MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Subject: ***Plan First!*** Family Planning Waiver

Effective: July 1, 2006

Programs Affected: Family Planning Waiver

The purpose of this bulletin is to announce the new ***Plan First!*** Family Planning Waiver.

The Michigan Department of Community Health (MDCH) submitted an application for a Section 1115 Family Planning Demonstration Waiver to provide family planning services to women who otherwise would not have medical coverage for these services. The waiver was approved by the Centers for Medicare and Medicaid Services (CMS) and will be effective July 1, 2006. ***Plan First!*** is the name of this single service family planning benefit program.

The attached ***Plan First!*** Family Planning Waiver Chapter details the services available under the waiver, as well as eligibility policy and process related to the waiver. Coverages described in the chapter will be effective for dates of service on and after July 1, 2006. In addition, this bulletin includes a current list of ***Plan First!*** Family Planning Waiver codes.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Susan Moran, Acting Deputy Director
Medical Services Administration

Plan First! Family Planning Waiver Chapter

SECTION 1 – GENERAL INFORMATION

This chapter applies to Family Planning Clinics (Provider Type 23), MDs, DOs, Certified Nurse-Midwives [CNMs] and Nurse Practitioners [NPs] (Provider Types 10, 11 and 77), Laboratory (Provider Type 16), Outpatient Hospitals (Provider Type 40), and Pharmacies (Provider Type 50).

Family planning services help women to reduce the incidence of closely spaced pregnancies and to decrease the number of unintended pregnancies. This in turn leads to healthier pregnancies, better birth outcomes and improved child health. It is the goal of Michigan Department of Community Health (MDCH) to assure that family planning services are available and accessible to eligible women without regard for living arrangement, marital status, or race. Family planning services may be provided and billed by family planning clinics, primary care physicians (MDs and DOs), and other Medicaid approved providers (i.e., Certified Nurse-Midwives and Nurse Practitioners).

Through this waiver, MDCH offers eligibility for Medicaid family planning services to women who:

- are of childbearing age (19 through 44 years of age);
- are not currently covered by Medicaid or the Adult Benefits Waiver (Adult Medical Program); and
- have family income at or below 185% of the federal poverty level (FPL).

Coverage is limited to women who reside in Michigan and meet Medicaid citizenship requirements. (Detailed eligibility requirements for ***Plan First!*** are discussed in the Eligibility Section of this chapter.)

1.1 EXPLANATION OF SERVICES

A family planning clinic or a primary care provider (i.e., MD, DO) or other Medicaid-approved provider (i.e., Certified Nurse-Midwife [CNM], Nurse Practitioner [NP]) can provide family planning services. Family planning clinics are limited to billing for those family planning services as identified in the Family Planning Chapter of this manual.

Beneficiaries eligible for this waiver are limited to the receipt of family planning services only. Family planning services are defined as any medically approved means, including diagnostic evaluation, medications, and supplies, for voluntarily preventing or delaying pregnancy. Covered services include:

- Office visits for family planning related services. This includes preventive evaluation and management office visits and other office/outpatient visits for family planning services.
- Contraceptives, including oral contraceptives and injectables.
- Contraceptive supplies and devices for voluntarily preventing or delaying pregnancy.
- Laboratory testing and pharmaceuticals related to contraceptive management or initial treatment of sexually transmitted infections (STIs).
- Sterilizations completed in accordance with current Medicaid policy.

A list of covered services is provided on the MDCH website in the MDCH Family Planning Waiver Code List. (Refer to the Directory Appendix for website information.)

Pharmaceuticals must be furnished under the supervision of a physician or dispensed by a pharmacy for eligible beneficiaries of childbearing age. Family planning supplies not furnished by the provider as part of the medical services must be prescribed by a physician and obtained at a pharmacy. Exceptions are condoms and similar supplies which do not require a prescription.

1.2 Beneficiary Co-pays

There are no beneficiary co-pays for services, pharmaceuticals or supplies related to family planning.

1.3 Reimbursement

MDCH reimburses for services provided to beneficiaries who meet the eligibility requirements of the ***Plan First!*** Family Planning Waiver. Only family planning services are covered under this waiver. Providers must include the V25 diagnosis code series on the claim in order to receive reimbursement.

