).
Describe circumstances	If <i>Emergency abdominal surgery</i> was selected, indicate the emergency operation performed and any relevant information about the circumstances requiring the emergency operation.
Physician's Signature	The physician who has verified consent and who actually performed the operation must complete this field after the sterilization operation. Signature stamps are not acceptable.
Date	Enter the date the physician signed the consent form, using month, day and year format. The physician's signature date must be on or within 30 days after the sterilization date.
* All "Type of Operation" fields must be worded exactly the same and must match the procedure billed on the claim.	

Sterilization Procedures

IHCP reimbursement is available for the following sterilization procedures.

Note: For sterilizations performed at the time of delivery, providers must bill with modifier XE, XP, XS or XU, as the situation dictates.

Vasectomy

Vasectomies are considered permanent, once-per-lifetime procedures. If a vasectomy has previously been reimbursed for the member, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

Tubal Ligation

Tubal ligations are considered permanent, once-per-lifetime procedures. If a tubal ligation has previously been reimbursed for the member, providers may appeal with documentation that supports the medical necessity for the repeat sterilization.

Hysteroscopic Sterilization With an Implant Device

Hysteroscopic sterilization with an implant device can be performed by a doctor of medicine or a doctor of osteopathy trained in the procedure.

Providers should bill the implantation procedure using CPT code 58565 – *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants*, and the

implant device using HCPCS code A4264 – *Permanent implantable contraceptive intratubal occlusion device(s) and delivery system*, as follows:

- When the procedure is performed in a physician’s office setting, both codes should be billed on the professional claim (*CMS-1500* claim form or electronic equivalent).
- For outpatient hospital or ambulatory surgical center (ASC) billing, CPT code 58565 should be billed along with the appropriate revenue code on the institutional claim (*UB-04* claim form or electronic equivalent). For separate reimbursement of the device, HCPCS code A4264 must be billed on the professional claim (*CMS-1500* claim form or electronic equivalent). Outpatient hospitals and ASCs bill for the device under the professional or durable medical equipment (DME) provider number.

Note: No additional reimbursement is available for the implant device if the procedure is performed in an inpatient setting.

A manufacturer’s cost invoice must be submitted with the claim to support the cost of the device. The IHCP reimburses 120% of the amount listed on the cost invoice. The maximum age for an MSRP or cost invoice is two years from the date of service. Providers will be required to submit the most current MSRP or cost invoice that is not older than two years with claims for manually priced items.

For all claims related to this service, the following additional billing requirements apply:

- Write “**Implant Sterilization**” in a claim note (for an electronic claim) or on the accompanying invoice.
- Submit a valid, signed *Consent for Sterilization* form with the claim.
- Ensure that the primary (principal) diagnosis on the claim is ICD-10 diagnosis code Z30.2 – *Encounter for sterilization*.