INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Family Planning Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Sept. 27, 2016	Scheduled update	FSSA and HPE
2.0	Policies and procedures as of July 1, 2017 Published: Oct. 24, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of July 1, 2018 Published: Feb. 12, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of Dec. 1, 2019 Published: Feb. 6, 2020	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of Oct. 1, 2020 Published: Nov. 24, 2020	Scheduled update	FSSA and Gainwell
6.0	Policies and procedures as of July 14, 2022 Published: July 14, 2022	Scheduled update	FSSA and Gainwell
7.0	Policies and procedures as of Oct. 1, 2023 Published: Jan. 30, 2024	Scheduled update: • Reorganized and edited text as needed for clarity • Added the *Transferring LARC Products* section • Added reimbursement information for FQHCs and RHCs in the *Billing for LARC Devices* section • Added reference to Obstetrical and Gynecological Services module in the *Informed Consent for Sterilization* section • Added a note about the change in MSRP and cost invoice requirement in the *Hysteroscopic Sterilization With an Implant Device* section	FSSA and Gainwell

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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 or Hoosier Healthwise 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 provided to individuals of childbearing age 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

> *Note: The IHCP Family Planning Eligibility Program provides 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 page 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* page at in.gov/medicaid/providers.

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
- Intrauterine devices (IUDs)
- Contraceptive implants

[1] *CPT copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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 Devices

Long-acting reversible contraception (LARC) devices are defined as implantable devices that remain effective for several years to prevent pregnancies. Devices 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

IHCP LARC coverage was updated to comply with *Indiana Code IC-12-15-47*. Under this new legislation, LARC intrauterine devices and birth control implants obtained for a Medicaid recipient may be transferred to another Medicaid recipient if the LARC was not delivered to, implanted in or used on the original Medicaid recipient to whom the LARC was prescribed if the LARC product meets the following conditions:

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

Effective for dates of service on or after Oct. 1, 2023, the IHCP will reimburse LARC claims through the pharmacy benefit for IHCP enrolled pharmacies meeting the resell, reuse or redistribute requirements set forth in *IC 25-26-13-25* only.

Claims for transferred LARC products will need to be reversed for the original Medicaid recipient and resubmitted for the Medicaid recipient to whom the product is being transferred. Pharmacy providers that do not meet *IC 25-26-13-25* requirements for dispensing returned products will no longer be reimbursed for LARC claims. The IHCP will continue to reimburse IHCP enrolled providers for LARC claims submitted through the medical benefit.

Providers may access the following links for information about purchasing LARC products, including the manufacturer-offered 90-day line of credit:

- Paragard Access Center at hcp.paragard.com
- Liletta – Healthcare Professionals at lilettahcp.com
- Bayer Women's HeathCare (Kyleena, Mirena and Skyla) at whcsupport.com
- Organon Pro (Nexplanon) at organonpro.com

Billing for LARC Devices

For certain LARC devices, when 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 device must be submitted on a professional claim (CMS-1500 claim form or electronic equivalent). For applicable HCPCS codes, see *Obstetrical and Gynecological Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

These same LARC devices are also reimbursable for **outpatient hospital** or **ambulatory surgical center (ASC) settings**, 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.

Effective for dates of service on or after Nov. 1, 2022, the IHCP separately reimburses federally qualified health centers (FQHCs) and rural health clinics (RHCs) for LARC devices from the prospective payment

system (PPS) rate. FQHC and RHC providers should bill the appropriate HCPCS code with place of service (POS) code 71 and without the HCPCS code T1015. Providers can bill for LARC devices and supplies on the same day as an encounter that has a T1015 – but it must be billed on a separate claim.

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* page at 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 provider renders the patient sterile as a result of an 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, when billing codes that would otherwise require a *Consent for Sterilization* form, the provider must include appropriate documentation to prevent the claim from denying. Such documentation may be either an operative report or a 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

A properly completed *Consent for Sterilization* form (HHS-687 or HHS-687-1) must accompany all claims for voluntary sterilization and related services. This requirement extends to all providers: attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services. Providers must attach a copy of the *Consent for Sterilization* form to each claim.

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* page at 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)

Field	Description
Consent to Sterilization	
Doctor or Clinic	Enter the name of the doctor or clinic. Providers can prestamp this line. 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 *and/or associates*.
*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 out the full name of the operation 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]	Providers must 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	Providers can prestamp this field. If the provider is a group, providers can list the professional group name, all names, or one or more names followed by the phrase *and/or associates*.
*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 on the bottom of the form.

Field	Description
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	The patient must enter the date the form is signed in month, day and year format. The date must be handwritten. The IHCP calculates the waiting period from this date.
Ethnicity and Race Designation	The information is voluntary and should be completed only by the patient.
Interpreter's Statement	
[Language]	If an interpreter was used, use this field to indicate the language in which the patient was counseled.
Interpreter's Signature	The interpreter must sign here.
Date	Enter the date the interpreter translated the consent form to the member. The interpreter must hand-write the date in month, day and year format, and it must be the same date the individual signed the consent form.
Statement of Person Obtaining Consent	
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. The member, the member's legal representative, or a staff member in the physician's office or clinic can complete this field.
*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 person providing sterilization counseling can be a physician or the physician's designee, such as an office nurse.
Date	The signature date of the person obtaining the consent must be the same as the date the member signed the consent form. The person obtaining consent must hand-write this date in month, day and year format.
Facility	Enter the name of the physician's office or clinic where the patient signed the sterilization consent form, which may not necessarily be the facility where the operation is performed. Providers can prestamp the name of the facility.
Address	Enter the address of the facility where the patient signed the sterilization consent form. The provider can prestamp the address. After the patient completes the *Statement of Person Obtaining Consent* section, the provider gives the patient a copy of the form.
Physician's Statement	
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, in month, day and year format, the specific date of the sterilization procedure. This date must be at least 30 days, and not more than 180 days, following the member'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, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation at the bottom of the form.

Field	Description
Instructions for use of alternative final paragraphs	The form provides two options: paragraph (1) or (2). Cross out the paragraph not used.
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	The member's physician estimates the date based on the patient's history and physical.
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	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	The physician's signature must be dated and must be on or within 30 days after the sterilization date. The physician must hand-write the date in month, day, year format.
** 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.

> *Note: Effective Jan. 7, 2024, 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.*