Family planning clinics are limited to billing those codes as specified in the MDCH Family Planning Clinic Database available on the MDCH website. (Refer to the Directory Appendix for website information.) The ***Plan First!*** Family Planning Waiver does not reimburse for physician services, lab tests, prescription drugs, or supplies beyond those specified in the Family Planning Clinic Database when billed by a Family Planning Clinic.

Michigan Medicaid fee screens apply to services provided to ***Plan First!*** beneficiaries. General billing instructions are located in the Billing & Reimbursement for Professionals Chapter of this manual.

1.4 Diagnosis Codes

The appropriate diagnosis code(s) from the International Classification of Diseases - Ninth Revision - Clinical Modification (ICD-9-CM) must be indicated on the claim form when billing for family planning services. Family planning services are limited to the V25 diagnosis code series range. Providers must enter the appropriate code on the claim form.

Section 2 – Covered Services

2.1 Office Visits

2.1.A. Preventive Medicine Services - Evaluation and Management/Office Visits

Eligible beneficiaries are limited to receiving preventive services for purposes of delaying or preventing pregnancy (i.e., family planning services). Services provided must be in accordance with the standards of care established for contraceptive management for initial and follow-up services as needed. The appropriate lab services required to manage contraceptive services are available when completed by the practitioner or laboratory. Providers must bill using the appropriate Preventive Medicine Evaluation and Management (E/M) codes from the Current Procedural Terminology (CPT) manual and/or the Healthcare Common Procedure Coding System (HCPCS). Counseling services are considered a part of E/M services. As such, no separate reimbursement is available for counseling-only services. The appropriate E/M code that most closely describes the service provided must be billed.

2.1.B. Information and Education Regarding Contraceptive Methods

Beneficiaries must be given information and education for all methods of contraception available, including reversible methods (e.g., oral, emergency, injectable, implant, IUD, diaphragm, cervical cap, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (e.g., tubal ligation). Education regarding all contraceptive methods must include relative effectiveness, common side effects, risks, appropriate use, and difficulty in usage. Basic information concerning sexually transmitted infections (STIs) must also be discussed. Prescriptions for a contraceptive method must reflect the beneficiary's choice, except where such choice is in conflict with sound medical practice.

2.1.C. Problem Visits

Beneficiaries should be encouraged to return whenever they have specific problems related to the contraceptive method or wish to have additional guidance or service, including additional supplies. This program covers only those visits related to family planning. All beneficiaries, 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.

2.2 Laboratory Services

Laboratory testing related to contraceptive management or STIs is a covered service. The practitioner or a Clinical Laboratory Improvement Act (CLIA) laboratory may provide services. Family planning clinics are limited to the lab services listed in the Family Planning Clinic Database and can bill only for services actually performed by the family planning clinic.

Laboratory services provided under this waiver must comply with all requirements contained in the Laboratory Chapter of this manual, including CLIA certification, daily reimbursement limits, and services being billed by the rendering provider.

2.3 Sterilization

A sterilization procedure is defined as any medical procedure, treatment, or operation for the purpose of rendering a female beneficiary permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under the ***Plan First!*** Family Planning Waiver's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy, hysterectomy). Refer to the Sterilization section of the Practitioner or Hospital chapters of this manual for other coverage requirements related to sterilizations.

2.4 Pharmaceuticals

Practitioners may dispense and receive reimbursement for contraceptives and pharmaceutical supplies. Oral contraceptives dispensed may not exceed a six-month supply, and the Nuvaring and contraceptive patches should not exceed a three-month supply. All other contraceptive supplies should be dispensed for one month, with the exception of implants and hormonal contraceptives such as Depo Provera, which is one injection every three months. If the only service provided is supplies, no visit code may be billed. A billing unit must equal a billing quantity of one on the claim. The products may also be prescribed by a physician and dispensed by a Medicaid-enrolled pharmacy. The Pharmacy Chapter of this manual or the local pharmacy may be referenced/contacted for details.

Section 3 - Excluded Services and Coordination of Care

The ***Plan First!*** Family Planning Waiver does **not** include coverage of abortions or treatment of infertility.

Inpatient hospital services are **not** a covered benefit of this waiver.

Should a beneficiary need additional services beyond what is covered under the waiver, the provider may either provide the services and work with the beneficiary to identify payment options, or they may refer or inform the beneficiary how to access primary care services at the nearest community health center. These community health centers are also known as Federally Qualified Health Centers (FQHC). A list of FQHCs can be found on the MDCH website. (Refer to the Directory Appendix for website information.)

SECTION 4 – ELIGIBILITY

4.1 ELIGIBILITY DETERMINATION AND VERIFICATION

The central office of the Department of Human Services (DHS) determines eligibility for the ***Plan First!*** Family Planning Waiver. Once eligibility is determined, the beneficiary is issued a **mihealth** card. ***Plan First!*** beneficiaries are identified with a scope/coverage code 1Y. Before providing services, providers must verify eligibility using the Eligibility Verification System (EVS). (Refer to the Beneficiary Eligibility Chapter of this manual for additional information).

Once a beneficiary is determined eligible for ***Plan First!*** family planning services, program eligibility will be for a 12-month period. Re-determination for eligibility will be completed every 12 months. A beneficiary's coverage may continue for the duration of the waiver as long as the eligibility criteria are met. Incarcerated women are not eligible for this coverage.

The begin date of eligibility for ***Plan First!*** is the first day of the month the application is received by DHS via US mail, fax or interoffice transfer. Questions regarding ***Plan First!*** coverage and Fee For Service (FFS) billing should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information.)

4.2 ELIGIBILITY REQUIREMENTS

Prior to enrolling women into the ***Plan First!*** program, DHS will evaluate the applicant based on information provided for eligibility for other Medicaid programs. To enroll in the ***Plan First!*** program, all applicants must fill out and submit a ***Plan First!*** Family Planning Program Application (form MSA-1582).

MDCH provides family planning service coverage under the waiver to Michigan residents who meet all of the following criteria:

4.2.A. GENDER

Applicant must be female. This program will provide services to women only.

4.2.B. AGE

The program will cover women ages 19 through 44.

The applicant must be 19 through 44 years of age. ***Plan First!*** coverage will not begin before the applicant's 19th birthday. ***Plan First!*** coverage will end the last day of the month in which the applicant turns 45 years of age.

4.2.C. INCOME REQUIREMENTS

4.2.C.1. INCOME

The adjusted gross income must be at or below 185% of the FPL. All income (earned and unearned) of the fiscal group must be reported on the application. Self-declaration of income by the applicant must include payee's name, relationship and the gross amount of monthly income. If the responsible parent/guardian receives child support on behalf of a child, then that amount must be considered as income for the child, unless it is an arrearage for child support.

4.2.C.2. EXCLUDED INCOME

Earnings of a child under age 19, if the child is living with the applicant who provides care and supervision, are excluded from determining ***Plan First!*** eligibility.

4.2.C.3. Income Deductions

The following expenses are deducted from income:

- Standard work expense of $90 from the countable earnings of each person who is working (applicant and/or spouse).
- Child care payments for a child for which the applicant claims a child care expense, regardless of the actual amount of the expense. A standard $200 is deducted monthly per child.
- $50 from the total child support received for each child.
- 65% of rental income for administrative purposes, or the actual rental expenses if the landlord claims a larger expense.
- For self-employment, the actual operating expenses claimed or 25% of the gross earnings (whichever is higher) benefiting the applicant are deducted. Operating expenses are based on the family's statement for self-employed persons.
- Court ordered support paid by a fiscal group member for a child who does not live with the fiscal group. Arrearage amounts are not included in this deduction.
- $60 from guardianship/conservator fees paid.

4.2.C.4. Child Care

Child care (dependent care) may be deducted only if the following are met:

- Child must be living with the family member who is paying for the care; and
- Child must be that family member's child; and
- Child must be under age 15, or under age 18 and need care because of a mental or physical limitation; and
- Other parent is not available to provide the child care due to conflicting work, school or training schedules.

4.2.C.5. Assets

No asset test is used.

4.2.D Citizenship Requirements

The applicant must be a citizen of the United States or a qualified alien.

A qualified alien is:

- Lawfully admitted for permanent residence under the Immigration and Nationality Act (INA); or
- Granted asylum under Section 208 of the INA; or
- A refugee admitted to the United States under Section 207 of the INA; or
- Paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year; or
- Waiting deportation which is being withheld under Section 241(b)(3) or 243(h) of the INA; or
- Granted conditional entry pursuant to Section 203(a)(7) of the INA; or
- A Cuban/Haitian entrant; or

- An individual who has been battered or is subject to extreme cruelty in the U.S. by a U.S. citizen or legal permanent resident spouse or parent, or by a member of the spouse's or parent's family living in the same household, or is the parent or child of a battered person.

Alien status can be verified by:

- Alien Registration Receipt Card (I-551)
- I-94 form stamped "Processed for I-551", "Cuban/Haitian Entrant (Status Pending)", "parole", "212(d) (5)", or "Form I-589 Filed"
- I-94 form indicating admission into the United States from Cuba or Haiti and letter or notice from the Bureau of Citizenship and Immigration Services indicating ongoing (not final) deportation, exclusion or removal proceedings
- Passport stamped "Processed for I-551 Temporary Evidence of Lawful Admission for Permanent Residence"

Any other notations on the I-94 or other forms (e.g., visa) are not acceptable and the applicant is not eligible.

4.2.E. Residency

The applicant must be a resident of the state of Michigan. A person is considered a resident if she lives in Michigan and intends to remain in Michigan. The applicant's or court-appointed guardian's statement of intent to remain or work in Michigan is verification of Michigan residency. Incarcerated women are not eligible for this coverage.

4.2.F. Social Security Number (SSN)

All applicants must have a Social Security Number. The applicant's statement of the SSN or pending SSN is acceptable verification.

4.2.G. Insurance Coverage

The applicant can be covered under a comprehensive health insurance policy (group or private). Private insurance coverage, if any exists for family planning related care, must be utilized first. The family planning waiver is the secondary payer of services if private insurance coverage exists. Reimbursement for services is specified in the Billing & Reimbursement for Professionals and the Coordination of Benefits chapters of this manual.

4.2.H. Medicaid Coverage

The applicant cannot be covered by Medicaid or the Adult Benefits Waiver (Adult Medical Program).

Section 5 – Appeals

The appeals process is outlined in the Administrative Tribunal Policy and Procedures Manual and can be found on the MDCH website. Any questions regarding this appeal process should be directed to the Administrative Tribunal. (Refer to the Directory Appendix for contact information.)

Plan First!
Family Planning Covered Codes

This document provides a current list of covered codes for the ***Plan First!*** family planning program. This information can be found on the MDCH website at www.michigan.gov/mdch, click on "Providers," "Information for Medicaid Providers," and then on "Provider Specific Information." This list will be updated when codes are added or deleted.

The ***Plan First!*** family planning program is a limited services benefit which covers office visits, routine laboratory, diagnostic tests and surgical procedures associated with family planning. Initial treatment for Sexually Transmitted Infections (STI) is covered when provided in conjunction with other family planning services. The ***Plan First!*** family planning program will cover all pharmaceuticals within the therapeutic drug classes appearing in Table 6 as they relate to family planning, initial treatment of STI's and sterilization services.

The Current Procedural Terminology (CPT) codes listed below in Tables 1 - 4 will only be covered when accompanied by one of the ICD-9-CM diagnosis codes identified in Table 5. All services billed must include an ICD-9-CM diagnosis code in the V25 series on the claim form. Services provided under this waiver are limited to the codes identified in this document.

Covered CPT Codes

Table 1

Evaluation and Management (Office Visit) Codes Codes are covered only if they are provided for a family planning visit.	
CPT Code	Description
99201	Office/outpatient visit, new
99202	Office/outpatient visit, new
99203	Office/outpatient visit, new
99211	Office/outpatient visit, established
99212	Office/outpatient visit, established
99213	Office/outpatient visit, established
99385	Preventive visit, new, ages 18-39
99386	Preventive visit, new, ages 40-64
99395	Preventive visit, established ages 18-39
99396	Preventive visit, established, ages 40-64

Table 2

Procedure and Laboratory Codes Codes are covered only if they are provided during an initial, annual or periodic family planning visit	
CPT Code	Description
11975	Insertion of contraceptive cap
11976	Removal of contraceptive cap
11977	Removal/reinsertion of contraceptive cap
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of intrauterine device
58301	Removal of intrauterine device
90772	Therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular
80048	Basic Metabolic Panel

Procedure and Laboratory Codes Codes are covered only if they are provided during an initial, annual or periodic family planning visit	
80053	Comprehensive Metabolic Panel
80076	Hepatic Function Panel
81000	Urinalysis, non-auto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, non-auto w/o scope
81003	Urinalysis, auto w/o scope
81015	Microscopic exam of urine
81025	Urine pregnancy test
82465	Assay, blood/serum cholesterol
82947	Assay, glucose, blood quantitative
82948	Reagent strip/blood glucose
84703	Chorionic gonadotropin assay
85013	Spun microhematocrit
85014	Hematocrit
85018	Hemoglobin
86592	Syphilis test, qualitative (e.g., VDRL, RPR, ART)
85660	RBC sickle cell test
86689	HTLV or HIV antibody, confirmatory test (e.g., Western Blot)
86701	HIV – 1
86702	HIV – 2
86703	HIV – 1 and HIV – 2 single assay
86781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)
87070	Culture, bacterial; any other source except urine, blood or stool, with isolation and presumptive identification of isolates
87075	Culture any source, except blood, anaerobic with isolation and presumptive identification of isolates
87077	Culture aerobic identify
87081	Culture screen only
87110	Culture, chlamydia, any source
87205	Smear, gram stain
87207	Smear, special stain
87210	Smear, wet mount, saline/ink
87270	Chlamydia trachomatis AG IF
87273	Herpes simplex virus type 2
87274	Herpes simplex virus type 1
87340	Hepatitis B surface antigen (HbsAg)
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple step method; Chlamydia trachomatis
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by a physician
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision.
88143	Cytopathology, with manual screening and re-screening under physician supervision

Procedure and Laboratory Codes Codes are covered only if they are provided during an initial, annual or periodic family planning visit	
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, with manual screening and re-screening under physician supervision
88166	Cytopathology, with manual screening and computer assisted re-screening under physician supervision
88167	Cytopathology, manual screening and computer assisted re-screening using cell selection and review under physician supervision

Table 3

Contraceptive Supply Codes	
CPT/HCPCS Code	Description
A4260	Levonorgestrel (contraceptive) implants system, including implants and supplies
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male
A4268	Contraceptive supply, condom, female
A4269	Contraceptive supply, spermicide (e.g., foam, gel)
J0696	Injection, Ceftriaxone sodium, per 250 mg
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg
J1056	Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25mg
J7300	Intrauterine copper contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7303	Hormone containing vaginal ring, each
J7304	Hormone containing patch, each
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gm
S4989	Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies
S4993	Contraceptive pills for birth control

Table 4

Sterilization Procedure Codes	
CPT Code	Description
00851	Anesthesia, tubal ligation/transection
58565	Bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring), vaginal or suprapubic approach
58670	Laparoscopy, surgical, with fulguration of oviducts (with or without transection)
58671	Laparoscopy with occlusion of oviducts by device (band, clip or Falope ring)

ICD-9-CM Codes

Table 5

ICD-9-CM Diagnosis Codes	
ICD-9-CM Code	Description
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive device
V25.03	Encounter for emergency contraceptive counseling and prescription
V25.09	Other counseling and advice for contraceptive management
V25.1	Insertion of Intrauterine Contraceptive
V25.2	Sterilization
V25.3	Menstrual Extraction
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

Pharmaceuticals

The waiver will cover all medications in the therapeutic drug classes identified in Table 6.

Table 6

Drug Therapeutic Class	
Description	**Description**
Contraceptives, Non-systemic	Cephalosporins
Systemic Contraceptives	Trimethoprim
Tetracyclines	Antivirals
Penicillins	Narcotic Analgesics (for sterilization surgical procedures)
Erythromycins	Non-Narcotic Analgesics (for sterilization surgical procedures)
Streptomycins	